# HEALTH AND WELLBEING BOARD

# AGENDA

HARTLEPOOL BOROUGH COUNCIL

**Friday 14th September 2018**

**at 10.00 a.m.**

**in Committee Room 'B'**
**Civic Centre, Hartlepool.**

MEMBERS: HEALTH AND WELLBEING BOARD

**Prescribed Members:**
Elected Members, Hartlepool Borough Council – Councillors C Akers-Belcher, Buchan, Harrison and Thomas
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group – Dr Timlin and Alison Wilson
Interim Director of Public Health, Hartlepool Borough Council - Dr Peter Brambleby
Director of Children's and Joint Commissioning Services, Hartlepool Borough Council – Sally Robinson
Director of Adult and Community Based Services, Hartlepool Borough Council, Jill Harrison
Representatives of Healthwatch - Margaret Wrenn and Ruby Marshall

**Other Members:**
Chief Executive, Hartlepool Borough Council – Gill Alexander
Director of Regeneration and Neighbourhoods, Hartlepool Borough Council – Denise Ogden
Representative of the NHS England – Dr Tim Butler
Representative of Hartlepool Voluntary and Community Sector – Tracy Woodhall
Representative of Tees, Esk and Wear Valley NHS Trust – Dominic Gardner
Representative of North Tees and Hartlepool NHS Trust – Deepak Dwarakanath / Julie Gillon
Representative of Cleveland Police, Jason Harwin
Representative of GP Federation – Fiona Adamson
Representative of Headteachers - Julie Thomas

Observer – Statutory Scrutiny Representative, Hartlepool Borough Council – Councillor Loynes

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 June 2018.

3.2 To receive the minutes of the meeting of the Children's Strategic Partnership held on 21 March 2018.

4. **ITEMS FOR CONSIDERATION**

4.1 Drug and Alcohol Service Needs Assessment and Next Steps for Service Delivery – *Interim Director of Public Health*

4.2 Sustainability and Transformation Partnership / Integrated Care Systems Update - *Hartlepool and Stockton-on-Tees CCG*

4.3 Update on Healthy Weight Strategy – *Interim Director of Public Health*

4.4 Joint Health and Wellbeing Strategy (2018-2025) – Implementation and Monitoring Update – *Interim Director of Public Health*

4.5 Audit and Governance Committee Work Programme 2018/19 – Investigation In to the Provision of Preventative Mental Health Services in Hartlepool – *Statutory Scrutiny Officer*

4.6 Departmental Restructure – *Director of Children's and Joint Commissioning Services*

4.7 Better Care Fund 2018/19: Q1 Performance Update - *Director of Adult and Community Based Services*

4.8 Presentation - CCG Annual Report – *Hartlepool and Stockton-on-Tees CCG*

4.9 HealthWatch Hartlepool and Hartlepool Deaf Centre Joint Investigation of Deaf Patient Experience of Local GP and Hospital Services – Update - *Healthwatch Hartlepool and Hartlepool Deaf Centre*

4.10 HealthWatch Hartlepool and Hartlepool Carers Joint Health Care Experience Consultation - *Healthwatch Hartlepool*

**5 ITEM FOR INFORMATION**

5.1 38 Degrees – Petition to the Secretary of State for the Reopening of University Hospital of Hartlepool A&E – *Statutory Scrutiny Officer*

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

Date of next meeting – Friday 10 December 2018 at 10.00 a.m. at the Civic Centre, Hartlepool.

# HEALTH AND WELLBEING BOARD

## MINUTES AND DECISION RECORD

25 June 2018

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

**Present:**

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

**Prescribed Members:**
Elected Members, Hartlepool Borough Council – Councillors Buchan, Harrison and Thomas
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group – Ali Wilson
Interim Director of Public Health, Hartlepool Borough Council - Dr Peter Brambleby
Director of Children's and Joint Commissioning Services, Hartlepool Borough Council – Sally Robinson
Director of Adult and Community Based Services, Hartlepool Borough Council, Jill Harrison
Representatives of Healthwatch - Margaret Wrenn

**Other Members:**
Representative of Tees, Esk and Wear Valley NHS Trust – Dominic Gardner
Representative of North Tees and Hartlepool NHS Trust – Julie Parkes (as substitute for Julie Gillon)
Representative of GP Federation – Fiona Adamson

Also in attendance:-

Graeme Niven, Chief Finance Officer, Hartlepool and Stockton-on-Tees Clinical Commissioning Group
Judy Gray, Healthwatch

Officers: Joan Stevens, Statutory Scrutiny Officer
Amanda Whitaker, Democratic Services Team

## 1. Apologies for Absence

Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group – Dr Nick Timlin
Representatives of Healthwatch - Ruby Marshall
Representative of the NHS England – Dr Tim Butler
Representative of Cleveland Police - Jason Harwin
Representative of North Tees and Hartlepool NHS Trust – Julie Gillon

## 2. Declarations of interest by Members

Councillor Akers-Belcher and Councillor Thomas reaffirmed interests as employees of Healthwatch Hartlepool.

## 3. Minutes

(i) The minutes of the meeting held on 5 March 2018 had been circulated for confirmation.

With reference to minute 52 – Review of Mental Health and Wellbeing Services for Children and Young People - the representative of the Tees, Esk and Wear Valley NHS Trust highlighted an omission from the minutes and referred to his comments at the meeting that the referral rate in Hartlepool was higher than anywhere else in the country.

The minutes were confirmed, subject to the minutes being amended to include the above comments.

(ii) The minutes of the meeting of the Children's Strategic Partnership held on 31 January 2018 were received.

## 4. CQC Local System Review – Action Plan Update *(Director of Adult and Community Based Services)*

The report provided the Board with an update on progress against the action plan that had been developed following the Care Quality Commission's Local System Review in Hartlepool. The Board was reminded that the Care Quality Commission had undertaken a Local System Review in Hartlepool in September / October 2017. The final report had been published on the CQC website on 8 December 2017 following a Local Summit on 7 December 2017 where the CQC had presented the report and work had began to develop an action plan in response to the areas for improvement that had been identified. Following the review, the local system had been required to develop an action plan for submission to the Department of Health in January 2018. This had been reported to the Board in February 2018 and it was noted that implementation and monitoring of the action plan would be overseen by the Board, which involved representatives from all of the key partners. The document, appended to the report, summarised progress to date against the agreed actions.

**Decision**

The Board noted progress against the action plan and agreed to receive a further update on implementation of the action plan in December 2018.

## 5. Hartlepool and Stockton-on-Tees Financial Plan 2018/19 *(Clinical Commissioning Group)*

The Board received a presentation by Graeme Niven, Chief Finance Officer, Hartlepool and Stockton-on-Tees Clinical Commissioning Group, which addressed the following issues:-

- Allocations – currently the CCG is below its fair share of allocation by approximately 1%. The allocation is split into three areas, programme for patient care, primary care delegated for GP practices and running costs for the management of the CCG.
- Summary financial plan – Expenditure is planned based on increasing population, increased age profile and an increase in disease prevalence. Planned expenditure included expected inflationary increases and for other investment based on the NHSE expectations. The demands for services exceeded the allocations received and the CCG had, therefore an efficiency plan.
- Efficiency plan – the key areas for efficiency plans are in acute spend, prescribing in primary care and continuing healthcare.
- Risk and mitigations – The efficiency plan had to be risk assessed with mitigations identified to manage the identified risks.

Board Members discussed issues arising from the presentation. Representatives of the Clinical Commissioning Group responded to issues raised by Board Members including the implications of the CCG having 'financial recovery' status. The background to the cost of continuing health care was debated by a number of Members. The representative of the Clinical Commissioning Group highlighted the prevention agenda to keep people well and living in their own homes for longer. The work undertaken by Healthwatch was highlighted together with the significance of Better Care Funding. The support for lobbying to be as wide as possible, for increased funding, was appreciated. The Chief Finance Officer responded to a question from the Chair of the Board regarding the impact on the budget of the vacant space in the One Life Centre. Clarification was provided also in relation to the lease on the property and an explanation was provided regarding unspent prevention funding provided to the voluntary sector which had been addressed through the provisions of a recurring budget for Hartlepool and Stockton. In response to concerns regarding use of public buildings for confidential mental health discussions with patients, assurance were provided by the representative of the Tees, Esk and Wear Valley NHS Trust.

**Decision**

The presentation, and issues arising from the presentation, were noted.

## 6. Health Status Update – Presentation *(Interim Director of Public Health)*

The Board received a presentation by the Interim Director of Public Health which provided an update in relation to the health status of the Hartlepool population. Recent outcome updates had been circulated in terms of the Child Health Profile (June 2018) and Public Health Outcomes Framework: Spine Charts. The presentation addressed the following:-

- Breastfeeding initiation statistics
- School readiness: the percentage of children achieving a good level of development at the end of reception class (Hartlepool)
- Mortality rate from causes considered preventable (Hartlepool)
- Life expectancy and affluence
- Length of Life versus quality of life
- Myth-busting: Prevention.
- JSNA "deep dive": substance misuse, including alcohol

Board Members discussed issues arising from the presentation including reasons for the breast feeding initiation statistics. Board Members sought assurances regarding availability of breast feeding support and public attitude towards breast feeding including breast feeding in public places. The Interim Director of Public Health responded to concerns expressed at the meeting regarding the unacceptable wide gap in life expectancy in the town and the number of years of ill health before end of life highlighted by the presentation. Board Members discussed also the screening programmes uptake with agreement that attending at screening appointments should be encouraged.

**Decision**

The Board noted the presentation.

## 7. Joint Health and Wellbeing Strategy (2018-2025) – Implementation And Monitoring Update *(Interim Director of Public Health)*

The report sought approval to a revised process for the implementation and monitoring of the Joint Health and Wellbeing Strategy (2018-2025) which had been approved by Full Council and the Governing Body of the Hartlepool and Stockton on Tees Clinical Commissioning Group, in March 2018. As part of the Strategy, five 'Deep Dive' project areas had been identified: A series of output / outcome measures had been also identified, against which implementation of the JHWS was to be monitored. As part of the process, it had been agreed that each meeting of the Board would consider progress against a single deep dive area, as detailed in the table set out in the report. This was to be followed by the presentation of an annual 'baseline' report, as part of the Board's annual Face the Public Event. Further to the decision of the Board on the 5 March 2018, it was clear that the level and complexity of

the work required to effectively progress the output/outcome measures for each deep dive area would be significant. On this basis, it was recommended that the Board focus its attentions on one specific deep dive area per Municipal year, allowing sufficient time for a detailed piece of work to be undertaken as follows:-

| **Health & Wellbeing Board Meeting** | **Deep Dive Project Areas** |
|---|---|
| 2018/19 | Reduce Drug and Alcohol Harm |
| 2019/20 | Dying Well / Voluntary Sector and Community Assets |
| 2020/21 | Improving Mental Health and Wellbeing |
| 2021/22 | Reduce Health Inequalities |

Subject to approval of the reviewed process, the Board was asked to consider the potential process for consideration of progress against the output / outcome measures relating to the 'Reduce Drug and Alcohol Harm' deep dive area. In going forward, it would be necessary to identify appropriate lead committees / bodies and officers to progress the desired outcome and output measures (as detailed in the JHWS and potentially added during consideration of the deep dive area by the Board). Nominations are sought in order to fill the positions as detailed in the table set out in the report.

**Decision**

(i) The Board agreed the reviewed process for the implementation and monitoring of the JWHS, as detailed in the report, and the selection of 'Reducing Drug and Alcohol Harm' as the deep dive area for consideration by the Board in 2018/19.

(ii) The review process, as outlined in the report, was approved.

(iii) It was agreed that nominations for the appropriate lead committees / bodies; lead officer and partner representatives to progress the desired outcome and output measures be forwarded immediately following the meeting.

(iv) That, in response to a referral from the Safer Hartlepool Partnership on the 9th February 2018 (minute number 52 refers), the provision of a report to the Finance and Policy Committee be deferred until October 2018, to allow the inclusion of feedback from the Board in relation to the wider provision of drug and alcohol preventative services.

## 8. Better Care Fund 2017/18: Q4 Performance Update

*(Director of Adult & Community Based Services)*

The report provided the background to the Better Care Fund reporting

arrangements and summarised the National Conditions and performance measures. Performance reports were submitted to NHS England on a quarterly basis. The Q4 return covering the period January – March 2018 had been submitted in April 2018 and had confirmed that all national conditions continued to be achieved. An analysis of performance data had also been provided which was summarised in the report.

It was reported at the meeting that despite a challenging target there had been a considerable improvement with regard to delayed transfers of care from hospital. It was also noted that targets in relation to care home admissions and non elective admissions to hospital had been achieved in 2017/18. The Director highlighted that the national Better Care Support Team had visited the Integrated Discharge Team the previous week and had provided very positive feedback about the work being undertaken locally to integrate services and improve outcomes for older people.

**Decision**

The Board retrospectively approved performance reports in relation to the Better Care Fund.

## 9. North East Culture Partnership *(interim Director of Public Health)*

The Board considered a letter, appended to the report, which had been received from the NECP for the addition of an 'observer' representative from the arts and cultural sector to its future Board meetings. It was highlighted at the meeting that there was a lot of cultural development work being undertaken and that it could be beneficial, therefore, for a separate meeting to be held with officers who do not sit on the Board.

**Decision**

(i) The Board accepted the request for a representative from the arts and culture sector to the board to be a representative on the Board.

(iii) The Board agreed that it would be beneficial for the nominated representative to meet with officers, who do not sit on the Board.

Meeting concluded at 11.50 a.m.

CHAIR

# CHILDREN'S STRATEGIC PARTNERSHIP

## MINUTES AND DECISION RECORD

21 March 2018

The meeting commenced at 2.00pm in the Centre for Independent Living, Burbank Street, Hartlepool

**Present:**

Councillor: Alan Clark (In the Chair)

Councillor Brenda Harrison
Sally Robinson, Director of Children's and Joint Commissioning Services
Danielle Swainston, Assistant Director, Children's and Families' Services
Assistant Chief Superintendant, Alastair Simpson, Cleveland Police
Dave Pickard, Chair of Local Children's Safeguarding Board
Chris Davies, Head of Service, CAMHS
Dave Wise, West View Project
John Hardy, Headteacher St John Vianney Primary School
Martin Todd, Changing Futures North East

In accordance with Council Procedure Rule 5.2 (ii), Deborah Clark was in attendance as substitute for Paul Edmondson-Jones (Interim Director of Public Health) and Jo Heaney was in attendance as substitute for Ali Wilson (NHS Hartlepool and Stockton on Tees Clinical Commissioning Group)

Also in attendance:
Philip Bithell, Young People's Foundation

Officers:
Angela Armstrong, Principal Democratic Services Officer

## 63. Apologies for Absence

Apologies were submitted by Mark Patton (Assistant Director, Education), Paul Edmondson-Jones (Interim Director of Public Health), Ali Wilson (NHS Hartlepool and Stockton on Tees Clinical Commissioning Group), Darren Hankey (Hartlepool College of Further Education).

## 64. Declarations of Interest

None.

# 65. Minutes of the meeting held on 31 January 2018

Confirmed.

# 66. Children and Young People's Plan Consultation

(*Assistant Director, Children's and Families Services*)

The Assistant Director, Children's and Families' Services referred to the Children and Young People's Plan which included a multi-agency strategic vision and plan for the whole Borough. The obsessions identified in the Plan were identified as follows:

- Stability, Health and Wellbeing and Education;
- Being and Feeling Safe; and
- Relationships and Resilience.

Break-out groups were facilitated to enable all members of the Partnership to consider the above obsessions including what intelligence was already known, what intelligence it would be useful to know and what the priorities of the Plan should be.

The groups provided feedback on the discussions undertaken on the above obsessions. The representative from the Young People's Foundation indicated that three surveys with primary school children, the youth services and youth voices had been undertaken. The outcomes from this survey will be collated and circulated to the Partnership. One of the highlights of the survey was that primary school children were asking for more responsible adults to be around including the police, PCOS's on the streets.

The representative from Cleveland Police referred to an ongoing project with Middlesbrough and Stockton Borough Councils to undertake research across a specific year group within a school and look at adverse experiences within the household. It was hoped that this project would be used as a pilot to develop principles of working with families.

**Decision**

The feedback from the break-out groups will be utilised to inform the Children and Young People's Plan.

## 67. Early Help Statement of Intent (*Assistant Director, Children's and Families' Services*)

The Assistant Director, Children's and Families' Services indicated that the Early Help Statement of Intent would be developed based on what services families would like to see developed to assist the future transformation of services and targeting of resources. It was suggested that break-out groups be facilitated to consider the following:

- Is there any additional information that you think needs adding to current position?
- Priority actions at beginning of implementation plan, are these the right ones?
- Are the actions within the plan the right ones?

The groups provided feedback on the discussions on the above which will be utilised to further develop the Early Help Statement of Intent. It was highlighted that community involvement was key to the success of the Statement including the use of Children's Centres to influence the shape of the community in the forward. It was suggested that the North Locality Team could be utilised as a blueprint for the further development of Locality Teams.

The Assistant Director, Children's and Families' Services indicated that the feedback received would be utilised to inform the Early Help Statement of Intent and an updated version will be circulated to all members of the Partnership for comments. The importance of all partners signing up to the agreement and including it within their individual governance processes was emphasised.

**Decision**

The feedback received would be utilised to inform and update the Early Help Statement of Intent and circulate to Partnership members for comments.

## 68. Any Other Items which the Chairman Considers are Urgent

The Chairman ruled that the following items of business should be considered by the Committee as a matter of urgency in accordance with the provisions of Section 100(B)(4)(b) of the Local Government Act 1972 in order that the matter could be dealt with without delay.

**Minute 69 – Young Inspectors**
**Minute 70 – Centre for Excellence in Creative Arts**
**Minute 71 – Additional meeting of the Children's Strategic Partnership**

## 69. Any Other Business – Young Inspectors/Annual Primary School Council Conference

The representative from West View Advice and Resource Centre highlighted that the Young Inspectors were currently undertaking an inspection of the North East Ambulance Service (NEAS) Headquarters. Ideas for future projects for the Young Inspectors were sought. The representative from Child and Adults Mental Health Services (CAMHS) indicated that there may be an opportunity for the Young Inspectors within CAMHS.

The Partnership was informed that the Annual Primary School Council will take place on 27 June 2018 at 9.30am to 2.30pm and will be held at The Domes, Seaton Carew. Representatives from NEAS and the NSPCC will be in attendance and all members of the Partnership were invited to attend. Anyone wishing to attend should inform West View Advice and Resource Centre.

## 70. Any Other Business – Centre for Excellence in Creative Arts

The Vice Chair informed the Partnership that the Centre for Excellence in Creative Arts (former Northern Lights Academy) would be holding an open day on 28 March 2018 and everyone was invited to attend. There would be a rolling programme of tours of the building.

## 71. Any Other Business – Additional meeting of the Children's Strategic Partnership

The Chair indicated that this was the last meeting of the municipal year, however should an additional meeting be requested, this could be scheduled at the end of May/early June. Further information would follow should an additional meeting be scheduled.

The meeting concluded at 4.15 pm

CHAIR

# HEALTH AND WELLBEING BOARD

**14 September 2018**

**Report of:** Interim Director of Public Health

**Subject:** DRUG AND ALCOHOL SERVICE NEEDS ASSESSMENT AND NEXT STEPS FOR SERVICE DELIVERY

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## 1. PURPOSE OF REPORT

1.1 To present to the Board the Drug and Alcohol Service needs assessment and next steps for service delivery.

## 2. BACKGROUND

2.1 This is a "deep dive" needs assessment, as an element of the Joint Strategic Needs assessment, and a priority topic agreed by the Health and Wellbeing Board to be brought, in draft, to its September 2018 meeting.

2.2 The Board is invited to receive and discuss the needs assessment and next steps, and send any further comments from the organisations they represent by 3rd October 2018.

## 3. DRUG AND ALCOHOL SERVICE NEEDS ASSESSMENT

3.1 Please see the attached needs assessment document (**Appendix A**).

## 4. NEXT STEPS FOR SERVICE DELIVERY

4.1 Three main options are outlined in Section 8 of the document (Appendix A), plus the option of applying for a contract exemption to the Addaction contract if more time is needed.

## 5. RISK IMPLICATIONS

5.1 No risk implications.

## 6. FINANCIAL CONSIDERATIONS

6.1 A breakdown of current investment is included in section 8 of the needs assessment. It is assumed that all service changes will have to be accommodated within the current, or similar, financial envelope.

## 7. LEGAL CONSIDERATIONS

7.1 Nil specific beyond re-procurement exercise.

## 8. CHILD AND FAMILY POVERTY

**8.1** Positive effect anticipated on child and family poverty, as one of the major outcomes of improved services, including breaking the generational cycle of addiction. An impact assessment attached at **Appendix B**.

## 9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 Positive effect anticipated on equality in health outcomes. Diversity issues are addressed in the assessment (Appendix A(1)) but has no major bearing in this needs area. An impact assessment is attached at **Appendix C**.

## 10. STAFF CONSIDERATIONS

10.1 There are considerations for staff training and skill mix within the needs assessment, and changes may arise from the need to re-procure time-expired contracts from April 2019.

## 11. ASSET MANAGEMENT CONSIDERATIONS

11.1 Facilities fit for purpose feature in the assessment and will feature in provider engagement dialogue.

## 12. RECOMMENDATIONS

12.1 That the Health and Wellbeing Board receives this first draft needs assessment and feeds back comments on the content and next steps within two weeks.

12.2 That the re-procurement of the Drug and Alcohol Service be referred to the Finance and Policy Committee.

## 13. REASONS FOR RECOMMENDATIONS

13.1 To improve the service and outcomes with respect to drugs and alcohol misuse in Hartlepool.

## 14. BACKGROUND PAPERS

See Appendix A (2) and (3) in the document for a full list of guidance, evidence and extant strategies used in compiling this assessment.

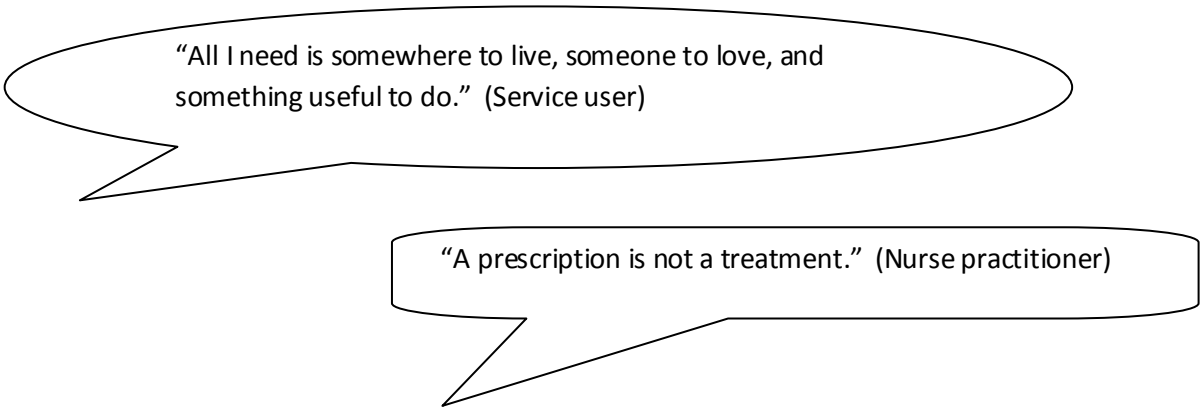
## 15. CONTACT OFFICER

Dr Peter Brambleby, DCH FRCP(Edin) FFPH
Interim Director of Public Health
Hartlepool Borough Council
Email: peter.brambleby@hartlepool.gov.uk

# Needs assessment for drugs and alcohol misuse in Hartlepool

## *(Draft, updated 3 September 2018)*

*This is part of the Joint Strategic Needs Assessment, under the auspices of Hartlepool Health and Wellbeing Board.*




## Executive summary

### What's the problem?

Hartlepool has the second highest death rate from drug misuse, and the highest under-75 death rate from alcohol-related liver disease, in the North East region. The Council recognises substance misuse as a major factor in child neglect, domestic violence, acquisitive crime, antisocial behaviour and children being taken into care. Total cost to the local economy and caring services is around £6 million per year. A year ago the Council decided to bring the psychosocial therapy element of service in-house, leaving the clinical prescribing element in a contract with Addaction. A series of unexpected leadership gaps and lack of service specification in the former have left the service as a whole without the clarity and unity of purpose intended. Nearly half of opiate users and high-level alcohol consumers drop out of the programme between assessment and first therapy session and others don't seek help at all. There is a particular gap in provision for those not yet sufficiently motivated to achieve abstinence, and a marked generational cycle of misuse that is proving difficult to break.

### How was the needs assessment tackled?

There have been four strands to this assessment of need. First and foremost was the insight provided by "***key informants***" – people who use the service, people who provide the service, people who refer in to the service, people whose work overlaps with the service (especially schools, criminal justice system and local NHS), and people with experience in commissioning these services (including, with thanks, Public Health England and Newcastle public health directorate).

The second strand was to look at ***routine data sources*** that give a profile of the nature and scale of the problem, chiefly from Public Health England and our own service providers. This shows the breakdown of drug and alcohol use by population type, trends over time and comparisons with other (and similar) populations. Not all the data that we might wish for is routinely collected, such

as associated physical and mental illnesses, or certain outcomes short of full abstinence, so these data gaps collection will need to be specified in any new service contracts. The profile is summarised at Appendix 1.

The third was ***published evidence*** of what is known to be effective in drugs and alcohol in the UK and abroad. A list of sources of evidence that were referred to in this needs assessment appears at Appendix 2.

The fourth strand was to draw on ***existing policies and strategies***, for example the delivery plan of the health and wellbeing strategy (2018-2025), the substance misuse strategy (2016-2019) and the harm reduction strategy (2018-2025). These are summarised at Appendix 3.

### An assessment, not a measurement

Given the nature of the topic, this needs assessment has relied more on narrative than numbers. "The things which count are not easily counted". It has required judgement and interpretation as well as information and evidence, and that is why further consultation is essential. Needs are not static but change over time, so adaptability has been built in.

It is concerned not just with ***"inputs"*** (such as finances, buildings and people) or ***"outputs"*** (such as numbers of people passing through the service) or even ***"outcomes"*** (such as abstinence, return to work or maintaining family unity). It is just as concerned with ***"outlooks"*** (such as the service values, purpose and focus). It therefore follows that the service specifications, monitoring and reporting should be driven by values, with emphasis on clients, leadership, partnership and adaptability.

### A pragmatic approach

From the outset the focus has been on solutions rather than problems, and certainly not criticism or blame. The commitment of those who work in the service is striking, as is the commitment of partner agencies whose interests overlap with the service. Just as striking, and often moving, were the contributions from people using the service and maintaining recovery, many of whom expressed a wish to put something back by way of mentoring their peers, sharing their stories for prevention initiatives or contributing to management.

Solutions to the issues and trends raised here cannot be met by statutory agencies alone but will require the resourcefulness of communities and service users themselves. This wider involvement will make the service more sustainable, more locally appropriate and more effective.

In conducting the review, certain current operational pressures were uncovered that needed to be addressed as they arose and these have been initiated. For example, a policy was needed on the opiate antidote naloxone, for emergency use by staff or carers, and this has been done.

The report is structured so as to translate easily into service specifications. It has uncovered the need for a fresh approach to commissioning, keeping the best of the old and developing the new. It also recognises that solutions have to be found within the current, or similar, resource envelope and that has meant looking to community resources and better coordination across the statutory sectors. In particular, this assessment has regarded service users, especially those on the road to recovery or successfully completing treatment, as expert resources in their own right.

**The problems are complex but need not be complicated.**

We have two issues to contend with: ***incidence*** and ***prevalence***.

***Incidence*** is the rate of ***new*** cases coming to attention every year. The only means to reduce incidence is prevention. Prevention includes reducing availability of supply, and improving awareness and resilience amongst potential users to "say no to drugs". Once the problem has begun, the user becomes part of the prevalence rate. Prevention is heavily determined by early childhood adverse events, assertive work with children and young people in emotional resilience, in awareness of risks and harms, and a collaborative approach to cutting off supply.

***Prevalence*** is the rate of ***existing*** cases at a given point in time. For a chronic state like drug or alcohol dependency, prevalence will usually be much higher than incidence, with all it means for misery, missed life chances and costs. The only ways in which prevalence will fall are if people become abstinent or die. (If drug users leave the Borough that would reduce our prevalence figure, but not help their problem or reduce the national prevalence.) The best way to limit prevalence is to tackle it in its early stages, with rapid recognition, rapid access and effective treatment aimed at abstinence. There is a growing body of evidence, particularly out of Europe, that adopting a health model rather than criminal model of drug addiction leads to earlier interventions, harm reduction, fewer deaths, and less acquisitive crime.

**Barriers to progress**

Obstacles that need to be overcome include:

- **Stigma**: seeing this group as weak-willed or undeserving
- **Lack of coordination**: seeing it as someone else's problem, a low priority or adopting a different model
- **Lack of ambition**: limiting objectives to containment rather than cure, or the "learned helplessness" that problems are intractable and national policy or legislation too difficult to change
- **Lack of imagination**: failure to recognise that users themselves, as they enter recovery, are an essential expert resource and part of the solution, not the problem.

## The main "needs" identified in this assessment are as follows:

### 1. The need for leadership, focus and greater user involvement

1.1 The need for a named senior officer of the Council (director or assistant director) to be accountable for commissioning the service overall, for outcomes and for leadership.

1.2 The need to regard this as one service for drugs and alcohol misuse, led and functioning as such, even if there is a mixed group of providers.

1.3 The need for a clear separation of commissioning and providing roles within the Council if an element of the service is to be provided in-house. Should there ever be a competitive element in market engagement and bidding for the service, this distinction is particularly important and must be challenge-proof.

1.4 The need for the senior officer to be supported by an operational leadership team and consisting of senior managers and clinicians from the service providers (including any in-house and/or externally provided elements) and recovering service users. This team would meet at least monthly to monitor the service, react to issues that arise, be responsible for stewardship of the financial and other resources, and reshape services to changing needs.

1.5 Those who use the services, especially those well on the road to recovery and abstinence, are experts in the service in the own right and should be seen as a resource, not just a need. Many of those interviewed during this assessment spoke of the wish to "put something back". Making a contribution can itself be therapeutic. It is proposed, therefore, that the input of current or recent service users should be actively sought, that they should undergo appropriate selection and training and be paid for their input. Suitable roles would include membership of the management group, peer mentoring, prevention campaigns such as into schools and prisons, service evaluations and research.

1.6 The need to re-invigorate the drugs and alcohol harm reduction implementation group where the various bodies coordinate their actions

**2. The need for ambition and imagination**

2.1 The need for a much stronger emphasis on prevention, especially amongst children and young people before they start experimenting or become addicted.

2.2 The need for a service ethos based on expectation of recovery, never lowering assumptions or giving up on an individual, with patience, persistence, and flexibility, accepting that while some may never shrug off dependency the duty of care should not cease. Simple "harm reduction" and "containment" are not sufficiently ambitious.

2.3 The need for continuity of care, ideally through a single nominated key worker, forming a lasting relationship with the service user and connecting all the other strands.

2.4 The need for rapid response: at times of crisis, or when a client suddenly becomes ready to change.

2.5 The need for a culture of innovation, research, evaluation and reflection, including risk-taking within reasonable governance.

**3. The need for whole-person care**

3.1 The need to meet all social as well as health needs, including dental, physical and mental health. The demographic profile (appendix 1) shows we have no older people with addiction – at present they all die early.

3.2 The need to recognise that "prescribing is not treatment" and the psychosocial element of recovery is of primary importance.

3.3 The need for clients to have "something useful to do" – a reason to get up, to become substance-free, and to maintain abstinence.

3.4 The need to understand clients in the context of family and friends. Not all relationships are conducive to recovery but others may be essential.

3.5 Continuity of care through an identified key worker.

3.6 The need for rapid response.

3.7 The need for risk assessment in the household and contacts, especially children or vulnerable adults, and to mitigate those risks.

**4. The need for flexibility and coordination**

4.1 The need for joint training and working.

4.2 The need for improved referrals into the service.

4.3 The need for improved discharge communication.

4.4 The need for close liaison with general practice and in-reach services such as leg ulcers, sexual and dentistry.

4.5 The need for expert pharmacy advice.

4.6 The need for feedback and reflection.

4.7 The need for whole-system audits.

4.8 The need for alignment with other Tees-wide services and wider networks, given the cross-boundary flows and shared working and facilities.

4.9 The service must use the National Drug Treatment Monitoring System (NDTMS), Treatment Outcomes Profile (TOP) and other measures to regularly monitor and review levels of successful treatment and completion and sustained recovery, and compare that performance with peer authorities and the national norms.

4.10 The role of schools came across very strongly in interviews with head teachers and pupil support staff.

4.11 The voluntary sector is a very significant partner, and with specific groups such as ex-service personnel.

4.12 The Council itself has a role in areas such as licensing and enforcement – pubs, clubs and festivals.

**5. The need for facilities fit for modern practice**

5.1 The need for facilities in accessible locations that are secure, confidential and provide a therapeutic ambience.

5.2 The need for an effective information technology (IT) system for data recording, and ideally one that integrates (with appropriate safeguards) with those of the NHS and criminal justice

system. That system should also facilitate electronic prescribing (subject to a change in law relating to controlled drugs) and eliminate paper prescriptions.

5.3 The need for accessible needle-exchange schemes and supervised medication schemes, including in pharmacies, and ideally wherever clients are seen.

5.4 The need for supervised consumption of prescribed medication such as methadone, including in pharmacies, and ideally close to where clients are seen.

5.5 The need for treatment rooms with a couch, stocked and equipped for dressings and minor injuries.

5.6 The need for "safe space" drop-in facilities, with catering, shower, laundry, relaxation space and training rooms.

**6. The need for a fresh approach to commissioning and contracting**

6.1 This review has deconstructed the word **commissioning** to mean **co-mission-ing**. "Co" implies collaboration - a co-production between the service users, the service providers and the service funders; "mission" implies clarity of values, vision and common purpose which steers the service; and "ing" implies an active process that is both sensitive and responsive to changing circumstances.

6.2 The need for **flexibility in contracts**. The needs assessment uncovered instances of people working to the letter of their contract rather than the needs of the client. Contracts should be simply the written confirmation of a pattern of services, desired outcomes and financial envelope that has been agreed between the parties. It should never be so rigid that it cannot be adapted, and service providers should be encouraged to work to the client not the contract, raising areas of difficulty with the leadership team.

6.3 The need for **sub-contracting** where this simplifies aspects of service such as needle-exchange, supervised consumption or health promotion campaigns. The budget and responsibility might be delegated to a main provider to then sub-contract as needed to meet its obligations.

6.4 The need for additional **economic appraisal** capacity within the Council. This need is especially acute when scarce resources are being deployed or redeployed in new ways, where multiple partners bring resources to the table and the outcomes or financial benefits impact in a different pattern. There are some rudimentary estimates of value for money and return on investment in this document, but a great deal more could be done to improve decision-making: in fields such as programme budgeting, marginal analysis, cost-effectiveness, social capital and social return on investment.

6.5 Contract monitoring: standards, indicators and targets; narrative and numbers.

**7. The need for a service model and specification based on pathways**

The service specification will adopt a pathway approach – walking in the service user's footsteps – with clarity of roles, interventions, expected outcomes, monitoring arrangements at each step. Those steps are:

Step 1 - Primary prevention. The person is abstinent or occasionally experimenting and has not formed a habit or become dependent.
Step 2 - Secondary prevention. The person is using regularly and becoming dependent, but not to a level that interferes with activities of daily life or the lives of others.
Step 3 - Tertiary prevention. The person is using frequently, is dependent, and it is adversely affecting functioning in daily life or causing distress or harm to others. The person has not yet been referred to therapeutic services.
Step 4 - Referral for assessment and treatment options
Step 5 - Assessed as needing therapy
Treatment pathway 5.1 Opiate addiction
Treatment pathway 5.2 Significant alcohol addiction (assessment score over 30 points)
Treatment pathway 5.3 Non-opiate substance use
Treatment pathway 5.4 Less severe alcohol addiction (assessment score less than 30 points)
Treatment pathway 5.5 Residential detoxification
Step 6 - Abstinent but under active therapy and supervision
Step 7 - Discharged to community/volunteer support

**8. Where we are now, and next steps**

The current position is that we have two main contracts:

- Addaction: (value £1.2 million). Responsible for: clinical prescribing, GP liaison, blood borne virus testing and vaccination, and drug rehabilitation order screening. This contract has already actioned its two extension options and must be re-procured by 1 April 2019.
- In-house service: (value £800,000). Responsible for: psychosocial interventions in groups or 1:1, 12 week community rehabilitation, community integration support, substance misuse training, sourcing residential detoxification and rehabilitation, community and family support, specialist young people support, criminal justice support, liaison with housing, employment and skills. This service suffered from loss of senior leadership and commissioning input through unforeseen circumstances and a tragic death, and so never developed a robust specification, realised its full potential or built all the links with Addaction and the wider networks. (Note that significant savings – circa £0.4 million per year – were envisaged by bringing this element in-house but these will not all be realised until at least March 2019.)
- Needle exchange in pharmacies: £45,000
- Prevention campaign: £17,000

Some needs identified by this review have already been addressed – other require more fundamental re-commissioning.

The options for commissioning afresh, in brief, are these:

1. Bring the whole service in-house, with an internal "purchaser/provider" separation of roles, and then possibly sub-contract smaller elements such as prevention campaigns or needle exchange as necessary.
2. Put a detailed specification out to tender, either in entirety or in lots, and see who responds.
3. Undertake a "market engagement" exercise over a few months with potential providers and service users, shaping the service as the dialogue evolves, and let the contracts at the end of the process.
4. An adjunct to all the above, to create more time, would be to apply to Council members for a "contract exemption" for a few months to find time for a longer term solution.

***Why do so many people with drug dependency die early ?***

- *If there is a family and local culture of low expectation; emotional, physical or sexual abuse or neglect; few positive role models; limited opportunities; financial dependency; learned helplessness.…then…*
- *the growing child (pre-school) lacks appropriate stimulation and/or endures repeated inescapable ("toxic") stress....so…*
- *brain development, emotional growth, behaviour and social interactions are impaired....so…*
- *the older child and young adult is vulnerable to health-risk behaviours and adverse social environment – obesity, smoking, drugs, alcohol, accidents, poor housing, crime....so…*
- *the adult experiences early onset of life-style related diseases – heart, lungs, cancer, liver, injury … as well as overdose, infection, etc....so…*
- *the adult dies earlier than his or her peers.*

***There are no elderly users (over 70) in the service in Hartlepool.***

***They all die early.***

***Prevention should start in early childhood.***

***Strategies for giving children the best start in life with respect to avoiding harm from drugs and alcohol will ameliorate other public health needs too.***

**The main "needs" identified in this assessment, in more detail, are as follows:**

**1. The need for leadership, focus and greater user involvement**

1.1 The need for a named senior officer of the Council (director or assistant director) to be accountable for commissioning the service overall, for making sure that needs are addressed, and for outcomes.

1.2 The need for one service for drugs and alcohol misuse, identified, led and functioning as such, even if there is a mixed market of providers.

1.3 The need for a clear separation of commissioning and providing roles, especially if an element of the service is to be provided in-house. Should there ever be a competitive element in market engagement and bidding for the service, this distinction is particularly important and must be challenge-proof.

1.4 The need for the senior officer to be supported by an operational leadership team, chaired by that officer, and consisting of senior managers and clinicians from the service providers (including any in-house and/or externally provided elements) and recovering service users. Service users should be recognised experts in their own right, undergo a selection and development process, and be paid for their participation. This team would meet at least monthly to monitor the service, react to issues that arose, be responsible for stewardship of the financial and other resources, and reshape services to changing needs.

1.5 Those who use the services, especially those well on the road to recovery and abstinence, are experts in the service in the own right and should be seen as a resource, not just a need. Many of those interviewed during this assessment spoke of the wish to "put something back" and making a contribution can itself be a therapeutic tool. It is proposed, therefore, that the input of current or recent service users should be actively sought, that they should undergo appropriate selection and training and be paid for their input. Suitable roles would include membership of the management group, peer mentoring, prevention outreach such as into schools and prisons, service evaluations and research.

1.6 The need to re-invigorate the drugs and alcohol harm reduction implementation group where the various bodies coordinate their actions

**2. The need for ambition and imagination**

2.1 The need for a much stronger emphasis on prevention, especially in young people before they start experimenting or become addicted. This need overlaps with other initiatives regarding lifestyle risks to young people and adults (such as tobacco, gambling, cyber bulling, and unwanted pregnancy). They share common determinants and common solutions, such as the mitigation of adverse childhood events ("ACEs"), building of self esteem and personal aspiration, educational attainment, emotional resilience, positive adult role models and positive peer pressure. The role for schools is substantial, and exclusion from school should be a rarity, but a great deal is being asked of schools and they need a lot of back-up. The

service needs to mount a convincing case for how it will reach those who need the service, wherever they are and intervene in ways that suit their lifestyle, including the right settings and the right formats (which may include e-mail, texting and digital solutions.) There will need to be a specific for young people.

2.2 The need for a service ethos based on expectation of recovery – never lowering assumptions or giving up on an individual – with patience, persistence, and flexibility, accepting that while some may never shrug off dependency the duty of care should not cease. Simple "harm reduction" and "containment" are not sufficiently ambitious.

2.3 The need for continuity of care, ideally through a single nominated key worker, forming a lasting relationship with the service user and connecting all the other strands.

2.4 The need for rapid responses at times of crisis or when a client becomes ready to change. Nearly half of all clients assessed for treatment drop out before the first session begins or soon after.

2.5 The need for a culture of innovation, research, evaluation and reflection, including risk-taking within reasonable governance. The service is currently supporting a research initiative from Sunderland and Newcastle universities. An "embedded" researcher, backed up by an experienced team, is conducting a **behavioural insight study** into why some people are reluctant to engage in treatment, what can be done about it, and how any system changes might be evaluated. The study is part-funded from a grant from the Local government association and partly from public health grant reserves. We need to promote this culture of inquiry and experimentation and to share the learning. Hartlepool has a wealth of challenges and opportunities, and ought to play its part in advancing knowledge in this treatment area.

**3. The need for whole-person care**

3.1 The need to meet all social as well as health needs, including dental, physical and mental health. The demographic profile (appendix 1) shows we have no older people with addiction – at present they all die early. This ties in with step 5 on the treatment pathway (see below). Experience from local GPs and service providers is that sepsis (infection) in the legs is common and leads to higher rates of leg amputation or life-threatening seticaemia (blood poisoning).

3.2 The need to recognise that "prescribing is not treatment" and that the psychosocial element of recovery is of primary importance. This statement was made eloquently and convincingly by a senior nurse practitioner during the interviews with key informants. It is a cornerstone of the philosophy of treatment (and could apply in many other clinical fields). There should be an expectation of full dependence-free recovery, and this should be integral to the assessment and early interventions. Clearly, the client has to be ready to change. Providing support, including peer support, until that stage is reached and the neurological-behavioural-psychosocial (NBPS) – or similar - therapy can begin. Reaching that stage of readiness may time, but this is a critical gap in the current service provision and the client must be part of active therapeutic support until ready.

3.3 The need for clients to have "something useful to do" – a reason to get up, to become substance-free, and to maintain abstinence. Evidence from service users can be summarised

under the headings of the five "ways to wellbeing" articulated by the New Economics Forum: *connect, take notice, learn, be active, make a contribution*. There are untapped resources in Hartlepool to fill this need, for example volunteering, education and skills, arts and music, employment and sport. Any service provider must make links with a variety of groups from these sectors to offer a menu of options to their clients, especially in recovery and beyond.

3.4 The need to understand clients in the context of family and friends. Not all relationships are conducive to recovery but others may be essential. Hartlepool has a particularly strong pattern of opiate addiction running in families, with as many as three generations from a single area being to known to the service at the same time. Outreach work and domiciliary visits are a desirable element of assessment, especially with children and young adults, within the rules of consent and confidentiality. Sorting out family or household difficulties may be as important as counselling is to the client. One interviewee with serious alcohol dependency said her turn-around began when she was re-housed away from a peer group who had been encouraging a drinking culture. Any service provider will need to make clear how this aspect of service will be provided.

3.5 The need for continuity of care worker. A very strong theme coming from users and providers was the therapeutic imperative of continuity of care, ideally through a single nominated key worker (or failing that, continuity within a small team), forming a lasting relationship with the service user and coordinating all the other strands.

3.6 The need for rapid response. Situations change rapidly in this client group – for the worse or for the better – for example on release from prison, from a relapse or when a client suddenly becomes ready to change. A case was made by some interviewees, especially in the youth outreach service, for front line staff having access to small amounts of cash to secure what is necessary to prevent a crisis. This might be a meal, a plumber or emergency child care, and such interventions may head off complete breakdown of a package of care or a recovery trajectory.

3.7 The need for assessment of risk. Consideration should be given to any children or vulnerable adults amongst the household and contacts, and appropriate mitigation put in place. Home visits should be conducted wherever practical and always where the risk is judged to be high.

**4. The need for flexibility and coordination**

4.1 One of the routes to integration is **joint training**, which should be the norm unless there is good reason not to. The new service specification arising from this needs assessment will require a programme of joint interagency multidisciplinary training on the new service model, how to refer, how to share data, how to work jointly, and how to review outcomes and patient experience. The principles of joint training and joint evaluation extend, where possible, to partner agencies such as criminal justice, general practice, the rest of the NHS and to education. It is particularly important that communication between agencies is quick, effective, and two-way, supported by shared information technology wherever possible (see below). Other ways of learning are through job shadowing, rotating appointments, creative flexibility with job roles and multi-skilling.

4.2 **Improved referrals**: it would improve efficiency and effectiveness if more information was included at initial referral – otherwise it has to be sought later and introduces delays. See Section 7, step 4, on "pathways" below.

4.3 **Improved discharge liaison**, when a client leaves hospital or prison, for example. The need for prior notification of the service if a client is coming back. Needs which were identified included:

- Inviting the drugs and alcohol service to multidisciplinary team meetings (MDT)
- Hospitals should not initiate methadone or other addiction-management therapy without reference to the service, and checking with the service (not just client) before prescribing such medicine to an existing user (note: dosages may be on a sliding scale, and a client's statement of current medication regimens may not be reliable.)
- Discharge planning needs to start as early as possible, even on admission, and maximum possible notification (with an appointment date back to the service) on discharge, with an up to date discharge summary, preferably electronically.
- Special liaison needs to be initiated where there are frequent readmissions or A&E attendances.
- Leg ulcer clinics, sexual health and similar frequent interventions need to be delivered in a community setting wherever practical and efficient.

4.4 The need for close liaison with **general practice and in-reach services such as leg ulcers, sexual and dentistry.**

4.5 The need for expert **pharmacy** advice.

4.6 **Feedback and reflection**. There needs to be regular whole-service meetings to learn from experience, sort out inefficiencies or communication breakdowns, consider strengths and weaknesses and plan ahead. No system can run efficiently without feedback loops. The leadership team will need to be responsible for regularly reviewing positive and negative outcomes and experiences and feeding these back – in a no-blame culture that seeks continual quality improvement. Any adverse events should initiate a look-back-and-learn exercise as a regular part of team building across all arms of the service. Peer review, including by mutual exchange visits from other service providers, should feature in the prospectus of any potential service provider.

4.7 **Whole-system audits** of infrastructure, processes, outcomes and finances will need to be a regular (probably annual) feature, including self-audit against the criteria of regulators such as the Care Quality Commission. Where there are extant forums for this collaboration, they need to be used as channels for communication as the service evolves and issues arise: where they do not exist they should be introduced. These links are important both strategically and operationally, and the latter came up frequently in conversations with key informants. A good example is crime. The government's drugs strategy of 2017 stresses the need to support people's drug dependency as a means to reduce crime. The strategy points to the fact that individuals dependent on opioids or crack cocaine are responsible for around 45% of

acquisitive crime (shoplifting, burglary, vehicle crime and robbery). There is a continuing (and ageing) group of prolific offenders.

4.8 The need for **alignment to other Tees-wide services and regional networks**, given the cross-boundary flows and shared working and facilities. For example: drug-related deaths. There is a current Preventing Drug-related Deaths Co-ordinator working across Middlesbrough, Redcar and Cleveland, and Stockton. Each LA contributes £13,500 p.a., therefore, if Hartlepool were to join the partnership, it would be £10,125 per L.A./annum. The benefits of collaboration include:

- Being part of the Early Warning System that is being developing re. drug alerts and trends to inform service planning/responses;
- Jointly agreed DRD reporting and investigation process, which will lead to improved shared learning and reduced DRD's;
- Improved links with key partners, including the Police, Coroner, regional colleagues and PHE;
- Expert knowledge and expertise being fed into the local substance misuse strategy/approach;
- Ability to review recent DRD's in Hartlepool and build a picture of trends;
- Additional capacity to represent Hartlepool at relevant meetings/forums;
- Alignment with other Tees LAs/recovery models and improved ability to share best practice.

4.9 The service must use the National Drug Treatment Monitoring System (NDTMS), Treatment Outcomes Profile (TOP) and other measures to regularly monitor and review levels of successful treatment and completion and sustained recovery, and compare that performance with peer authorities and the national norms.

4.10 The role of schools came across very strongly in interviews with head teachers and pupil support staff. Schools are required by regulators to focus on the curriculum, but many also recognise their role as "safe haven", good adult role models and source of diversionary activities for children from less advantaged backgrounds. School exclusion should be a last resort but is too high in Hartlepool and compounding the risk to children vulnerable to substance misuse and exploitation. Cannabis and alcohol were the principle substances misused by schoolchildren. Case histories were related where the pupil support officer was performing a *de facto* key worker role, holding the ring with chaotic families with multiple needs, sometimes when let down by other agencies (including the NHS) who were applying rigid eligibility criteria. Schools need more recognition and support in the struggle to break Hartlepool's significant generational cycle. Opiate and alcohol addiction run in families here.

4.11 The voluntary sector is a very significant partner, and with specific groups such as ex-service personnel. One of the interviewees, a veteran of Afghanistan, spoke of successful re-employment and family life after overcoming addiction to cocaine and post-traumatic stress disorder.

4.12 The Council itself has a role in areas such as licensing and enforcement – pubs, clubs and festivals.

**5. The need for facilities fit for modern practice**

5.1 The need for facilities in accessible locations that are secure, confidential and provide a therapeutic ambience. It was evident from site visits that some of the building stock, especially Whitby Street, is past its useful date and is not ideal for purpose.

5.2 One or more treatment centres, to include:

- Ease of access in town centre away from residential areas
- Disabled access
- Secure reception area with welcoming ambience
- Secure waiting areas
- Adequate interview rooms (6 +) with soft furnishings and desk/computer for note-taking – as non-clinical as possible
- Treatment room for dressings and minor procedures, with couch, sink and storage
- Personal alarm systems
- CCTV for inside and outside, monitored at reception
- Adequate staff rest rooms and training rooms
- Adequate office space and secure storage for stationery
- Medicines storage facility (this is an innovation needs further discussion), including naloxone, and cardiac defibrillator
- Needle exchange facilities
- Water cooler and/or drinks dispenser

5.3 One or more community based facilities – eg Gladstone House

- Drop-in centres with multi-use, eg washing machines/driers, drinks and snacks
- Shower rooms
- Arts and skills rooms
- IT training room and internet access
- Games rooms
- Therapy rooms for 1:1 or group sessions
- Treatment room eg visiting dental checks, wound dressings.

5.4 **Residential detoxification/rehabilitation**

Suitably home-like but clinically equipped rehabilitation facility (at least 4 beds).

5.5 **The need for an effective IT system** for data recording, and ideally one that integrates (with appropriate safeguards) with those of the NHS and criminal justice system. That system should also facilitate electronic prescribing (subject to a change in the law permitting electronic prescribing of controlled drugs) and eliminate paper prescriptions. The need for an effective IT system for data recording and team sharing, and ideally one that integrates (with appropriate safeguards) with those of the NHS and criminal justice system. At present both the in-house (Hartlepool Borough Council) service and Addaction service use the ***Theseus IT system*** for clinical data recording and case management. There was universal feedback from staff that this system needs to be replaced or upgraded. In particular, it cannot "talk" to the

GP system (System One) and this is hampering critical data exchange and response to changing needs. Another major improvement would be ***electronic prescribing*** to take out the paper prescription altogether. At a stroke, this would remove problems with security, falsification, loss, misappropriation, illegal transactions and delay.

5.6 The need for accessible needle-exchange schemes, including in pharmacies, and ideally wherever clients are seen. A number of needs were articulated around supervised consumption. **The ideal would be to have on-site dispensing to allow the service to prescribe, dispense and supervise administration at the same visit.** The current alternative is a contract with named pharmacies, though both parties reported difficulties with this, especially the issue of keeping to appointments and not interfering with core pharmacy business.

**6. The need for a fresh approach to commissioning and contracting**

6.1 This review has deconstructed the word **commissioning** to mean **co-mission-ing**. "Co" implies collaboration - a co-production between the service users, the service providers and the service funders; "mission" implies clarity of values, vision and common purpose which steers the service; and "ing" implies an active process that is both sensitive and responsive to changing circumstances.

6.2 The need for flexibility in contracts. The needs assessment uncovered instances of people working to the letter of their contract rather than the needs of the client. Contracts should be simply the written confirmation of a pattern of services, desired outcomes and financial envelope that has been agreed between the parties. It should never be so rigid that it cannot be adapted, and service providers should be encouraged to work to the client not the contract, raising areas of constraint with the leadership team.

6.3 Sub-contracting. There is a case for allowing a core service to sub-contract elements of their offer, for example in-patient rehabilitation, needle exchange schemes, pharmacy supervised consumption, or prevention and awareness campaigns, and include the necessary budget in its core contract.

6.4 The need for additional economic appraisal capacity within the Council. This need is especially acute when scarce resources are being deployed or redeployed in new ways, where multiple partners bring resources to the table and the outcomes or financial benefits impact in a different pattern. There are some rudimentary estimates of value for money and return on investment in this document, but a great deal more could be done to improve decision-making: in fields such as programme budgeting, marginal analysis, cost-effectiveness, social capital and social return on investment. Rather than employ its own health economist, who might become professionally isolated and limited, it might be prudent to buy this in from a local university department and tap in to that wider pool of expertise and benefit from other potential links such as training and evaluation.

6.5 Contract monitoring: standards, targets and indicators; narrative and numbers.

**Standards** to be met will be included in the contracts which are negotiated. A standard is a baseline that any service of acceptable quality must meet. They are unlikely to change much

over time since they are always relevant. These might conveniently be arranged under the headings used by the Care Quality Commission (CQC) which are:

- Caring and responsive – eg care planning, complaints, compliments, access to interpreters, staff skill mix and level of training, female service users are offered a female key worker, all injecting users have access to clean needles and syringes, clear pathways from the criminal justice system, use of peer support from recovering or recovered users, helping clients reach the point where they are ready to change and engage with psychosocial therapy

- Safe – eg cleanliness, infection control, screening and immunisation for blood-borne viruses, security, personal alarms, overdose awareness training and availability of naloxone, risk assessment for household contacts such as children and vulnerable adults

- Effective – treatment outcomes, retention rates, client satisfaction, evidence-based such as the "community integration and motivation to change" model by John Strang under the auspices of the National Treatment Agency and similar NICE and PHE guidance (see Appendix 2)

- Well-led and administered – staff appraisals, general data protection regulations, risk management, record keeping, audits of drug-related deaths

**Targets** are more aspirational and are intended move the service forward beyond the minimum standard. They would be few in number, relevant to local objectives, and "SMART", ie, specific, measurable, ambitious, realistic and time-bound. They might be tied to incentives and have a pass/fail rating. An example of a target would be time from referral to first assessment.

**Indicators** are different from targets as their primary purpose is monitoring and a "challenge to explain". They are not pass/fail as such, nor linked to rewards and sanctions, but serve as a tool for management and review. There would normally be many of them, perhaps organised as a regular "dashboard" for governance review. An example of an indicator would be Hartlepool's ranking in a league table of mortality from alcohol-related deaths.

**Narrative as well as numbers**. Quality monitoring should be qualitative as well as quantitative. The commissioner and his/her leadership team, and the individual service provider(s) will need to hear users' stories and the results of quality assurance visits, not just the numerical values of standards, targets and indicators.

**Quality control** is the responsibility of the provider.

**Quality assurance** is the responsibility of the commissioner.

7. **The need for a service model and specification based on pathways**

Pathways start and end at a point where an individual is addiction-free and achieving their full potential. This means starting with prevention in the first place, and if this fails, moving on to assessment, treatment and support, through to full rehabilitation and supported, sustained

abstinence. Although steps in the pathway may be provided by different agencies or in different locations, it is important that all staff (and all service users) should feel that they are part of one service and one pathway.

**Step 1 - Primary prevention.** The person is abstinent or occasionally experimenting and has not formed a habit or become dependent. This applies to the great majority of young people and adults. This is the stage of prevention, and the main thrust is in schools, colleges, workplaces and public spaces, making people aware of the harms and giving them alternatives. It should be part of every school's PSHCE (personal, social, health, citizenship education). It is a place where recovering or abstinent service users can share the power of their individual experience.

**Step 2 - Secondary prevention.** The person is using regularly and becoming dependent, but not to a level that interferes with activities of daily life or the lives of others. There is a need for early recognition and intervention of this step, through awareness campaigns and signposting to services in the usual outlets, including HBC and NHS premises. There is a role here for voluntary agencies experienced in the field, and diversionary activities through "social prescribing".

Everyone in England aged 40-74 who has not already been diagnosed with a chronic condition is invited once every five years for a "Health Check". Screening questions for alcohol use, and a chance to take action, is part of that screen. More could be done to improve uptake and rigour of this programme.

**Step 3 - Tertiary prevention.** The person is using frequently, is dependent, and it is adversely affecting functioning in daily life or causing distress or harm to others. The person has not yet been referred to therapeutic services. Some people's health and social functioning can deteriorate to a great degree at this stage. As for step 2, there is a need for greater awareness and opportunities for signposting people to the appropriate services, in this case the probable need to escalate to step 4.

**Step 4 - Referral for assessment and treatment options.** The initial referral (or re-referral after relapse) is a critical part of the therapeutic pathway. If it is done well it can potentiate a successful outcome.

Critical referrers:

- Social workers
- General Practitioners and hospital doctors
- School nurses and health visitors
- Police, probation and prisons

Routes of referral: (whichever route is chosen, the core information requirement is the same)

- E-mail
- Letter
- Phone call (reception staff or receiving professional takes down the details from the referrer)
- Self referral (reception staff or receiving professional takes down the details from the client)

Critical elements of a referral:

- Name and basic demographic data
- NHS and NI numbers if possible
- Name of GP and any other key caring agencies involved
- Relevant medical and psychiatric history and medicines
- Relevant social history, including housing
- Safeguarding risks, eg children or vulnerable adults in household, and client's own risks
- Reason for referral, including substances being misused
- Client's consent and expectations (what has client been told?)

**Step 5 - Assessment and triage**

At this stage the service specification will need to address several needs, summarised here;

- A full social and clinical needs assessment, with onward referral to appropriate agencies for non-service issues such as housing, benefits, safeguarding, psychiatric needs, medical needs.
- Client added to the computer database (or previous file reactivated for a returning client).
- All data logged in a secure confidential format but available to share across the service, with GPs, and where authorised, with other partners such as probation service. Ideally using a system that reads across to GPs, eg System One (see point 19 above).
- Liaison with GP about any gaps in the referral form regarding past and current medical history and medication, relevant social history (including safeguarding), home circumstances, etc. This will be facilitated by a shared IT system, but speed of communication is of the essence if vulnerable clients, perhaps ready to change, are not to receive a rapid response. Prescribing cannot begin without the GP response.
- Appointment booked with the next treatment pathway, according to triage of need.

**Treatment pathway 5.1 - Opiate addiction**

Allocation of a named key worked as single, constant, point of contact.

Consider domiciliary visit to assess home circumstances.

- This is a programme of care that will be customised to individual needs regarding who does the assessment, who else is involved, timing and location of each next follow-up. Case notes to be updated on line at or immediately after each session.
- Complete any outstanding elements of clinical/social assessment
- Discuss client commitment to the programme and readiness for change
- Consider residential detoxification where appropriate
- Initiate psychosocial support
- Initiate prescribing (and ideally simultaneous dispensing and supervised consumption on site). Where there is no on-site provision, refer to community supervised consumption and/or needle exchange.
- When ready, start scaling back prescription
- Group sessions as appropriate, plus voluntary associations
- Finding suitable diversionary activity/education/skills – "something useful to do"

**Treatment pathway 5.2 - Significant alcohol addiction (assessment score over 30 points)**

- Allocation of a named key worked as single, constant, point of contact.
- Consider domiciliary visit to assess home circumstances.
- This is a programme of care that will be customised to individual needs regarding who does the assessment, who else is involved, timing and location of each next follow-up. Case notes to be updated on line at or immediately after each session.
- Complete any outstanding elements of clinical/social assessment and arrange for those needs to be met
- Discuss client commitment to the programme and readiness for change
- Consider residential detoxification where appropriate
- Initiate psychosocial support
- Initiate prescribing (and ideally simultaneous dispensing and supervised consumption on site)
- When ready, start scaling back prescription
- Group sessions as appropriate, plus voluntary associations
- Finding suitable diversionary activity/education/skills – "something useful to do"

**Treatment pathway 5.3 - Non-opiate substance use**

- Allocation of a named key worked as single, constant, point of contact.
- Consider domiciliary visit to assess home circumstances.
- This is a programme of care that will be customised to individual needs regarding who does the assessment, who else is involved, timing and location of each next follow-up. Case notes to be updated on line at or immediately after each session.
- Complete any outstanding elements of clinical/social assessment and arrange for those needs to be met
- Discuss client commitment to the programme and readiness for change

**Treatment pathway 5.4 - Less severe alcohol addiction (assessment score less than 30)**

- Allocation of a named key worked as single, constant, point of contact.
- Consider domiciliary visit to assess home circumstances.
- This is a programme of care that will be customised to individual needs regarding who does the assessment, who else is involved, timing and location of each next follow-up. Case notes to be updated on line at or immediately after each session.
- Complete any outstanding elements of clinical/social assessment and arrange for those needs to be met
- Discuss client commitment to the programme and readiness for change

**Step 6 - Abstinent but under active therapy and supervision**

- Consolidate psychosocial gains
- Plan for discharge, including education, skills, employment, hobbies and interests, including those from voluntary agencies/groups
- Inform GP and relevant agencies of readiness for discharge

**Step 7 - Discharged**

- Discharge details logged on system
- Client offered ongoing peer support groups
- Client offered chance to engage in prevention/peer therapeutic support/ management of service, with appropriate training.
- Inform GP and relevant agencies of discharge.

## 8. Where we are now, and next steps

The current position is that we have two main contracts:

- Addaction: (value £1.2 million). Responsible for: clinical prescribing, GP liaison, blood borne virus testing and vaccination, and drug rehabilitation order screening. This contract has already actioned its two extension options and must be re-procured by 1 April 2019.
- In-house service: (value £800,000) recently brought in-house. Responsible for: psychosocial interventions in groups or 1:1, 12 week community rehabilitation, community integration support, substance misuse training, sourcing residential detoxification and rehabilitation, community and family support, specialist young people support, criminal justice support, liaison with housing, employment and skills. This service suffered from loss of senior leadership and commissioning input through unforeseen circumstances and a tragic death, and so never developed a robust specification, realised its full potential or built all the links with Addaction and the wider networks. (Note that significant savings – circa £0.4 million per year – were envisaged by bringing this element in-house but these will not all be realised until at least March 2019.)
- Needle exchange in pharmacies: £45,000
- Prevention campaign: £17,000

Some needs identified by this review have already been addressed – other require more fundamental re-commissioning.

The options for commissioning afresh, in brief, are these:

1. Bring the whole service in-house, with an internal "purchaser/provider" separation of roles, and possibly sub-contract elements such as prevention campaigns or needle exchange as necessary.
2. Put a detailed specification out to tender, either in entirety or in lots, and see who responds.
3. Undertake a "market engagement" exercise over a few months with potential providers and service users, shaping the service as the dialogue evolves, and let the contracts at the end of the process.
4. An adjunct to all the above, to create more time, would be to apply to Council members for a "contract exemption" for a few months to find time for a longer term solution

# Appendix 1 – profile of the drugs and alcohol problem in Hartlepool

## A1.1 Drugs

**Setting the scene.** This appendix presents an update current of intelligence, evidence and informed opinion regarding drugs within Hartlepool. The most up to date information is presented for a range of areas including attitudes to drugs, the local market, the treatment system, harm reduction, enforcement activity, drug related deaths and the active involvement of service users and carers. The report can be read in conjunction with a range of other sources which provide more detailed information where required.

**National trends and policy shifts.** Nationally, the *Crime Survey for England* shows that around 1 in 12 adults aged 16-59 years (8.4%) has taken an illicit drug in the previous year. This proportion more than doubles amongst young adults aged 16-24 years (18%). 3.3% of all adults were considered frequent users (i.e. more than once a month), rising to 4.7% in young adults.

The most commonly used drugs amongst all adults are **cannabis, powder cocaine and ecstasy**. **Novel Psychoactive Substances (NPS)** use were included for the first time in 2014/15 and 2015/16 data shows this continues to be concentrated amongst young adults (16-24 years – 2.6%), particularly males. Young adults who had previously used another illicit drug were significantly more likely to have used NPS than those who had not. Herbal smoking mixtures were most commonly used amongst all NPS users (52%), followed by powders, crystals, tablets and other substances. NPS were most commonly obtained from a friend, neighbour or colleague and were likely to be associated with visits to pubs or nightclubs, consumption of alcohol and previous drug use.

The Home Office funded DrugWise annual snapshot of the UK drug scene for 2016 highlights:

- Unprecedented street purity levels for heroin, crack, powder cocaine and ecstasy
- The Psychoactive Substance Act achieving high level goals, but new forms of street dealing and distribution putting vulnerable groups at risk as rough sleeping numbers increase
- Reports of young people using heroin to self-medicate from effects of synthetic cannabinoids
- Extension of drug distribution system known as county or country lines
- Increasing numbers coming forward to agencies with cannabis as a primary problem
- Continued reporting of widespread non-medical use of prescription and over the counter drugs not necessarily confined to traditional drug treatment service groups

The Global Drug Survey (GDS) is a large online survey, with response from 50 countries worldwide. It provides information about trends and use by non-traditional drug user groups, the majority of whom are a younger profile and use differently to those accessing specialist drug services. The key findings from the GDS include:

- More people using the "dark net" to shop for drugs, 1 in 10 reported buying drugs off the dark net.
- The UK had the highest rate of NPS purchases of any GDS country (12%), with over 58% reporting they purchased this online. This has increased after declining rates over the previous 4 years
- Excluding alcohol, tobacco and caffeine products, the top 10 drugs used across the world were: cannabis, MDMA, cocaine, amphetamines, LSD ,magic mushrooms, prescribed and non- prescribed opioid medication, nitrous oxide, ketamine and poppers
- Synthetic cannabinoids are more likely to lead to emergency medical treatment

than any other drug, and therefore considered amongst the most dangerous drugs in the world. 1 in 8 using weekly or more often report seeking emergency medical treatment. Overall risk of seeking medical treatment is 30 times higher compared to using skunk. Over half of frequent users (50+ uses) who have tried to stop have reported withdrawal symptoms

- Use of both MDMA and cocaine has increased in last 3 years, and in higher doses. There has been a four- fold increase in British clubbers seeking emergency medical treatment in last 3 years, and women are twice as likely as men to seek help. UK users take more MDMA in a single night than anyone else (almost half a gram)
- Nitrous oxide use is increasing in the UK and globally, now 7th most popular drug in the world. 10% of users are worried about the physical and mental impacts on health and 4% report symptoms of nerve damage due to vitamin B12 deficiency.

**Attitudes to alcohol and services.** Respondents to the Crime Survey for England (aged 16-59 years) are asked about the acceptability for people of their own age to take drugs and how easy it is to obtain illegal drugs. The "most acceptable" use was for cannabis (33%). Actual use of cannabis is estimated to be 6.5% of the population. 9% of adults thought it acceptable to take cocaine or ecstasy occasionally, but this fell to 0.5% to take it frequently. Perceived acceptability of drugs varied by age (a third of 16-19 year olds thought occasional cannabis use was acceptable) and gender (42% of men compared to 29% of women felt some drugs-taking to be acceptable). Half of 16-24 year olds thought it would be easy for them to personally obtain illegal drugs within 24 hours. This fell to 38% for adults over 25.

**Prevalence. T**he estimated prevalence of opiate use in the 15-64 years age range in Hartlepool is 15.5 per 1,000 (918 individuals), against a national rate of 7.3 per 1,000. Looking at those known to services, it is estimated that around 29% of the prevalence is a gap, or an "unmet need". Interestingly, the unmet need is nearer 43% nationally, implying that the Hartlepool services do reach a greater number in need than the norm, though more needs to be done to bring our missing third into the services.

The estimated prevalence of crack use in the 15-64 years age range in Hartlepool is 3.6 per 1,000 (210 individuals). The unmet need here is 63%, the same as nationally, implying a large missed need.

**Treatment pathways and outcomes.** In Hartlepool the most common pathway for opiate users was "prescribing and psychosocial" with 582 clients attending. In 2016-17, 30 clients successfully completely treatment, a rate of 5% which equates to national norms. The most common pathway for non-opiate clients was "psychosocial only" – 94 clients with a success rate of 19% which is lower than the national norm.

Women make up 28% of attendees, but tend to have greater care needs due to childcare responsibilities, domestic violence and mental health problems.

The table below shows the age breakdown of those in drug treatment in Hartlepool during 2016-17. Percentages for males and females by age were very close so have not been shown here. Note that the greatest concentration is in adults of working age and that no service users survive into their 70's.

Table: durug services users in Hartlepool by age, 2016-17

| Age (years) | Number of clients | % of clients | *% of clients - National* |
|---|---|---|---|
| **18-29** | 166 | 20% | 19% |
| **30-39** | 393 | 46% | 37% |
| **40-49** | 228 | 27% | 31% |
| **50-59** | 57 | 7% | 11% |
| **60-69** | 2 | 0% | 2% |
| **70+** | 0 | 0% | 0% |
| | | | |

By ethnicity, 95% of service users are "white British"; 2% "other Asian"; 1% "Indian"; 1% "other white" and 1% "White and Asian".

By country of origin, 98% were born in the UK.

By **religion**, 72% declined to answer or had no religion, 285 were Christian, 1% Buddhist and 1% Muslim.

By **sexuality**, 96% were heterosexual, 2% were gay or lesbian, 25 preferred not to say, and 1% were bisexual.

By self-declared disability, 77% declined to answer or had no disability, 1% described behavioural or emotional disability, 1% learning disability, and 1% progressive conditions. (We know from service providers that mental health problems are highly prevalent and under-reported. 8% of clients were simultaneously under the care of a mental health service, and others will have been under GP supervision for mental health issues.)

**Engagement in treatment** brings additional benefits in that engaged clients use less drugs, commit less crime, improve their health and manage their lives better – and this benefits the wider community. Data are kept on people dropping out of therapy within 12 weeks. Hartlepool's overall unplanned exits from treatment in 2016-17 was 27%, which breaks down to: 21% for opiates, 44% for non-opiates and 29% for non-opiates and alcohol. A feature that many staff raised frequently in discussion was the need to allocate client a key worker to prepare people for behavioural change, and act as mentor, life-coach and supporter.

**Routes into treatment**. In 2016-17, 180 people self-referred; 74 came through the criminal justice system (police, courts, prison or probation service); 17 were referred by social services; 9 by GPs; 3 by hospital A&E, and 43 by other routes. (Where no route was specified, the number is not given here: the actual number of cases is substantially higher.)

Some clients are **parents or carers of children**. In 2016-17 146 were not a parent and had no contact with children; 143 were not a parent but did have contact with children; 49 were living with children (their own or a partner's). One new female presenter was pregnant. 87 children lived with a drug user entering treatment that year.

**Prescription-only medicines used illicitly, and over-the–counter medicines used inappropriately** accounted for 236 individuals at a rate of 28%, which is high compared to a National rate of 15%. Note that these drugs may be used in addition to opioids and others.

New psychoactive drugs and club drugs. In terms of new presentations to the service, numbers are very low at present – only 6 in all of which 2 were also using opioids.

**Location of care**. 844 individuals received some form of high level intervention in 2016-17. All but 19 had some form of psychosocial intervention, and 632 also had pharmacological intervention (7 as in-patients). 196 received recovery support in the community and 5 in hospital (3 men and 2 women).

**Length of time in treatment**. Current experience suggests that those in treatment for 2 years or less have greater chance of sustained recovery. 53% of opiate clients in Hartlepool (48% nationally) have been in treatment under two years. Data from the National Drug Treatment Monitoring Service suggests that clients who stop using illicit opiates within 6 months of treatment are five times more likely to complete successfully than those who continue to use.

At 6 month review:

47 of opiate-using clients (36%) were abstinent – the national figure is similar at 39%.

8 of the crack users (100%) were abstinent – the national figure is 42%.

18 cocaine users (72%) were abstinent – the national comparator is 66%

(Cannabis and alcohol tended to be associated rather than sole use; their abstinence rate at 6 months were 47% and 11% respectively.)

The proportion of all in treatment who successfully completed treated and did not re-present with 6 months were 6.0% for opiates (national rate 7.1%), and non-opiates 19.4% (national rate 37.1%).

**Blood borne viruses** are a risk to injecting drug users and those who share high risk practices with them. Almost all new attendees in 2016-17 accepted Hepatitis B and C testing but only 20 accepted Hepatitis B vaccination (10% of those eligible) and only 7 of those are recorded as completing the course. Providing clean injecting equipment and moving to oral compounds reduces risk very substantially.

**Hospital admissions** are the tip of a larger iceberg of ill-health but usually indicate accelerated deterioration and higher risk of a future fatal event. Since admission may be for complications rather than overdose or suicide, the true impact on hospitals may be substantially higher. Providing Naloxone (and opiate antidote) for domestic or community administration may head off admissions or deaths from overdose.

The rate of hospital admissions for drug poisoning in Hartlepool (primary or secondary diagnosis): 91.6 per 100,000 total population (higher than average for similar local authorities, and than the national average of 52.3 per 100,000). This pattern has held true since 2014-15.

Co-occurring mental health problems (other than addiction itself) may be under-represented in the data returns, especially in general practice where it is most common, but we do know that in 2016-17 a total of 27 individuals (8%) were also receiving unrelated mental health services. National data leads us to expect 3 times as many patients, so there may be unmet need here.

Concern about small but rising **deaths** amongst drug users has led to drug-related death rates being included in the national public health performance indicators. The Hartlepool rate for drug-related deaths aggregated up over the three years 2014-16 is 10.1 per 100,000 population, which is more than twice the national rate of 4.2 per 100,000.

Improving **employment** is not only an objective in its own right but it promotes sustained abstinence. Local employment rates are similar to national ones. At the start of treatment in 2016-17, 49 were in regular employment, 164 were unemployed, 2 were in education and 110 were long

term sick or disabled. None were engaged in voluntary work. There are no good data on treatment outcomes with respect to return to employment.

At the start of treatment, 11 clients had an urgent housing need and another 47 had other housing problems. 276 cited no housing problem. These mirror national rates.

**Safeguarding. T**he Advisory Council on the Misuse of Drugs *Hidden Harm* report identified the level of parental substance misuse in the UK, highlighting that around a third of the adult drug treatment population had child care responsibilities and that there could be five times as many children affected by parental alcohol misuse. Not all parents with substance misuse problems cause harm to their children, but substance misuse can impact on their ability to provide practical and emotional care. It can also mean that children and young people can become carers of parents with substance misuse problems.

Early identification and intervention is key when looking at parental substance misuse, as well as joint working between substance misuse treatment services and children and family services, to ensure families and children get the right support to protect and improve health and wellbeing.

**Value for money.** Investing in drug treatment cuts crime and saves money. For every £1 spent on adult drug treatment, a saving of £2.50 is made in costs to society. Drug treatment prevents an estimated 4.9 million crimes every year. Drug treatment saved an estimated £960m costs to the public, businesses, criminal justice and the National Health Service (Public Health England)

The Department for Education cost-benefit analysis found that for every £1 invested in young people's substance misuse services, there is a saving of £1.93 within two years and £8.38 in the long term. Specialist services engage young people quickly, the majority leave in a planned way and do not return to treatment. This indicates that this is a cost-effective way of securing long-term outcomes, reducing future demand on health, social care, youth justice and mental health services, alongside supporting the Troubled Families agenda.

The social and economic cost of drug use and supply to society is estimated to be around £10.7bn per year nationally, of which £6bn is attributable to drug related crime. There is a strong association between drugs and acquisitive crime. An estimated 45% of acquisitive offences are committed by regular heroin / crack users which equates to more than 2 million offences.

Although heroin and crack use do not necessarily cause people to start committing crime, they may have offended previously. This use can accelerate and extend criminal careers creating a cohort of very prolific offenders. Tackling organised crime linked to drugs – particularly heroin and opiates - remains one of the National Crime Agency priorities. Complexity of global markets, including new technological advances, and changes in the drugs market (such as the new psychoactive substances being developed rapidly) remain of concern, particularly connected to new methods of carriage and crossing borders.

Public Health England provides estimates of crime reduction and cost benefits from investment in drug treatment by relating national figures to local populations. For Hartlepool, the latest estimates are:
Estimated crimes prevented per year (mostly acquisitive crimes): 9,706, or 15% reduction in the total
Social benefits: £406,800
Economic benefits: £2,906,200
NHS and LA benefits: £859,700
Total benefits: £3,162,700

## A1.2 Alcohol

**Alcohol-related hospital admissions.** Alcohol-related hospital admissions can be due to those regularly consuming more than safe limits, dependent drinkers and binge drinkers. Health conditions in which alcohol plays a role can be classified as either "***alcohol-specific***" where there is a direct causal link (eg alcoholic liver disease), or "***alcohol-related***" where alcohol is a contributory factor but not the sole contributor (eg high blood pressure, breast and bowel cancer, and falls). In this summary, the Public Health England (PHE) of "narrow" alcohol-related events is used, ie where alcohol was the primary reason for admission but not the only one.

In 2015/16 there were 749 admissions per 100,000 population in Hartlepool for alcohol-specific conditions (national rate 583 per 100,000) which is statistically significantly higher than expected. 28 of these admissions in Hartlepool were in people under the age of 18.

Of these admissions, 308 were first admissions, 60 were second admissions and 74 were 2 or more admissions – all of which were higher than the national rate.

Taking the PHE definition of narrow alcohol-related admission the figure rises to 839 per 100,000 locally compared with 647 per 100,000 nationally.

Compared with a group of our peers (Redcar and Cleveland), NE Lincolnshire, Sunderland, Gateshead, S Tyneside, N Tyneside, St Helens, Middlesbrough, Knowsley, Wallsall, Wolverhampton, Kingston-upon-Hull, Stoke-on-Trent, Halton, Blackpool) our admission rates are better than the group average.

Breaking down the admission rates for "narrow" alcohol-related diseases into more detail, in 1915/16 the rates per 100,000 for Hartlepool were as follows:

- Injuries: males 252, females 88
- Mental and behavioural: males 130, females low - not recorded
- Intentional self-poisoning: males 58, females low - not recorded
- Cancer incidence: males 54, females 32

**Dying before their time**. Public Health England publishes a useful indicator on "years of life lost". It assumes the age of 75 is a reasonable expectation, so if someone days at, say, 65 years they would have "lost" 10 years. If all the deaths due to alcohol-related conditions are added up it gives an indication of the scale of the problem. In 2015 the rate of years of life lost per 100,000 Hartlepool residents due to alcohol-related conditions was 1,669 for males (797 for England) and 517 for females (311 for England).

Death rates from alcohol-specific diseases over the three-year period 2013-2015, for Hartlepool, men and women, per 100,000, was 21.0 for men (11.5 for England). For alcohol-related deaths the figures were 76.9 and 46.1 respectively.

So, by both indicators – the years of life lost and the mortality rate – Hartlepool is worse than the national average by a wide margin and the differences are statistically significant (ie not likely to be due to random chance).

**Patterns of alcohol consumption.** Harm from alcohol is determined chiefly by volume and frequency of drinking. In 2016 the Chief Medical Officer for England issued revised guidance on alcohol consumption for adults which is no more than 14 units per week. Harm can be instantaneous, as when intoxicated, or build up over years as with liver disease, high blood pressure and certain cancers.

The Health Survey for England shows the following:

| | Hartlepool | National |
|---|---|---|
| **Abstain from alcohol** | 11% | 16% |
| **Drink less than 14 units/week** | 60% | 59% |
| **Drink more than 14 units/week** | 29% | 26% |

These figures show that while most adults drink within recommended limits, Hartlepool has a slight excess of people drinking at levels that will cause harm.

**Unmet need** Public Health England have used prevalence data to estimate the number of people who are dependent on alcohol and would benefit from specialist intervention. By their estimates, around 71% of such individuals are not known to the caring agencies, ie have an unmet need. In England as whole the unmet is even higher, at 82%. This suggests that with respect to alcohol dependency, although there is a high level of potential service users not coming forward, the coverage in Hartlepool is better than average.

**Treatment success rates**. In Hartlepool, the majority of service clients are on the "psychosocial only" pathway, ie not prescribed medication. Success rates tend to be at or better than national averages for heaviest drinkers and those with additional complex needs.

The table below shows local and national treatment success rates at various levels of alcohol consumption:

| | Hartlepool | National |
|---|---|---|
| **Less than 15 units per day** | 37% | 46% |
| **16-30 units per day** | 35% | 40% |
| **More than 30 units per day** | 38% | 37% |
| **More than 15 units per day plus complex needs** | 47% | 36% |

### Value for money (should we invest in alcohol addiction services?)

Economists at Public Health England have looked at national rates for crime and reduction after alcohol treatment programmes, and local treatment rates, and come up with some estimates of return on investment. These are just estimates, and a prompt for discussion, but they do support the case for investment in prevention and treatment.

| | |
|---|---|
| Estimated annual savings in social costs after treatment: | £53,509 |
| Estimated annual economic benefits after treatment: | £147,240 |
| Estimated savings to NHS and Hartlepool Borough Council | £70,198 |
| ***Estimated total annual savings (financial return on investment)*** | ***£271,947*** |

### Population profile for alcohol treatment services

In 2016-17 there were 261 clients in treatment solely for alcohol addiction, of whom two thirds were male. In addition, alcohol was a significant factor in a further 372 clients whose primary problem was opiate addiction. The figures in the rest of this section relate to alcohol dependency alone.

***Age breakdown of clients in treatment***

| Age | number | % | National % |
|---|---|---|---|
| **18-29** | 20 | 8 | 9 |
| **30-39** | 54 | 21 | 22 |
| **40-49** | 85 | 33 | 32 |
| **50-59** | 80 | 31 | 26 |
| **60-69** | 20 | 8 | 10 |
| **70-79** | 2 | 1 | 2 |
| **80+** | 0 | 0 | 0 |

**Other demographic characteristics**. There were 150 new entrants to treatment in 2016-17, of whom 149 were white British and one white Irish. 37 reported their religion as Christian – all the rest were no religion or declined to answer. By sexuality, 140 were heterosexual, 3 were gay/lesbian, 1 was bisexual and 6 were not stated. By self-reported disability, 3 had learning difficulty, 3 had chronic health difficulty and 3 had sight impairment.

**Waiting times** No-one waited more than three weeks to be seen.

Treatment engagement. When engaged in treatment, people use less alcohol, commit less crime, improve their health and manage their lives better – with wider benefits to families and society. In 2016-17 there were 29 unplanned exits from treatment (19%) compared with a national average of 14%.

**Source of referral into treatment, 2016-17**

| | Number | % | National % |
|---|---|---|---|
| **Self-referral** | 79 | 54 | 55 |
| **Via criminal justice** | 9 | 6 | 7 |
| **Via GP** | 22 | 15 | 15 |
| **Via hospital/A&E** | 3 | 2 | 6 |
| **Via social services** | 11 | 7 | 2 |
| **Other** | 23 | 16 | 15 |

Locally, we appear to have more referrals via the social services route, and fewer via hospital and A&E than the national average.

**Parents and children**. These figures relate to those entering alcohol treatment in 2016-17.

- 28 were living with children (own or other)
- 43 were not living with children
- 79 were not a parent and had no household child contact
- 42 children were living in a household with an adult entering treatment
- 1 new female entrant was pregnant

## Duration of treatment

NICE clinical guideline CG115 recommends harmful and mildly dependent drinkers receive a treatment intervention lasting 3 months, those with moderate and severe dependence should receive treatment for a minimum of 6 months while those with higher or complex needs may need longer in specialist treatment.

***Table: length of time in treatment***

| | Number | % | National % |
|---|---|---|---|
| Less than 1 month | **7** | **4** | **9** |
| 1-3 months | **44** | **24** | **24** |
| 3-6 months | **46** | **25** | **31** |
| 6-9 months | **34** | **18** | **16** |
| 9-12 months | **18** | **10** | **9** |
| 12 + | **37** | **20** | **13** |

## Other profile factors

- One individual with alcohol as their sole dependency received residential rehabilitation for detoxification.
- 17 new entrants to treatment were also in the care of mental health services
- 36 individuals (24%) were in employment
- 44 individuals (29%) were long term sick or disabled
- No individuals reported being engaged in voluntary or unpaid work.
- At the point of leaving treatment, 24% were in full or part-time employment.
- 7 new entrants reported a housing problem (1 urgent)
- On leaving treatment, 3 reported a continuing housing problem

## Successful completions

In 2016-17 90 individuals (34%) came out of treatment successfully (40% nationally)

The proportion who successfully completed treatment and did not re-present within 6 months was 136% (39% nationally).

# Appendix 2: sources of evidence and guidance

## HM Government

2017 Drug Strategy

## Public Health England

Evidence reviews

- The public health burden of Alcohol
- Drug misuse treatment in England: evidence review of outcomes

Guidance for commissioners and providers

- Drugs misuse and dependence: UK guidelines on clinical management
- Alcohol, drugs and tobacco: commissioning support pack
- Alcohol and drug prevention, treatment and recovery: why invest?
- New psychoactive substances toolkit for commissioners
- Alcohol and drug treatment quality governance
- Routes to recovery from substance addiction
- Treating drug dependence recovery with medication
- Preventing drugs and alcohol misuse: effective interventions
- Service user involvement in alcohol and drug misuse treatment
- Services to treat dependence on medicines
- Developing local substance misuse safeguarding protocols
- Mutual aid toolkit for drug and alcohol misuse treatment
- Treating substance misuse and related harm: turning evidence into practice
- Local alcohol services and systems improvement tool

Social return on investment value for money tools

- Social return on investment of alcohol and drug treatment
- Social return on investment for treating substance misusing parents
- Estimating the cost-effectiveness of alcohol and drug treatment

Reducing harm and preventing drug-related deaths

- Fentanyl: preparing for a future threat
- Trends in drugs misuse deaths in England
- Preventing drug related deaths
- Health matters: preventing drug misuse deaths
- Widening the availability of naloxone
- Providing take-home naloxone for opioid overdose
- Issuing public health alerts about drugs
- Shooting up: infections among people who inject drugs in UK

Professional roles

- Social workers
- Clinical psychologists
- Addiction specialists
- Non-medical prescribing
- Nurses

Specific patient groups

- Substance misuse services for men involved in chem-sex
- People with co-occuring conditions: commissioning and providing services

Spend and outcome tool (SPOT)

Public Health Outcomes Framework (PHOF)

## National Institute for Health and Clinical Excellence (NICE)

### NICE pathways

- Co-existing severe mental illness and substance misuse: assessment and management in healthcare settings
- Coexisting severe mental illness and substance misuse: community health and social services
- Drug misuse management in over-16s: psychosocial interventions
- Drug misuse prevention
- Needle and syringe programmes

### NICE guidelines

- Co-existing severe mental illness and substance misuse: assessment and management in healthcare settings
- Coexisting severe mental illness and substance misuse: community health and social services
- Drug misuse in over-16s: opioid detoxification
- Drug misuse management in over-16s: psychosocial interventions
- Drug misuse prevention: targeted intervention
- Needle and syringe programmes
- Naltrexone for the management of opioid dependence

### Quality standards

- Drug misuse prevention
- Drug use disorders in adults

# Appendix 3 Current strategies and groups relating to drugs and alcohol

## A3.1 Health and wellbeing strategy and delivery plan (2018-2025)

This strategy has five elements that all have a bearing on drugs and alcohol:

- Starting well - all children and young people living in Hartlepool have the best start in life
- Working well – workplaces in Hartlepool promote and support healthy living
- Ageing well – older people in Hartlepool live active and independent lives and are supported to manage their own health and wellbeing.
- Living well – Hartlepool is a safe and healthy place to live with strong communities
- Dying well – people in Hartlepool are supported for a good death.

In appendix 1 of the strategy there is a delivery plan 2018-2025. Section 3 of that appendix relates to "reduce drug and alcohol harm".

Understanding needs and demand

- Utilise multi-agency data, information and demographics across Hartlepool to provide a better overview of need to help redirection action through the Joint Strategic Needs Assessment.
- Map current activity to help redirect action to areas of most need through the development and implementation of a multi-agency drug and alcohol harm reduction delivery framework and to improve access to interventions – to include a focus on children and young people's misuse and parental impact.

Targeted awareness and social marketing

- Design and launch a "Hartlepool big conversation" programme that will support multi-agency and town-wide social marketing on drugs and alcohol harm – use sport as an engagement tool for prevention and recovery.

Promoting behaviour change

- Pilot a behaviour insight project to help understand behavioural barriers to accessing interventions and implement appropriate ethnographic interventions in response in order to improve uptake of services.

Children and young people's (CYP) health

- Develop local CYP workforce (to help make every contact count) to provide parental and CYP education and to indentify drug and alcohol misuse issues and intervene early; and to support schools and colleges to play a lead role
- Design and implement a multi-agency model that will support early indication of 2hidden harm" and intervention in order to minimise the impact of drugs and alcohol on CYP
- Build and provide multi-agency integrated early help services for "hidden harm"

# Hartlepool substance misuse strategy 2016-2019

## *(under the auspices of the Safer Hartlepool Partnership)*

The substance misuse strategy is required in accordance with the Crime and Disorder Act 1998 whereby Community Safety Partnerships (in our case, Safer Hartlepool Partnership) have a statutory duty to develop and implement strategies to reduce crime and disorder, substance misuse and re-offending in local areas.

Safer Hartlepool Partnership draws membership from the Local Authority, police, Public Health England, probation, Balance (to March 2019), NHS and fire service.

It reports to the Youth Offending Service Management Board; the Hartlepool Children's Safeguarding Board; Hartlepool Vulnerable Adults Board and Hartlepool Health and Wellbeing Board.

It conducts its work in six sub-groups:

- Domestic violence and abuse group
- Re-offending group
- Substance misuse group
- Antisocial behaviour group
- Communication group
- Neighbourhood action group.

Since December 2010 national drug strategies have shifted focus from maintenance therapy to recovery. It requires a "whole system" approach with education, training and employment, housing, family support services, NHS and criminal justice.

The strategy may be simplified to 3 objectives:

- Prevention and early intervention
- Supporting individuals and families affected by substance misuse whilst working towards recovery and abstinence
- Achieve outcomes and sustained recovery by delivering high quality treatment systems

Responsibility for monitoring progress and success is vested in Public Health, reporting via the substance misuse strategy group to the Safer Hartlepool Partnership.

# Hartlepool Drug and Alcohol Harm Reduction Delivery Framework (2018-2025)

## Our Ambition

*By 2025, Hartlepool will be a safer and healthier place to live, work or visit with minimised impact from harm caused by drugs and alcohol misuse*

## Our Aims

- Reduce drugs and alcohol related health and wellbeing harm to individuals, families and communities
- Minimise the negative impact of drugs and alcohol misuse on children and young people (CYP) and communities

## Our Objectives

1. Facilitate improved knowledge; positive attitudes; and behavioural change to drugs and alcohol misuse
2. Improve early identification of risk and intervene to reduce progression of vulnerability to self /others
3. Provide seamless drugs and alcohol treatment pathway for services users
4. Develop streamlined pathways of care with other services for people with multiple needs e.g. mental health, domestic abuse
5. Provide a safer, environment with minimised harm from drug and alcohol for children and empower young people to make informed decisions
6. Reduce drugs and alcohol related homelessness, anti-social behaviour and crime.

## Actions Required *(numbers relate to objectives, above)*

### Objective 1.

- Continue to work with Balance North East to support national, regional and local campaigns and advocacy including medicines optimisation and minimum unit price
- Utilise community action initiatives to drive prevention in vulnerable communities
- Develop and implement a framework to support prevention in work places and community settings

### Objective 2.

- Utilise multi-agency intelligence to develop the Joint Strategic Needs Assessment (JSNA) and target appropriate risk groups
- Provide training to all partners to implement effective screening and IBA
- Build and provide early help services for 'hidden harm'
- Raise awareness of local services and clarify referral processes for all partners
- Continue to implement the blood-borne virus (BBV) screening and immunisation scheme, including needle exchange
- Align service pathways with the care navigator programme.
- Implement a behaviour insight programme to improve uptake of support by services
- Develop a health equity audit for drugs and alcohol

**Objective 3.**

- Ensure referral process for community services is communicated to all partners
- Establish multi-agency approach to treatment and recovery based on clients' need
- Establish multi-agency arrangement for transition between services e.g. NBPS, homelessness service and supported housing
- Produce detailed directory of aftercare support services with access criteria, available in the community and share with all providers
- Align with hospital based treatment pathways

**Objective 4.**

- Implement cross organisational information gathering and sharing protocol for all providers
- Continue to embed the dual diagnosis pathway into practice
- Implement regular multidisciplinary team review for complex patients (to include housing and employment leads)

**Objective 5.**

- Provide regular training and marketing in conjunction with schools and colleges to increase awareness of the harmful impacts of drugs and alcohol to parents and CYP
- Provide and promote diversionary activities for CYP
- Work with communities and businesses to reduce availability/ illegal sale to CYP
- Align prevention programmes with other ongoing programmes e.g. crucial crew to raise awareness in schools and embed in curriculum

**Objective 6.**

- Tackle supply and related crime/anti-social behaviour – alcohol, legal highs, new psychoactive substances (NPS), controlled drugs etc
- Utilise universal programmes and services to enable re-integration and recovery
- Continue to commission assisted housing support and align to the homelessness pathway
- Utilise legal and enforcement powers to reduce crime and anti-social behaviour
- Continue to implement the challenge 25 scheme with businesses
- Utilise the BHAWA to provide employer-led schemes

**Expected Outputs *(numbers relate to objectives, above)***

**Objective 1.**

- 'Hartlepool Big Conversation' launched
- Multi-agency social marketing programme designed and implemented
- Community champion/peer educator/network programme implemented

**Objective 2.**

- JSNA refreshed
- Training framework produce with annual log of institutions trained
- Early help service offer clearly outlined and documented
- Directory of local services with referral criteria available to all partners
- Health equity audit completed and used to direct resource utilisation based on need

**Objective 3.**

- Clear multi-agency pathways agreed and implemented
- Directory of local services with referral criteria available to all partners

**Objective 4.**

- Multi-agency information sharing protocol agreed and implemented
- MDT review process established

**Objective 5.**

- Annual CYP training and marketing programme agreed with schools and colleges and implemented
- Business model for reducing illegal sale to CYP established with regular monitoring

**Objective 6.**

- Increased uptake of universal programmes
- Improved progression of clients from assisted housing to longer term tenancy
- Reducing trend in drug and alcohol related crime and anti-social behaviour
- Increase in number of businesses signed up to the challenge 25 scheme
- Reduced drug and excess alcohol consumption
- Cultural change of attitudes to drugs and alcohol

For comments or questions on this draft needs assessment, contact:

Dr Peter Brambleby, Interim Director of Public Health, peter.brambleby@hartlepool.gov.uk)

**POVERTY IMPACT ASSESSMENT FORM: drugs and alcohol needs assessment**

| | | | | |
|---|---|---|---|---|
| **1. Is this decision a Budget & Policy Framework or Key Decision?**<br><br>**YES** | | | | |
| **2. Will there be an impact of the decision requested in respect of Child and Family Poverty?**<br><br>**YES** | | | | |
| **GROUP** | **POSITIVE IMPACT** | **NEGATIVE IMPACT** | **NO IMPACT** | **REASON & EVIDENCE** |
| **Young working people aged 18 - 21** | Improve life chances, skills and employability | Nil | | Drugs and alcohol misuse are major causes of joblessness and poverty |
| **Those who are disabled or suffer from illness / mental illness** | Improved recovery rates | Nil | | Addiction and mental health needs frequently co-exist and need to be addressed together for greater chance of successful outcome |
| **Those with low educational attainment** | Improved education and/or skills | Nil | | Service outcome objective |
| **Those who are unemployed** | More employable, less sickness absence | Nil | | Service outcome objective |
| **Those who are underemployed** | Improved employment chances | Nil | | Service outcome objective |
| **Children born into families in poverty** | Breaks the generational cycle seen in addictions | Nil | | Evidence cited in the strategy document |
| **Those who find difficulty in managing their finances** | Yes | Nil | | Social, housing and financial support is part of the wrap-around in this needs assessment |
| | | | | |
| **Poverty is measured in different ways. Will the policy / decision have an impact on child and family poverty and in what way?** | | | | |
| **Poverty Measure (examples of poverty measures appended overleaf)** | **POSITIVE IMPACT** | **NEGATIVE IMPACT** | **NO IMPACT** | **REASON & EVIDENCE** |

| | | | | |
|---|---|---|---|---|
| Children in Low Income Families (%) | Yes<br><br>Reduces inequalities | No | | Addiction disproportionately high in low income families |
| Children in Working Households (%) | No | No | | |
| Overall employment rate (%) | Yes, marginal | No | | Evidence from current service shows small but important return to work within 6 months of recovery |
| Proportion of young people who are NEET | Yes, marginal | No | | Ditto |
| Adults with Learning difficulties in employment | No | No | | This group not greatly represented in addiction |
| Free School meals attainment gap (key stage 2 and key stage 4) | no | no | | Usually affects older groups |
| Gap in progression to higher education FSM / Non FSM | Possibly | no | | Through prevention |
| Achievement gap between disadvantaged pupils and all pupils (key stage 2 and key stage 4) | Possibly | no | | Through prevention |
| Number of affordable homes built | No | No | | |
| Prevalence of obese children in reception year | no | no | | |
| Prevalence of obese children in reception year 6 | no | no | | |
| Life expectancy | Yes | no | | Likely to be very significant improvement |

| **Overall impact of Policy / Decision** | | |
|---|---|---|
| **The impact will be positive.** | | |
| | | |

# Impact Assessment Form

| Department | Division | Section | Owner/Officer |
|---|---|---|---|
| *Children and joint commissioning services* | *Public Health* | | *Interim Director of Public Health, Dr Peter Brambleby* |
| **Service, policy, practice being reviewed/changed or planned** | **Drugs and alcohol needs assessment leading to revised service specifications** | | |
| **Why are you making the change?** | Current needs assessment out of date and service contract expiring | | |

**How might this impact (positively/negatively) on people who share protected characteristics?**

| | *Please tick* POSITIVELY | NEGATIVELY |
|---|---|---|
| **Age** | **Reduce premature mortality (<75 years) from drugs and alcohol** | |
| **Disability** | **Reduce physical, mental and social disability** | |
| **Gender Re-assignment** | **nil** | |
| **Race** | **nil** | |
| **Religion** | **nil** | |
| **Gender** | **nil** | |
| **Sexual Orientation** | **nil** | |
| **Marriage & Civil Partnership** | **nil** | |
| **Pregnancy & Maternity** | **Positive impact for females of child-bearing age with addiction** | |

| | |
|---|---|
| **Has there been consultation /is consultation planned with people who will be affected by this policy? How has this affected your decision making?** | Yes – service users were consulted and had a major impact on shape and direction – referred to in the text. A new role is proposed for service users in the management team, service provision and evaluation. |
| **As a result of your decision how can you mitigate negative/maximise positive outcomes and foster good relationships?** | Further continual dialogue with service users and those charities, voluntary organisations and faith groups that work with drugs and alcohol users through existing channels. |
| **Describe how you will address and monitor the impact** | Next steps are to re-commission the service to meet the needs identified, and monitor via commissioning and monitoring of key performance indicators and targets. |

| | | | |
|---|---|---|---|
| Initial Assessment | | Reviewed | |
| Completed | | Published | |

# NARRATIVE AND COMMUNICATIONS PACK FOR NHS ORGANISATIONS IN NORTH CUMBRIA AND THE NORTH EAST

## Integrating and optimising healthcare services to meet local need and maximise stability

## Content



**Members of the communications and engagement work stream (which includes health provider, CCG and NHS England representatives) for our aspiring ICS have developed the attached pack to support a collaborative and consistent dialogue regarding our emerging picture across North Cumbria and the North East.**

## A case for change

Since its creation in 1948, the NHS has evolved and adapted to meet changing needs and expectations.

Patients now have access to a wider range of treatment, using new technology, techniques and medicines, and provided by a changing workforce who have new skills and expertise. Positive outcomes have increased, with more people living longer and healthier lives, often as a result of tailored support for long-term conditions and more successful treatment for serious illness or injury.

The nature of how and where care is provided - whether that's in hospitals, community clinics, GP surgeries or at home - continues to change. For example,

many operations and treatments that would previously have needed long recovery in bed are now routine, done in a day, and carried out in local hospitals, or even clinics and GP surgeries.

Spending less time in hospital is better for patients' recovery and we know most people prefer to be cared for at home if possible. New technologies and ways of working allow this to happen more easily, which also means a greater need for social care and community health services to be coordinated, and new approaches to prevention and wellbeing, patient centred care and integration of health services across settings.

The NHS needs to continue evolving because everyone deserves access to high quality treatment and care, provided by experienced teams. Sometimes this will be in the home or community settings and sometimes in hospital. For some conditions and illnesses this will be close to where patients live and sometimes it will be in 'centres of excellence', with a larger catchment area.

In many situations, particularly emergencies such as stroke and heart attack, treatment in the right place from an experienced specialist team can mean the difference between death or life long disability and getting a good outcome and resuming a normal life.

## The wider context

As well as the changes above, a number of national and local priorities are influencing how, when and where health care is provided, particularly in relation to services becoming more integrated and coordinated.

It is inevitable that some care will need to be provided in a different way, to ensure the best clinical standards are met, that services are fit for future purpose, safe and sustainable.

The NHS is complex and patients can experience a number of different organisations, processes and systems during their journey.

The majority of people – around 80 per cent - receive most care via their local GP surgery. GP practices are increasingly offering longer opening hours and more appointment slots, and a wider range of treatment can be provided at local surgeries or into patients' homes. Over the last few years, the range and availability of care provided in the community has increased and this is linked with changes to how services are provided in hospital too.

The range of care in hospitals depends on how services have grown over the years and the expertise and experience of staff working there. Medical advances, technology, the needs of local populations and staff skills, combined with national and local priorities, are shaping how services need to be planned and delivered in the future.

In future, more care currently provided in hospital could move to the community but still be delivered and funded by health, and some hospital services may need to be organised in a different way to meet the best clinical standards and changing expertise of NHS staff.

Wherever services are provided, the priority will always be to improve quality and outcomes for patients and make best use of staff skills and expertise.

Digital health approaches, through programmes such as the Great North Care Records (GNCR), is developing systems to enable patient records to be shared with appropriate health and care providers, with appropriate controls and consent. In addition, where possible, this will provide patients and citizens with secure access to their own health care records electronically, to enable then to participate and contribute to their own health and care management.

## How we're working together

Senior leaders and doctors from NHS organisations across Cumbria and the north east are working together regionally and locally to:

- Plan and develop services to meet the needs of local populations from North Yorkshire to the Scottish Borders now and in the future – taking into account how services are currently provided and where they need to change or develop. In particular, where new models of care might need to be introduced to integrate what is provided and ensure patients are seen in the right place, by the right person to meet their needs.
- Use information held by each organisation to ensure planning and development of services is based on patient and population need and available skills and resources.
- Consider how the current and predicted NHS workforce affects the provision of services.
- Look at services such as tests, scans, x-rays and other diagnostics, and how they could be provided in a more accessible and efficient way.

Initial thinking and priorities for this were outlined in sustainability and transformation plans published in the autumn of 2016. The partnership working that has evolved since then is focused on bringing about change in a number of areas. The rationale and context for making the changes is not dependent on organisational form however, a number of developments are taking place to ensure organisations are best aligned to support the changes, which are often needed across organisational boundaries.

Our partnership working involves a focus on number of areas of work (workstreams), all of which have interdependencies that we need to understand. These include:

Main themes

- Acute care including specialised and core services which are vulnerable due to staffing shortages, e.g. Pathology; Paediatrics; Radiology etc.
- Care closer to your home/ Primary Care

Pathways

- Urgent and emergency care
- Cancer
- Mental health
- Digital
- Learning disabilities
- Prevention
- Continuing healthcare

Supporting workstreams

- Workforce – staff engagement is key to this
- Communications and engagement
- System development / knowledge sharing
- Demand management
- Estates
- Transport

A cross-cutting work stream newsletter is planned for stakeholders and NHS organisations to keep all partners updated on developments.

## Integrated care system and partnerships

There has been a lot of discussion about how NHS organisations can work together to deliver required change.

This is particularly so in relation to patient flows (how and where patients use services), clinical networks (how we share clinical expertise), and in relation to the strong partnerships that have been in place for many years across the region.

As a result we have been thinking about how we could deliver the positive changes we need for our patients, and how planning for those changes would benefit from taking place across the whole North Cumbria and North East footprint, working for people from North Yorkshire to the Scottish Borders.

Integrated care means working together, focused on the same outcomes for patients, and often involves NHS organisations, councils and the voluntary or charity

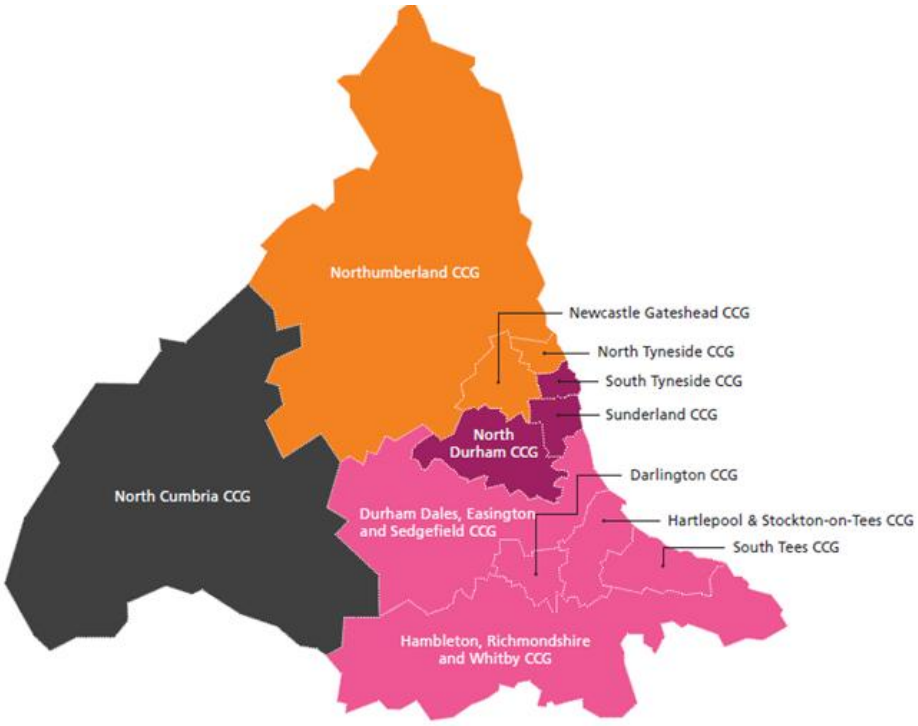
sector, in particular when providing care closer to home and tackling the causes of ill health.

- **Integrated care systems (ICSs)** are evolving and will lead and plan care for their specific population and provide coordinated leadership across NHS organisations. This involves where appropriate taking a 'do once' approach to joint priorities and pieces of work that are common to all organisations in the area.

- **Integrated care partnerships (ICPs)** are alliances of providers and commissioners who are collaborating to deliver care. In North Cumbria and the North East, the proposal is for four ICPs to be in place, to run alongside a Cumbria and North East ICS, which will take responsibility for overall coordination in the whole geographical area, by April 2019. Health providers include hospitals, community services, mental health services, GPs, and independent and third sector providers. The ICPs will focus initially on bringing together enough critical mass to sustain vulnerable acute services within their geography, and the commissioning of non-specialist acute care. CCGs within these ICP geographies will continue to develop place-based arrangements for the planning and provision of primary and community care and health and social care integration, aligned to the overall ICS strategy.

We aim to build strong collaborative relationships with patient groups, local HealthWatch and VCSE organisations operating across the region, including organisations and groups working with some of the most excluded and hard to reach communities.

# Proposals for North Cumbria and the North East




**North Cumbria ICP – proposed footprint**

- Population 327k
- North Cumbria CCG
- North Cumbria University Hospitals Trust
- Cumbria Partnership NHS Foundation Trust
- Cumbria County Council

**'North' ICP – proposed footprint**

- Population 1.025 million
- 3 CCGs: Northumberland; North Tyneside; Newcastle Gateshead
- 3 Foundation Trusts: Northumbria, Newcastle, Gateshead
- 4 Councils: Northumberland, North Tyneside, Newcastle, Gateshead

**'Central' ICP – proposed footprint**

- Population 675k
- 4 CCGs: South Tyneside; Sunderland; North Durham; Durham Dales Easington and Sedgefield
- 3 Foundation Trusts: Sunderland-South Tyneside, CDDFT
- 3 Councils: South Tyneside, Sunderland, County Durham

**'South' ICP – proposed footprint**

- Population 1.1 million
- 6 CCGs: Durham Dales Easington and Sedgefield; North Durham; Hartlepool and Stockton; Darlington; South Tees; Hambleton, Richmondshire and Whitby
- 3 Foundation Trusts: North Tees, South Tees, CDDFT
- 7 Councils: County Durham, Darlington Hartlepool, Stockton, Middlesbrough, Redcar & Cleveland, North Yorkshire

We envisage the two mental health trusts, working in ongoing collaboration with eachother, the North East Ambulance Service NHS Foundation Trust (FT) and neighbouring foundation trusts (such as the Yorkshire Ambulance Service NHS FT and North West Ambulance Service NHS FT) will continue to play into ICPs at the appropriate level, given their size and geographies.

## The status of integrated care systems

ICSs are not statutory bodies or organisations. Although they need clear leadership, decision-making and governance structures, they are essentially about individual organisations joining together to improve health and care. ICSs are expected to:

- Have a formal agreement with NHS England and NHS Improvement to implement faster improvements in care, to agreed shared targets.
- Manage resources for a defined population by taking shared responsibility, including a joint agreement and approach to finances.
- Have effective collective decision-making and governance structures aligned with the statutory accountabilities of each constituent organisation.
- Show how providers will collaborate across boundaries, for example doctors and nurses from different organisations working as a clinical network 'horizontally' across hospital sites but also integrating 'vertically' with GP and community services.
- Use data and evidence to improve the prevention of ill health, manage avoidable demand and reduce variation.
- Ensure people have the information they need to make an informed choice about where they are treated.

Within an integrated care system, constituent organisations will have:

- Delegated decision making for commissioning primary care and primary care, community services and acute care.
- A streamlined relationship with NHS England and NHS Improvement and the opportunity to access resources, including relevant staff and funding from the two organisations in support of ICS work.

To achieve integrated care system status, organisations must demonstrate the following:

| Criteria | Key measures |
|---|---|
| **Effective leadership and relationships, capacity and capability** | • Strong leadership, with mature relationships including local government.<br>• Clear shared vision and credible strategy.<br>• Effective collective decision-making.<br>• Effective ways of involving clinicians and staff, service users/public and community partners.<br>• Ability and capability to carry out decisions that are made. |
| **Track record of delivery** | • Tangible progress towards delivering the *Five Year Forward View* priorities (redesigned urgent and emergency care services, better access to primary care, improved mental health and cancer services).<br>• Progress in improving performance (relative to rest of country) against NHS Constitution standards (or sustaining performance where those standards are being met). |
| **Strong financial management** | • Strong financial management, with a collective commitment from CCGs and trusts to system planning and shared financial risk management, supported by system control total and system operating plan. |
| **Focused on care redesign** | • Compelling plans to integrate primary care, mental health, social care and hospital services, and collaborate horizontally (between hospitals).<br>• Starting to use population health approaches to redesign care around people at risk of becoming acutely unwell.<br>• Starting to develop primary care networks. |
| **Coherent and defined population** | • A meaningful geographic footprint that respects patient flows.<br>• Contiguous with local authority boundaries, or – where not practicable – clear arrangements for working across local authority boundaries. |

## Hospital services in North Cumbria and the North East – priorities for change

Since Autumn 2017, around 70 senior clinical staff, doctors and nurses from across North Cumbria and the North East have been discussing how to work together to provide the best possible services for patients.

Discussions have confirmed pressures relating to the sustainable delivery of some services, particularly due to challenges around workforce, quality and optimum levels

of safety. They have highlighted that some services need to be provided in a different way to ensure they meet the best possible clinical quality standards.

Safe and high quality services need to be provided by the correct medical professional, with access to the best diagnostics and treatment to give patients the strongest possible chance of recovery. The discussions have shown that some services don't currently operate like this, meaning not all patients are provided with the best possible chance of recovery.

Often, these services are the ones facing the most severe workforce and quality challenges, driven predominantly by a shortage of medical staff. This situation results in risks to service provision and quality, and additional financial pressures. It is likely that a failure to bring improvement to such 'vulnerable' services could lead to emergency suspension or closure, putting patient safety at risk, i.e. increasing the possibility of harm or a life-long health condition or disability.

The most vulnerable hospital services across North Cumbria and the North East have now been agreed, including the underlying reasons for changes that need to take place. This clinically-led list identifies priorities to provide more patients with access to high quality and safe services in the most appropriate place. By definition, this will not always be local to all patients.

The need for change to these services does not pre-determine decisions on potential future structure and location of services. The priorities for change have been discussed by boards and governing bodies of hospital trusts and clinical commissioning groups. With the ongoing input of the wider group of senior doctors, the urgent steps to improve the safety and sustainability of these vulnerable services will be defined over the coming months and link with the development of the integrated care partnerships and system outlined above.

The responsibility to engage with staff, stakeholders, patients and the public – as well as to formally consult on future service arrangements – remains essential. Engagement with local authorities, Health and Wellbeing Boards and key stakeholders will take place during 2018 and beyond, led by clinical commissioning groups.

## A collaborative communications approach

There is a need for a coordinated system-wide approach to communications, engagement and, where necessary, consultation activity to create a wider understanding and support for the system and service change outlined above.

Organisations in Cumbria and the north east (CNE) are asked to sign up to the joint communications approach and narrative in this document to help create a better understanding amongst patients, staff and other stakeholders about what is happening.

This will be the basis of a communications and engagement strategy which we are now developing to deliver the objectives below.

**Collaborative leadership communications objectives**

- Keep public confidence in the system through a co-ordinated approach.
- Manage a safe and robust process for all system change.
- Ensure the voice of patients and our communities is heard at all levels of the system and at every step of change and improvement.
- Ensure consistent language and terminology supports a wider understanding of the rationale and evidence for change - a key principle of this strategy will be the use of transparent language with the public and stakeholders, avoiding technical terms, jargon and acronyms where at all possible.
- Provide a leadership role in delivering joint communications strategies and activities, i.e. using agreed key messages and resources to support internal and external communications and engagement, with coordinated and consistent timings (where possible) including: staff briefings, stakeholder briefings/letters, board/governing body papers, media statements.
- Commit organisational resource to a joint communications approach.
- Endorse and support the delivery of communications work through the NCNE communications network and regional communications and engagement workstream, including resources as required.

CNE-wide or 'do once' communications, engagement and, where necessary, consultation strategies will be developed by the nominated leads for NHS England, provider organisations and CCGs/NECS, via their strategic communications group meeting. This will happen when joint objectives and business needs are identified.

In terms of delivering this activity, the work stream for communications and engagement will consider resource requirements and identify how the work will be delivered. In most cases, delivery will be a shared responsibility between provider organisations and CCGs, in partnership with NHS England. Teams will ensure communications and engagement activities are implemented across system partners and through their 'owned' channels, including internal and external.

Regional and national approvals from NHS England and NHS Improvement will still be required for certain elements of communications and engagement work. This will be managed in partnership with the regional communications teams for NHSE and NHSI.

## Appendix A - Communications objectives and actions

| Objective | Action | Who | When | Status |
|---|---|---|---|---|
| Agree overarching narrative and clear messages setting out the rationale and evidence for service change | Produce narrative and core messages to form context/rationale for trust, CCG and NHSE internal and external communications materials | NHSE to draft. ICS lead and communications and engagement workstream SRO to agree | May 18 | Complete |
| Map key stakeholders and information/engagement needs – including staff, unions/staff representatives, overview and scrutiny committees, elected members, MPs, campaign groups and third sector/partner organisations - and map the methods/channels available in each organisation to reach these groups and individuals. | Stakeholder and influencer mapping exercise to identify priorities.<br>Identify 'owned' and 'earned' communications channels to reach and engage with identified individuals and groups | NECS and providers | Ongoing | |
| Identify and produce a core set of communications and engagement materials (linked with above stakeholder mapping) to support all organisations with their internal and external communications and engagement activities | Map what's already available and identify gaps.<br>Produce materials and information to use with key individuals and groups (above), including briefing documents, papers, videos, internal communications, digital and other content. | All – work to be allocated and progressed in discussion with communication and engagement work stream SROs | April onwards | |

| | | | | |
|---|---|---|---|---|
| Agree communications and engagement approach, including content and timings, with NCNE leaders. | ICS lead to circulate agreed communications pack and narrative, inviting leaders to use in their communications with key stakeholders. | ICS lead | May 18 | |
| Set a best-practice framework for communications, engagement and formal consultation activities, so organisations across the health system can demonstrably meet statutory requirements and stakeholder needs. | Produce summary overview and checklists to ensure statutory obligations are understood and met. Provide evidence of 'what works' based on previous activities and evaluations. | NECS and provider reps | June 2018 | |
| Work with and through NHS communications network in Cumbria and the north east to deliver the joint communications and engagement requirements of emerging integrated care system. | Establish new terms of reference and reframe NHS communications network and agree a programme of work to deliver the joint communications and engagement requirements and, potentially, integrated care systems across the area. | New ToRs agreed.<br>Development and implementation of work programme ongoing. | March 18 onwards | |
| Agree a systematic approach to communications and engagement activity about ICS developments across | Agree content and approach for consistent and timely stakeholder | All | Various - ongoing | LA leader and communications lead meetings |

| | | | | |
|---|---|---|---|---|
| CNE health economy. | engagement, including:<br>- briefings and meetings with LA chief executives, directors of social services, directors of public health and key elected members.<br>- staff engagement | | | taking place or arranged.<br>OSC meetings to be mapped and paper tabled.<br>Staff briefing to be produced. |
| Agree consistent protocols for: handling joint 'regional' work, including: media enquiries, production of materials and formal briefings e.g. for health overview and scrutiny committees, parliamentary activity, attendance at (J)OSCs etc. | NHSE, CCG and provider representatives to draft and agree protocols and share with communications network. | NHSE and NECS | July 2018 | |

## Communications materials – priorities

| **Material** | **Status** |
|---|---|
| Generic video animation explaining the case for change. | Two versions available for use and comment |
| Grid of agreed core messages for use with mapped stakeholders. Narrative above document provides backdrop and context but themed messages by service / work stream are required, i.e. to explain context and proposed service change, as well as a geographical overview of local priorities | NECS to draft by geographical area. |
| Timetable and core content for 'regional' LA engagement regarding ICP/ICS. | To be agreed with ICS lead and CCG AOs |
| Timetable and core content for local LA and MP engagement regarding ICP/ICS | To be finalised by trusts and NECS and cross referenced to above. |
| Programme and content for wider staff engagement regarding ICS progress (not specific engagement regarding service change). | To be finalised by all – June |

**NB.** Individual organisations retain statutory responsibility for engagement and consultation regarding service change involving and affecting their organisation. This joint approach relates to wider communications and engagement about ICS and the rationale and requirement for change.

## Appendix B - Key facts

- *Over the course of a year in North Cumbria and the North East, NHS organisations provide 14 million appointments, including 680,000 emergency appointments and 3 million out-patient appointments.*
- *In a 12 month period, over 78 million prescriptions are written across the region.*
- *While the number of patients treated continues to increase, medical advances and a shift towards treatment and care outside of hospital, means the number who have long-term stays in hospital has reduced.*
- *In 1974, about 7% of procedures were carried out as day cases. By 2013 this had increased 35% (an increase from 417,000 to 6.3 million!)*
- *Ten years ago the average time spent in hospital after a hip operation was about nine days, it's now about two and a half days. The average time spent in hospital after a knee operation has also reduced by about six days in the last ten years.*
- *One week of bed rest equates to 10% loss in strength, which can be the difference between dependence and independence, and meaning it is very beneficial to help patients be as mobile as possible and support them to return home.*
- *It costs the NHS approximately £820million a year for older people to stay in hospital beds when, in many cases, they could be successfully cared for at home or in the community.*
- *Patients and their families repeatedly tell us they want to be treated at home or as close to home as possible.*

## Appendix C - Animation

We have produced an amination for public / staff facing use which summarises the case for change. There is a shorter version for social media platforms.

https://www.dropbox.com/s/u0zwumw1c2gns0x/NHS%20Journey%20SOCIAL%20EDIT%20CCG.mp4?dl=0

https://www.dropbox.com/s/kv9v8ag8txevre0/NHS%20Journey%20CCG%20social%20edit%20further%20cuts.mp4?dl=0

# HEALTH AND WELLBEING BOARD

**14 September 2018**

HARTLEPOOL BOROUGH COUNCIL

**Report of:** Interim Director of Public Health

**Subject:** UPDATE ON HEALTHY WEIGHT STRATEGY

## 1. PURPOSE OF REPORT

1.1 To provide the board with an update on the progress of implementing the 10-year Healthy Weight Strategy for Hartlepool, that was approved and launched in September 2015.

1.2 To agree proposals, and key next steps, for priority actions within the strategy and develop a clear performance and outcomes framework for future delivery of the strategy.

## 2. BACKGROUND

2.1 The Healthy Weight Strategy was developed in September 2015, in response to members of the Health and Wellbeing Board selecting childhood obesity as a key priority for action in Hartlepool. A large stakeholder conference and engagement event on childhood obesity was subsequently held in February 2015 to inform the development of the new strategy, which succeeded and built upon the previous 'Healthy Weight, Healthy Lives' obesity action plan for Hartlepool, which had been in place since 2013.

2.2 The most recent National Childhood Measurement Programme (NCMP) data tells us that 25.5% of reception age children and 39.2% of year 6 children are classified as overweight or obese (3 year pooled average, 2014/15-2016/17). Rates have increased slightly since 2010/11-2012/13 when 24.1% of reception age and 38.7% of year 6 children were of excess weight.

2.3 Looking specifically at childhood obesity rates, recently published figures looking at 5-year combined data, tells us that in Hartlepool 11.4% of reception age children (3rd highest rate in region behind Middlesbrough and Redcar and Cleveland) and 23.8% of year 6 children are classed as obese (highest rate in region).

2.4 The Healthy Weight, Healthy Lives multi-agency steering group continues to meet on a bi-monthly basis to review progress with the Healthy Weight Strategy and contribute to its aims. This report presents a summary of the

key progress made since the last update report in September 2016 and sets out some proposals and next steps over the next 12-36 months.

## 3. KEY PROGRESS

3.1 At an earlier committee meeting it was recommended that Cleveland Police and other partner organisations consider committing to the North East Better Health at Work Award in order to support this agenda among their staff. Hartlepool Borough Council, Cleveland Fire Brigade, Hartlepool and Stockton-on-Tees Clinical Commissioning Group (HAST CCG), Cleveland Police and Harbour Support Services are now signed up to the award scheme. Housing Hartlepool/Vela Group has been involved previously but has not signed up since becoming Thirteen Group.

3.2 **Key progress with Healthy Weight Strategy action plan (Appendix 1):**

**Strategic Theme 1: Universal – To transform the environment so that it supports healthy lifestyles (Primary Prevention)**

Action 1(a) – Planning and Retail: Trading Standards continue to work with Take Away food providers to support healthier cooking practices such as healthier frying techniques, low salt dispensers and reduced fat/sugar/salt through sharing of recipes and good practice using food analysis of common dishes between different outlets. Most recently, work has been undertaken with Indian takeaway owners to identify use of 'Southampton Colours' which have been linked to hyperactivity in children.

Public Health continue to be consulted on all A5 hot food take away planning applications in relation to the possible health impact and have contributed to the development of a new A5 Hot Food Take Away Policy within the recently published Local Plan.

Action 1(b) – Physical Activity: Hartlepool Borough Council (HBC) has been successful with a bid to the Sport England Families Fund, which has secured approximately £280k over four years from September 2018, to support disadvantaged and vulnerable families to overcome barriers to being physically active and impact on family relationships and mental wellbeing outcomes.

Sport and Recreation, within community-based and preventative services, are working with education to develop a school's physical activity 'charter' or offer, which will link to active learning and energiser sessions currently being piloted, the 'daily mile' initiative, and support schools to secure the best outcomes from their Healthy Pupils capital funds[1] and school sports premium.

[1] Healthy Pupils capital fund – £56,685 shared between 16 schools in Hartlepool to help pupils benefit from healthier, more active lifestyles - supporting physical education (PE), after-school activities and healthy eating.

Action 1(c) – Travel and Infrastructure: Hartlepool Cycle Development Plan has been developed. Two cycleway improvement projects completed at Queen's Meadow and Oaksway Enterprise zones. Living Streets 'Walk To' project legacy to support schools in providing walk to school incentives and supporting active travel opportunities. Work underway to establish a series of distance markers on Seaton promenade linked to the 'Move a Mile' initiative so encourage walking and cycling on this stretch. Designs and content being evaluated and work will go out to tender.

**Strategic Theme 2: Preventative – Making Healthier Choices Easier by providing information and practical support (Secondary Prevention)**

Action 2(a) – Social Marketing and Communications: Greater links and utilisation of HBC social media channels and local press to communicate clear and consistent messages around obesity and healthy lifestyles linked to national Public Health England (PHE) campaigns.

Action 2(b) – Early Intervention: Early Help as a whole operates to reduce the impact of adversity for children and families in the area. The workforce has had up to date awareness training on the impact of healthy eating on children and their families, which is now imbedded in day to day practice. We make every contact count and support children and families to develop healthy lifestyles. Targeted support is offered to children and families where needs are more enhanced from school nursing and health visiting service, within the 0-19 Health Child Programme. Healthy eating and lifestyle is now included into parenting programmes and children's groups, which operates across all Children's Services. The Early Help offer will be available on Hartlepool Now with links to information to support reduction in obesity such as Breastfeeding groups and advice, weaning, healthy diet with links to local and national support groups.

The National Childhood Measurement Screening Programme is targeted at all School Children and identifies those children who are overweight. School Nurses offer targeted support to those children and families. Discussions are underway regarding how the School Nursing Service and Early Help when working with families who need support with weight management and lifestyle issues can work in partnership with community based and prevention services to access further support.

**Strategic Theme 3: Services – To secure the services needed to tackle excess weight (Tertiary Prevention)**

Action 3(a) – The National Diabetes Prevention Programme (NDPP) and Escape Diabetes Act Now (EDAN) diabetes services: The NDPP commenced in April 2018 and Ingeus were appointed as the national provider. There have been 117 referrals from Hartlepool surgeries (including McKenzie Group Main Practice, Hartfields Medical Centre, Havelock Grange Practice and Wynyard Road Medical Centre) with the first education course commencing on the 7th August 2018, at the Community Hub South. Ingeus are to deliver 4 core

sessions (one per week) then 9 maintenance sessions (one per month), with a check point at 6 months where GP surgeries are informed of progress. No outcome data is available at this time, until the first cohort has been completed.

Coordinators for the Hartlepool Exercise for Life Scheme (HELP) are promoting the NDPP to those referred into HELP for other reasons, where multiple health issues indicate that they may fit the criteria for access. HBC is represented on the HAST Group that regularly discusses the programme and this ensures that as an authority we are supporting the promotion of this national intervention. It has been agreed with the North East Lead on the NDPP service that, where appropriate, we will have a two way referral process that enables sign posting to each of the existing diabetes prevention models to support local residents, i.e.:

- The Sport and Physical Activity Team Help scheme strand; operates
- The EDAN programme, (Escape Diabetes Act Now) this can pick up patients who are at risk of developing Type 2 Diabetes when their HbA1c blood test is outside the strict parameters of the NDDP programme.

In addition to this, those whose commitments prevent them from accessing the times offered on the NDPP can also be catered for, with the HELP scheme able to provide supervised exercise within the weekly (Exercise Referral) programme. This is for those patients who are motivated to increase their physical activity level which is a key message from the NDPP Educators. Weight loss is the primary goal to instigate clinical changes to blood glucose levels. As a service, we have also offered to drop into the maintenance sessions to promote the wide range of HBC physical activity support available throughout the town.

Action 3(b) – Future in Mind and Families Fund - In April 2018 Hartlepool Borough Council was awarded £280,620 grant by Sport England to deliver a four-year project working on bringing families closer together through sport and physical activity. The project aims to respond to the needs of families in the borough and involve them in a range of fun activities that promote good social, mental and physical wellbeing. Recruitment is currently taking place for a full time Project Coordinator and part time Activator to commence employment, it is hoped that these positions will be filled by October 2018. During the summer a couple of family events took place in south of the borough at Summerhill and Brierton Sports Centre. These events were used to consult with families as to their needs and saw over 500 people attending both events. Following feedback and work with partners a delivery programme for the first year has now been devised.

Action 3(c) - Obesity and Maternity Services: Working links with midwifery have been enhanced to identify parents where perinatal weight requires additional consideration. Identifying needs pre birth we are able to offer support to reduce BMI before birth for targeted families. The record of BMI is communicated to the allocated health visitor who can support the family to maintain and manage the changes to support positive weight and decrease

the likelihood of childhood obesity. IT systems are being developed to better support the communication between midwifery and health visiting.
Further development is planned to support families whose needs would sit outside of targeted services to reduce the likelihood of childhood obesity and increase community capacity.

Action 3(d) - Community Hubs: Community Hubs offer a range of services and programming to support the health and wellbeing of Hartlepool, there are on average 24,000 visits per month across all three Community Hubs. The three Community hub sites are developing a Social Prescribing Model and the Hartlepool Community Connector service is a key function within each, supporting individuals to make positive lifestyle changes and access services to improve their health and wellbeing.

i) All three of the Community Hubs: North, South and Central:

- Have established weekly Health Walks and regular Social groups have been well received;
- Engage in the promotion of national health campaigns and the Connector team can contribute to any group sessions that run in the hubs from both the voluntary sector groups and external partners; and
- provide free Motivational 1:1 sessions to all who access the service, in an effort to address a broad range of issues. M.I interviews support to empower the service users to confidently make the necessary behavior changes that they feel matter most to them.

To date, from April, 72 individuals have been signposted to other agencies to address the area which they feel is their priority of need.

ii) The South Hub Connector facilitates, with the support of the library staff, a structured system that permits residents who have experienced a Stroke to have access to a specialist piece of equipment called a 'Motormed'. This is a motor generated machine that enables both arm and leg ambulation, which is recommended by the NHS Stroke team as an ideal level of support to encourage recovery of both physical and psychological improvement. Each service user following an induction has the option to book independent sessions to use this equipment on a weekly basis.

iii) Planned for September - the Sport and Physical Activity Team will implement Locality Teams to each Hub to utilise the time more efficiently of key officers who will be working together to target the hard to reach groups in their specific areas. Increasing outreach work and responding to the views of the residents by means of contact through regular community forums to identify the greatest need in relation to health inequalities and gaps in provision.

Following a successful pilot in summer 2016, Finance and Policy Committee have funded extensions to the 'Filling the Holiday Gap' community ring-fenced grant for Christmas 2017 (£10k), Easter 2018 (£6k) and summer 2018 (£25k).

Further funds have been allocated for Christmas 2018 (£10k), Easter 2019 (£10k) and summer 2019 (£25k).

3.3 An internal audit of obesity management services was carried out on 4 June 2018 with two of the current schemes in operation selected for review: FiiT Hart (family weight management service) and Early Years interventions. The aim of the audit was to ensure that the priorities for the Obesity Management Services were clearly and consistently detailed in the HBC and regional/national policies and strategies and to ensure that the services are provided in accordance with the contract arrangements and in line with identified need. The overall opinion was that satisfactory assurance could be placed on the systems and controls in place at the time of the audit and no further actions were required (report attached at **Appendix B**).

## 4. FUTURE STRATEGIC DIRECTION

4.1 On 25 June 2018, the government published the second chapter of 'Childhood Obesity: A Plan for Action', which set a new national ambition to half childhood obesity rates by 2030. Within the plan, the government sets out a range of further national measures, including:

- Target to halve the rate of childhood obesity by 2030 but no numerical targets around reducing health inequalities;
- Consult on ending sales of energy drinks to children;
- Consult on 9pm watershed for advertising of high fat/salt/sugar (HFSS) products;
- Better advertising regulation of HFSS products on social media;
- Consult on calorie labeling for the out-of-home food sector; and
- Consult on ending promotions on HFSS products e.g. BOGOF.

4.2 It is reassuring to note that the Hartlepool Healthy Weight Strategy has actions and objectives that align closely with many of these national objectives, and it is hoped that in the coming years there will be continued support and a national focus around each of these topics that will enable Hartlepool to address the issues more effectively at a local level. It is disappointing however, that there is no:

- Cabinet sub-committee or mandatory monitoring of actions across departments;
- Reference to new powers for local government to use health as a licensing objective;
- Mention of a ban on cartoon characters in advertising HFSS products or limiting adverts near schools;
- Target around breast feeding; and
- Announcement around access to effective services for children and families.

4.3 It is recognised that a more detailed performance framework and annual monitoring matrix is required to sit alongside the strategic 10-year action plan

in order to highlight specific progress milestones, identify clear timescales for action, impact and create more ownership and accountability from wider partners and stakeholders around specific areas of the plan. It is proposed that a RAG-rated, annual KPI matrix is created in conjunction with members of the board to clearly demonstrate progress against key local indicators and highlight impact on national targets and statistics.

## 5. RISK IMPLICATIONS

5.1 There is a risk that without a clear and robust strategy for tacking obesity in Hartlepool, rates may continue to rise in both children and adults, leading to a greater strain on health and social care systems within the Local Authority and the NHS.

## 6. FINANCIAL CONSIDERATIONS

6.1 In order to fulfil the actions and objectives within the strategy, there will be a need to identify funding sources or access existing budgets for specific projects and initiatives. Where possible, this will be sourced from existing budgets and funding streams, and achieved by more efficient and collaborative working arrangements between partners.

## 7. EQUALITY AND DIVERSITY CONSIDERATIONS

7.1 There are no equality and diversity considerations arising from this report. The strategy ensures there is support in place for all residents of the Hartlepool borough.

## 8. STAFF CONSIDERATIONS

8.1 Aspects of the Hartlepool Healthy Weight Strategy require support from the Council workforce and its partners. All staff have a role to play in supporting the obesity agenda and considering the impact of their roles and choices on their personal health and wellbeing as well as that of the wider community.

## 9. RECOMMENDATIONS

9.1 The Health and Wellbeing Board note the progress to date in implementing the strategy and approve the future strategic direction in line with the national approaches.

9.2 Approve the recommendation to develop an annual performance and monitoring framework for the strategy with key priorities and indicators to ensure engagement and accountability among partners.

## 10. REASONS FOR RECOMMENDATIONS

10.1 Obesity continues to be a significant Public Health issue in Hartlepool.

## 11. BACKGROUND PAPERS

Appendix A: Hartlepool Healthy Weight Strategy Action Plan (July 2018)

Appendix B: Obesity Management Audit final report (June 2018)

Appendix C: Childhood Obesity: A Plan for Action Chapter 2. Department for Health, HM Government (2018)
https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action-chapter-2

## 12. CONTACT OFFICERS

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# Healthy Weight Strategy for Hartlepool
## 10 Year Action Plan (2015-2025)

| **Strategic Theme 1: Universal – To transform the environment so that it supports healthy lifestyles (Primary Prevention)** | | | | | | |
|---|---|---|---|---|---|---|
| **Key Objective** | **Areas of action** | **Desired Outputs** | **Expected Outcomes** | **Lead stakeholders** | **Timescales** | **Progress (as at July 2018)** |
| (a) Planning and retail: Work with partners to improve access to healthy food options and remove barriers to adopting a healthy diet | Restrictions on advertising of high fat, sugar and salt foods to children | Develop a policy for organisations to follow<br><br>Restrict food adverts on bus shelters locally and any advertising space within statutory authority control or influence e.g. public transport | Reduced exposure to advertising reducing demand from parents<br><br>Healthier vending options in Council buildings and leisure facilities | PHE<br>HBC procurement<br>Leisure facilities | Ongoing<br><br>Timescale to be determined by current contracts and procurement cycles | Regional sugar reduction project targeting early years – regional task and finish group established<br><br>Exploring bus shelter advertising opportunities across Tees<br><br>Regional work with Nexus to influence advertising contract |
| | Develop Healthy Catering Guidelines linked with breastfeeding and Better Health at Work Award | Work with businesses to alter the menus offered to become healthier options, actively support breastfeeding and create a healthier staff working environment<br><br>Ensure the Healthier Catering guidelines are promoted and followed<br><br>Guidelines on warming baby and toddler food | Increased breastfeeding initiation and maintenance at 6-8 weeks<br><br>Catering premises will have low fat, sugar and salt content items across a minimum of 30% of their menus<br><br>Corporate catering will comply with the guidelines on 90% of occasions | Employers<br>Environmental Health | Ongoing | Better Health at Work Award criteria – healthier catering guidance<br><br>Continued promotion and awareness of Government Buying Standards for food to workplaces and businesses<br><br>Work with A5 hot food takeaway businesses around healthier cooking practices – factsheet developed for Chinese takeaway owners and awareness with Indian takeaway owners around illegal food colourings and additives<br>Children's Centres / Early Year's providing advice as |

| **Strategic Theme 1: Universal – To transform the environment so that it supports healthy lifestyles (Primary Prevention)** | | | | | | |
|---|---|---|---|---|---|---|
| **Key Objective** | **Areas of action** | **Desired Outputs** | **Expected Outcomes** | **Lead stakeholders** | **Timescales** | **Progress (as at July 2018)** |
| | | | | | | part of revised weaning programme |
| | Develop licensing conditions to reduce the number of fast food catering establishments in areas of high density, including near schools | Audit through food mapping<br><br>Approved licence conditions<br><br>Development of hot food takeaway policy as part of Local Plan | Prevent an increase in the number of fast food outlets in the town<br><br>Control proliferation of fast food outlets and restrict growth in key areas | Planning team | Complete | Hot food takeaway policy RC18 is part of final HBC Local Plan – imposes restrictions on A5 planning permission in areas of high fast food concentration and near to schools with high childhood obesity rates |
| (b) Physical activity: improve access to green spaces for health and exercise reasons | Increase the capacity of buildings and workplaces to support physical activity | Increased cycle parking / storage<br><br>Improved shower & locker provision<br><br>Development of universal and consistent stairs and lifts policy | All new buildings and alterations are compliant with NICE guidance | Employers<br>HBC Planning<br>Developers<br>Road safety team | Ongoing | Active travel and physical activity criteria embedded within Better Health at Work Award for workplaces<br><br>Community Sports Hub links – Sport England Families Fund |
| | Increase the availability of green space across Hartlepool for play and recreational use | Identify existing green space<br><br>Identify existing plans to improve<br><br>Community involvement in where, what, when and how | Increased green space<br><br>Improvements to existing green spaces<br><br>Improvements in physical activity / sedentary behaviour | HBC Planning<br>Developers<br>Parks and Countryside team<br>HBC Sport & Recreation | Longer term outcome (2020 onwards as part of Hartlepool Vision) | HBC Playing Pitch Strategy published<br><br>Policies around green spaces and consideration of the obesogenic environment in new developments are included within HBC Local Plan |

| **Strategic Theme 1: Universal – To transform the environment so that it supports healthy lifestyles (Primary Prevention)** | | | | | | |
|---|---|---|---|---|---|---|
| **Key Objective** | **Areas of action** | **Desired Outputs** | **Expected Outcomes** | **Lead stakeholders** | **Timescales** | **Progress (as at July 2018)** |
| | | Consider outdoor activity space/green gyms within new and existing community spaces | (inactivity rates) | | | |
| | Support charities and projects which improve aspects of the obesogenic environment such as Living Streets and Sustrans | Community Street Audits to identify barriers to physical activity<br><br>Development of Cycling Development Plan – link to National Cycling and Walking Strategy<br>Also links with Dementia Friendly Communities | Improvements to built environment resulting from street audits – improved access to waking and physical activity opportunities | Planning and regeneration<br>Road safety team<br>Developers<br>Living Streets<br>Sustrans | Complete | Living Streets Walk To project 2016-18 has concluded – several community street audits produced<br><br>Cycling Development Plan produced<br><br>Traffic infrastructure work completed via Access Fund (Truro Drivo-Queen's Meadow, A179) – further projects identified |
| (c) Travel and infrastructure : create a more supportive environment for cycling and walking to improve rates of active travel in schools, workplaces | Reducing the proportion of Hartlepool adults and children who are sedentary | Engagement with businesses through the Better Health at Work Award<br><br>Offer sedentary workers physical activity options<br><br>Cycle repair and training (Bikeability) scheme | Increased use of green space<br><br>Increased participation in sport and active recreation | Employers<br>HBC Sport & Recreation | Ongoing | Corporate discount scheme for Council leisure facilities launched<br><br>Move a mile project launched for schools and workplaces – schools charter in development<br><br>Cycle repair hub established at Summerhill outdoor activity centre |
| | Utilise LSTF funds to | Target business enterprise zones | Improved cycle provision and links | Road safety team<br>Employers | Complete | Addressed via Hartlepool Cycle Development Plan |

| **Strategic Theme 1: Universal – To transform the environment so that it supports healthy lifestyles (Primary Prevention)** | | | | | | |
|---|---|---|---|---|---|---|
| **Key Objective** | **Areas of action** | **Desired Outputs** | **Expected Outcomes** | **Lead stakeholders** | **Timescales** | **Progress (as at July 2018)** |
| and communities | improve cycle route infrastructure and encourage active travel in workplaces and schools | Develop travel plans for workplaces and schools | across town<br><br>Reduced car use, increased rates of active travel | Schools<br>Living Streets<br>Sustrans | | (Sustainable Transport Officer) and Living Streets Walk To project |
| | Develop no parking zones around schools in favour of park and stride sites | Extend parking exclusion zones around schools<br><br>Extend 20mph zones | Improved road safety<br><br>Increased walking levels in children and parents | Road safety team<br>Living Streets<br>Sustrans | Longer term objective (2020 onwards) | No progress currently |

| **Strategic Theme 2: Preventative – Making Healthier Choices Easier by providing information and practical support (Secondary Prevention)** | | | | | | |
|---|---|---|---|---|---|---|
| **Key Objective** | **Areas of action** | **Desired Outputs** | **Expected Outcomes** | **Lead stakeholders** | **Timescales** | **Progress** |
| (a) Develop a social marketing and communications plan for Hartlepool to promote and facilitate a healthy weight and lifestyle | Develop a public opinion which supports the key actions of strategy | Work with media to create a public opinion shift<br><br>Work through social media to create a step-change in behaviours | Public will support the actions predominantly rather than oppose them | HBC Public Relations<br>PHE<br>HBC workforce<br>Employers | Ongoing<br><br>Complete | Links to PHE One You and Change 4 Life campaigns<br><br>Development of social media channels (Facebook, Twitter) – regular PH messages promoted via HBC social media |
| | Undertake further insight work with young people on fast food and sugar-sweetened | Work with Youth Parliament and Young People's Participation Team to produce relevant insight | Insight to enable appropriate alternative marketing | HBC Standards, engagement and development team | Ongoing | Initial consultation undertaken with young people as part of Hartlepool obesity conference – further development needed |

| **Strategic Theme 2: Preventative – Making Healthier Choices Easier by providing information and practical support (Secondary Prevention)** | | | | | | |
|---|---|---|---|---|---|---|
| **Key Objective** | **Areas of action** | **Desired Outputs** | **Expected Outcomes** | **Lead stakeholders** | **Timescales** | **Progress** |
| | beverages | | | | | |
| | Using the Change 4 Life and Health Trainers to engage and mobilise citizens to make healthier choices | Develop an agreement to ensure any public body led campaigns and incentives to take part in them, would be compliant with <u>all</u> principles of healthier choices within the Change4Life campaign. Embed agreement across all directorates and other organisations | Consistent messages promoting healthier choices across all media from all directorates within the Council and all organisations in Hartlepool | Community connector team<br>PHE<br>HBC Public Relations | Ongoing | Links to PHE One You and Change 4 Life campaigns |
| | Embrace new technologies to engage and support individuals with health & wellbeing activities and services | Explore potential of health-related mobile apps and online activity tracking programs for leisure facilities and healthy weight services<br><br>Explore use of text messaging and social media to communicate key public health messages | Improved monitoring of adult and young people's physical activity<br><br>Increased motivation for service users | Community connector team<br>Leisure facilities | Complete<br><br>Ongoing | Directory of weight management and healthy lifestyles apps produced<br><br>Promotion of Change4Life 'Be Food Smart' app |
| (b) Ensure obesity is tackled by early intervention through improved training and awareness | Promote healthy lifestyles within the Hartlepool workforce | Train and support council staff and partners to provide healthy lifestyle information to customers<br><br>Better Health at Work Award promotion and workplace campaigns | Increased awareness of healthy weight services among staff and service users | HBC Sport & Recreation<br>Employers | Ongoing<br><br>Ongoing | Health & Exercise Activator recruited to support physical activity provision for workplaces<br><br>Better Health at Work physical activity criteria throughout all award levels |
| | Support | Individual behaviour | Individuals will | Community | Ongoing | Regional MECC steering |

| **Strategic Theme 2: Preventative – Making Healthier Choices Easier by providing information and practical support (Secondary Prevention)** | | | | | | |
|---|---|---|---|---|---|---|
| **Key Objective** | **Areas of action** | **Desired Outputs** | **Expected Outcomes** | **Lead stakeholders** | **Timescales** | **Progress** |
| for front line staff and in communities | individual behaviour change around diet, physical activity and breastfeeding | change will be supported by Community Connectors and Advocates<br><br>Front line practitioners and volunteers will be trained in MECC | receive support to change health behaviours in conjunction with higher tier services | Connector team<br>Specialist Weight Management Service (SWMS)<br>Employers<br>HBC Sport & Recreation | | group established<br><br>Action to be supported through the Sport England Families Fund project |
| | Fiit Hart will continue to provide education to children and families on healthy eating and physical activity | All children and their families who are identified as overweight or very overweight will be offered support from the FiiT Hart team | Childhood obesity prevalence will reduce | Paula Edwards, Sport & Recreation | Ongoing | FiiT Hart family weight management programme established including healthy lifestyle advice, physical activity and cooking skills (pilot) elements |
| | Training of front line staff on Healthy Weight Management | Key staff trained in weight management, motivational interviewing and brief intervention skills | Staff knowledge & confidence on WM improves | Community Connector team<br>HBC Sport & Recreation<br>Thirteen Group<br>Cleveland Fire Service<br>Cleveland Police | Complete | 2-day childhood obesity training provided<br><br>Links to MECC training offer |
| | Tackle post-natal baby weight | Support Well Baby clinic attendees | Reduction in obesity rates<br>Improvements to breastfeeding rates | 0-19 service<br>Children's centres<br>Mums on the Move programme | Longer term objective | New weaning programme established – obesity awareness training provided to 0-19 service staff |
| (c) Ensure that tackling obesity is a key priority as part of the | Implement the DHSC Childhood Obesity Plan objective with | 70% of all menus to be compliant with nutritional information as outlined in the PH Responsibility deal | Healthy options will be obvious and priced accordingly | HBC Trading Standards<br>Catering businesses | Longer term objective | |

| **Strategic Theme 2: Preventative – Making Healthier Choices Easier by providing information and practical support (Secondary Prevention)** | | | | | | |
|---|---|---|---|---|---|---|
| **Key Objective** | **Areas of action** | **Desired Outputs** | **Expected Outcomes** | **Lead stakeholders** | **Timescales** | **Progress** |
| planning and implementation process for the Hartlepool Vision | respect to labelling of nutritional information on menus | | | | | |
| | Strengthen the role of health impact assessments in planning applications to ensure the physical environment supports physical activity | Potential health impacts to be assessed on all new developments and projects | New developments / projects to consider impact on obesity and physical activity | HBC Planning | Longer term objective | PHE have provided HIA training regionally |

| **Strategic Theme 3: Services – To secure the services needed to tackle excess weight (Tertiary Prevention)** | | | | | | |
|---|---|---|---|---|---|---|
| **Key Objective** | **Areas of action** | **Desired Outputs** | **Expected Outcomes** | **Lead stakeholders** | **Timescales** | **Progress** |
| (a) Create an integrated pathway of support to improve accessibility into healthy weight services (driven by GPs and | Ensure the care pathways adequately meet the needs of those carrying excess weight | Ensure there is a smooth transition and good links between all obesity service pathways | Service provision will be appropriate to meet the needs of the client group | CCG<br>Tier 2/3 service leads | Complete | Obesity infographic developed in 2017 to highlight tier 2 services – evaluation report produced by Teesside Uni – now in need of updating |
| | Monitor the efficacy of Family Healthy Weight | Successful programme will be recorded<br><br>Future of service will be | Service provision will be appropriate to meet the needs of the client group | Paula Edwards, HBC | Complete | Pursue opportunities to monitor and sustain family/children's weight management services – link |

| **Strategic Theme 3: Services – To secure the services needed to tackle excess weight (Tertiary Prevention)** | | | | | | |
|---|---|---|---|---|---|---|
| **Key Objective** | **Areas of action** | **Desired Outputs** | **Expected Outcomes** | **Lead stakeholders** | **Timescales** | **Progress** |
| Primary Care) | Programmes for children and adults | secured | | | | to Sport England Families Fund project |
| | Ensure appropriate Early Years interventions for those with excess weight are in place | Evaluate the needs of this age group<br><br>Ensure services are in place | Funding and services will be in place as required<br><br>Care pathways will be complete and adequate | Mel Calvert, HBC Children's Centres | Longer term objective | Links to new early years weaning programme (see below theme 3) |
| | Secure long term funding for a Tier 3 Weight Management Service | Support the commissioning process to ensure strong links with tier 2 community weight management services | Clear and robust obesity pathway for the client group | Will Smith<br>CCG<br>Specialist Weight Management Service provider | Complete | Action to be revisited based on future commissioning arrangements and CCG plans – new obesity pathway in development (on hold until the successful transfer of T4 commissioning responsibility to CCG) |
| | Produce guidance for primary care regarding National Child Measurement (NCMP) and adult obesity pathways | Ensure G.P's and primary care staff are aware of the NCMP & adult obesity pathways and referral process<br><br>Identify and train advocates in GP practices to firm up referral processes | Increase in referrals from Primary care into children's and adult weight management services | Community connector team<br>FiiT Hart team<br>CCG | Complete<br><br>Longer term objective | |
| (b) Support schools and children's centres to develop a 'Curriculum | Promote Healthier Weaning | Continuation of weaning programme for Children's Centres and early year's providers | Reduce the proportion of 12 – 18 month olds who exceed the Estimated Average Requirement for | Mel Calvert, HBC Children's Centres teams | Ongoing | |

| **Strategic Theme 3: Services – To secure the services needed to tackle excess weight (Tertiary Prevention)** | | | | | | |
|---|---|---|---|---|---|---|
| **Key Objective** | **Areas of action** | **Desired Outputs** | **Expected Outcomes** | **Lead stakeholders** | **Timescales** | **Progress** |
| for Life' which promotes a healthy weight and lifestyle from an early age | | | Energy intake | | | |
| | Increase rates of breastfeeding | Increase proportion of excess weight mothers who breastfeed<br><br>Establish closer links with midwifes and health visitors | Increased rates of breastfeeding<br><br>Reductions in low birth weight babies | Midwifery<br>Health Visiting<br>Children's Centres teams | Longer term objective | Breastfeeding workshops<br>All about baby programme<br>Latch on programme<br>'Big Latch On' breastfeeding event |
| | All families with children under 5, who are most at risk of becoming overweight or obese, are identified through key contacts with professionals working with this age group and are referred to appropriate services | Engage family support workers, health visitors and housing staff working with the most at risk families | Increase numbers of the most at risk families and young people who are identified and supported | Health Visiting<br>Children's Centres<br>Early help<br>Social care | Ongoing | Obesity awareness training being rolled out across 0-19 staff |
| | Ensure healthy weight support is incorporated into the Future in Mind emotional wellbeing programme | Physical activity as a tool for family engagement and improvements in mental health and relationships | Improvements in mental wellbeing in children and families engaged in the programme | Education Psychology Team<br>HBC Public Health<br>Sport & Recreation | March 2019 | Links to Families Fund |

| **Strategic Theme 3: Services – To secure the services needed to tackle excess weight (Tertiary Prevention)** | | | | | | |
|---|---|---|---|---|---|---|
| **Key Objective** | **Areas of action** | **Desired Outputs** | **Expected Outcomes** | **Lead stakeholders** | **Timescales** | **Progress** |
| | Offer support to mothers who are excess weight to improve post-partum weight management | Further development of the 'Mums on the Move' programme | | Midwifery<br>Health Visiting<br>Paula Edwards, Sport & Recreation | Longer term objective | |
| (c) Ensure healthy weight services are part of the vision for the provision of a Hartlepool 'Health and Social Care Plan' | Develop an integrated model of 'community wellness hubs', bringing together a public health offer alongside health and social care services with a whole-family approach | Establish new public health 'offer'<br><br>Identify and sustain community hub sites and develop offer further with wider partners and stakeholders | More integrated and accessible services<br><br>Improve take-up of NHS health checks<br><br>Improved signposting and referrals<br><br>Improved care and support to those in need | HBC Public Health | Complete | Community Hub sites and initial offer established<br><br>Sport England Families Fund – Community Sports Hub outcome |
| | Address the issue of 'holiday hunger' for the most at risk families over school holiday periods | Assess need<br><br>Develop cost-effective model and pilot project<br><br>Develop links to the Hartlepool Food Network | Reduced levels of young people suffering under nourishment and malnutrition in school holidays<br><br>Improved attainment in schools due to reduced 'learning loss' | HBC Public Health<br>Children's Hub<br>JRF | Complete | 'Filling the Holiday Gap' community grant scheme established. Pilot completed in summer 2016 followed by summer 2017, Christmas 2017, Easter 2018 and summer 2018 schemes. Funding secured until summer 2019 |

| **Strategic Theme 3: Services – To secure the services needed to tackle excess weight (Tertiary Prevention)** | | | | | | |
|---|---|---|---|---|---|---|
| **Key Objective** | **Areas of action** | **Desired Outputs** | **Expected Outcomes** | **Lead stakeholders** | **Timescales** | **Progress** |
| | Embed healthy weight in the Better Childhood Programme delivery model | Healthy weight will be considered as part of the Better Childhood Programme | Children's workforce supported to raise the issue of healthy weight<br><br>Children's workforce enabled to provide families with advice, information and support to maintain a healthy weight | | Longer term objective | |

HARTLEPOOL
BOROUGH COUNCIL



# Internal Audit Report
## Obesity Management Services
## Final Report Issued: 4th June 2018

Internal Audit is an independent appraisal function that reviews the Council's activities, both financial and non-financial. Internal Audit provides a service to the whole Council in order to provide assurance on the arrangements for risk management, internal control and corporate governance, and to provide advice to support achievement of best practice.

All audit work has been carried out in accordance with the CIPFA Code of Practice for Internal Audit in Local Government in the UK, as reflected in the Internal Audit Manual.

The auditors involved in the work have no links to the subject matter of this audit or relationships with the clients that could compromise the impartiality or objectivity of the work undertaken.

## Audit Team:

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## Audit Summary and Opinion

The overall opinion is that **Satisfactory Assurance** can be provided that the risks identified are well controlled.

The Joint Strategic Needs Assessment (JSNA) and HBC's Healthy Weight Strategy both extensively cover the priorities for Obesity Management. The Council Plan and Health and Wellbeing Strategy are higher level documents and as such don't include specific or detailed performance indicators, targets or priorities for weight management but they do cover themes such as helping children to get the best start in life, people living well, and encouraging more people to live active and healthy lifestyles of which managing weight/obesity would be a part.

There is a Healthy Weight Healthy Lives Partnership in place which helps co-ordinate and bring together all the different steams and aspects of obesity management such as sport and recreation, food schemes, National Childhood Measurement Programme, health visitors, midwife led support for babies and their mothers/families and GP referrals. A wide range of staff are involved in the partnership which has representation from appropriate teams. The partnership has a suitable Terms of Reference (this was not reviewed at this audit as it was viewed at the last audit follow up), meets regularly, minutes meetings and has an action plan which is used to ensure completion of tasks.

Following discussion with the Health Improvement Practitoner for Obesity, two of the current schemes in operation were selected for review, these were: FiiT Hart and Early Years Interventions.

Both services are provided in house and therefore no commissioning has taken place and no contracts are in place to review. The public health budget and reserves supports both services with no grants being received and no restriction on spending through ring fencing of funds.

FiiT Hart:
A small sample of individuals who have engaged with the service following their referral were selected for review. There are no targets set for the number of participants each year/month as engagement with the service is purely voluntary. Outcomes for each individual are personal to their circumstances and might include learning to make healthier food choices, taking more regular

exercise or bringing the whole family in to discuss weight management. Those who chose to engage are entered into an access database and their personal aims/targets/outcomes are noted, along with any purchases made to assist them such as technogym keys, swim sessions, active card for use at the leisure centres in Hartlepool. Continued engagement is monitored and contact is made to keep track of progress (this is noted and scanned onto Iclipse) until the individual either reaches their goal, moves on to not require assistance to reach and/or maintain their goal or decides to no longer engage with the support offered.

At present no follow up action is completed after the individual has reached their goal to ensure they are maintaining their weight/activity/healthy eating, however, following a review of the service that was happening alongside the audit staff had already discussed the possibility of starting to follow up after 6 months and 1 year, this is yet to be implemented.

Only those who engage with the service after contact are recorded on the database, those who do not return calls or turn up to appointments are not recorded anywhere as there is no obligation to access the support offered. The team should perhaps consider recording the number of individuals/families who have been contacted but have chosen not to take up the offer of support to show take up figures.

Performance is recorded on a spreadsheet, Covalent is no longer used to record them (it was prior to April 2017). Performance is no longer reported anywhere as for information reports to Committee have now ceased for all departments. The team should consider if there is any forum, group or manager who needs to receive the performance data for this area and arrange to provide the data as required. No testing was completed to validate the performance figures as funding is not dependant on them and targets are not set for take up.

Early Years Interventions:
There are a number of different schemes in operation which allow pregnant women, new mothers/families and babies to receive a variety of advice and support around health in pregnancy, healthy eating, activity, breastfeeding and weaning to enable them to make healthier choices for them and their babies/children. The schemes operate through Children's Centres and include appointments being offered for all women up to 12 weeks pregnant, appointments being offered for all babies of 4 months old and breastfeeding groups. Identified support can also be provided in the home if required; either Healthy Early Years Coordinator, Health Visitors or Community Nursery Nurses would advise around weaning / healthy eating – this would be recorded on System

1. All of the schemes are voluntary and individuals provided with an appointment are under no obligation to attend and take up the support offered.

The schemes are all evaluated annually with take up numbers being recorded. Assessments to date would indicate high take up of services offered and also show that some of the most vulnerable families are being reached and that advice and support is being acted upon.

Performance is measured through a number of indicators that are part of The Children's and Young People's Plan. Performance is no longer reported to Committee as the taking of for information reports has now ceased. The annual evaluation reports are reported through the Early Help management structures ensuring that managers have all available data on which to base decisions for the future. No testing was completed to validate the performance figures as funding is not dependant on them and targets are not set for take up.

Overall it can be seen that Obesity/Weight Management is taken seriously by HBC and that there are a number of schemes and support in place for those who wish to engage, and where individuals and families do engage there are positive outcomes.

## ACTION PLAN

There are no actions required at this time.

HM Government

# Childhood obesity: a plan for action

Chapter 2

September 2018

| DH ID box |
| --- |
| **Title: Childhood obesity: a plan for action, Chapter 2** |
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# Contents

# Foreword by the Prime Minister

The health and well-being of our children critically determines their opportunities in life.

Today, nothing threatens that more than childhood obesity.

Children who are obese or overweight are increasingly developing type 2 diabetes and liver problems during childhood. They are more likely to experience bullying, low-esteem and a lower quality of life and they are highly likely to go on to become overweight adults at risk of cancer, heart and liver disease. They are also disproportionately from low-income households and black and minority ethnic families.

So when more than one in three children are obese or overweight by the time they leave primary school, and with these numbers only getting worse, it cannot be a question of whether we act to address this, but rather how.

We all have responsibility to work together to support young people in meeting this challenge. Whether we are parents, teachers, businesses, local leaders or health professionals, we must all play a role in helping to improve the health of our children and give future generations the best possible start in life.

I am determined that this Government will lead this national effort.

That is why, in 2016, we published our world-leading childhood obesity plan and why we are now publishing this next instalment.

The actions we are proposing will ensure that, by working together across society, we can improve the nutritional content of the food and drink our children consume, strengthen the information available to parents about those products and change the way that unhealthy food and sugary drinks are promoted.

This work will support the renewed focus on the prevention of ill-health, which I have asked NHS leaders to develop as a critical part of our long-term plan for the NHS.

It will improve our children's health, enhance their chances in life and, in doing so, also fundamentally reduce the pressures on the health service in the years ahead.

Some of the measures in this document will provoke debate – and we welcome that. But we also know that it will take a determined collective effort to turn the tide against childhood obesity. That is what we must do – for the future wellbeing of our children, our NHS and for the prosperity of the nation as a whole.

# Foreword by Secretary of State for Health and Social Care

Every developed nation is facing up the problem of childhood obesity. This is an issue, eventually, no country will be able to ignore. I want us to be the first country in the world to really do something about this and that is why I have set a new national ambition to halve childhood obesity rates by 2030 and significantly reduce the health inequalities that persist.

We know that this isn't going to be easy to do but it is a measure of our ambition and resolve to tackle this issue.

As a parent I know that making the healthiest choices isn't always easy. In fact sometimes it feels very difficult. I think most parents have been in a position where your sleeve gets tugged as your child's eyes get drawn to the sweets or crisps at the checkout or you have to repeatedly resist the calls for Saturday night pizza.

That is why we're bringing forward policies that will make it easier for us all, but particularly for parents, to make healthier choices for their families. I want to see parents empowered to make informed decisions about the food they are buying for their families when eating out. I want to mitigate pester power by preventing stores from pushing unhealthy food at checkouts and helping make healthy food the default option for 'buy one get one free' deals. I want to protect children from advertising that encourages demand for unhealthy food. I want to see the food and advertising industries using their world-leading talents to help all parents find the healthier choice the easier choice.

As a parent it is also difficult to find the time for sport and physical activity – crucial to maintaining a healthy weight. That is why we want to encourage every primary school to adopt an active mile initiative such as the fantastic Daily Mile. Initiatives like this can improve the physical, social, and mental wellbeing of our children – regardless of age, ability or circumstance. Building this kind of activity into daily life and encouraging young people away from their screens will be instrumental in helping achieve our ambition.

Our attitude to food and drink is changing and changing fast – consumers want healthier choices. I am heartened by the progress the food and drink industry have already made in reformulating products and reducing sugar in soft drinks. I am cheered by those forward thinking businesses taking action, and want to make sure others follow their example. We will not shy away from further action if we do not see the progress we need to support parents all across the country to do what every single one of them wants and strives to do - protecting their children's health now and in years to come.

# Introduction and summary

Childhood obesity is one of the biggest health problems this country faces. Nearly a quarter of children in England are obese or overweight by the time they start primary school aged five, and this rises to one third by the time they leave aged 11.[1] Our childhood obesity rates mean that the UK is now ranked among the worst in Western Europe.[2]

The burden of childhood obesity is being felt the hardest in more deprived areas with children growing up in low income households more than twice as likely to be obese than those in higher income households.[3] Children from black and minority ethnic families are also more likely than children from white families to be overweight or obese and this inequality gap is increasing.[4] We want to address these disparities to ensure that all children, regardless of background, have the best start in life.

We need to be ambitious if we are to meet and beat the challenge of childhood obesity. Therefore we are setting a **national ambition to halve childhood obesity and significantly reduce the gap in obesity between children from the most and least deprived areas by 2030.** Doing so will bring multiple physical health benefits and we aim to reverse the emergence of Type 2 diabetes in children. Achieving this is not going to be easy. It will require us all to get behind this ambition to play our part in making healthier decisions, providing healthier options and creating healthier environments. As Government we are committed to playing our part but recognise that this will require sustained collaboration across the political divide, across society and across public and private sector organisations.

The scale of action we are seeking is justified by the profound health effects of childhood obesity. For overweight or obese children we know that life can be difficult: they are more likely to experience bullying, stigmatisation and low self-esteem.[5] They are more likely to develop Type 2 diabetes in childhood,[6] a condition that was once very rarely seen outside adulthood. They are also far more likely to go on to become obese adults,[7] with a higher risk of developing life threatening conditions such as some forms of cancer, Type 2 diabetes, heart[8] disease and liver disease.[9] Therefore, we have a lot to gain from succeeding in the task ahead and from being ambitious in our approach.

Addressing childhood obesity will also reduce the huge financial costs that obesity places on us as a nation. It is estimated that obesity-related conditions are currently costing the NHS (and therefore every UK tax payer) £6.1 billion per year.[10] The total costs to society of these conditions have been estimated at around £27 billion per year,[11] with some estimates placing this figure much higher.[12] As we celebrate the 70th birthday of the NHS, tackling childhood obesity can help us secure the sustainability of this coveted institution for future generations.

Our food environment is constantly evolving, and offers a growing range of choices of what to eat and when to eat. This supports a thriving food and drink industry, full of innovation and culinary adventure. Maintaining this choice is important, but it is also important to help children and their parents to navigate this environment and be able to easily identify healthy options.

Against this backdrop, all of us - parents, manufacturers, the out of home sector (e.g. restaurants, cafes, takeaways) and retailers, broadcasts, online media, local authorities and schools - must take responsibility for promoting healthy choices. This is not always easy: two thirds of parents are concerned about making sure their families eat a healthy diet.[13] In supporting parents, Government needs to take a balanced approach: considering the steps we can take to create a fair food environment that does not drive excess consumption and which makes the healthy choice the easy choice; whilst ensuring parents are able to choose what food they feed their families and have access to affordable healthy food options.

In August 2016 we laid strong foundations for our fight against childhood obesity with our world-leading *Childhood obesity: a plan for action*. Based on the best evidence, and informed by expert opinion, the plan identified the central issue that must be tackled if we are to reduce obesity: the food and drink children consume needs to be healthier and, for many children, less calorific.

# Summary of actions

Our 2016 plan was the start of a conversation, not the end. In the two years since it was published we have seen some important successes, particularly in reformulation of the products our children eat and drink most. However, we have always been clear we would consider where further action was needed, and where sufficient progress was not being delivered. The continuing magnitude of the challenge on childhood obesity means now is the right time to build on the 2016 plan both to cement the action already taken, and to expand our focus into other areas.

## Sugar reduction

At the heart of our plan was the ambition to make the food our children eat healthier. Reducing sugar content in the food children eat most was a key part of that. The Soft Drinks Industry Levy (SDIL) was introduced to incentivise industry to reduce the sugar content of soft drinks, and has delivered strong results, with the majority of the soft drink industry reducing the sugar content before the Levy came into force on 6th April 2018. Tesco and Asda have both reformulated their own brand soft drinks to be below the Levy rates.

We also challenged industry to take 20% of sugar out of the food most commonly eaten by children by 2020, with a 5% reduction target for the first year. This has already led to many parts of the food and drink industry removing sugar from their most popular products. For example, Kellogg's have cut between 20%-40% of sugar from their cereals most popular with children; Yoplait have reduced the amount of sugar by 13.2%, and Waitrose have taken 5.5% of sugar out of their confectionery.

Importantly, we have also seen an increasing consumer demand for healthier food and drink as a result of these programmes. Large parts of the food and drink industry have taken this seriously, with many parts of the sector leading the way and there is more reformulation in the pipeline. However, despite some sections of industry meeting the 5% one year progress target, overall the 5% goal has not been achieved.

To ensure we continue to drive progress on sugar reduction:

- HM Treasury will consider the sugar reduction progress achieved in sugary milk drinks as part of its 2020 review of the milk drinks exemption from SDIL. Sugary milk drinks may be included in the SDIL if insufficient progress on reduction has been made.
- We will consult before the end of 2018 on our intention to introduce legislation ending the sale of energy drinks to children.
- We may also consider further use of the tax system to promote healthy food if the voluntary sugar reduction programme does not deliver sufficient progress.

In 2019, Government will look at the level of progress towards a 20% sugar reduction in the foods most commonly eaten by children and will be able to assess if this challenge has been met in 2020. We will not shy away from further action, including mandatory and fiscal levers, if industry is failing to face up to the scale of the problem through voluntary reduction programmes.

## Calorie reduction

Childhood obesity is not just about eating too much sugar; it is about the whole diet. We know that on average overweight and obese children are consuming up to 500 extra calories per day.[14] To address this, in 2017 we started work on our calorie reduction programme, which challenges all food and drink companies - whether they are manufacturers, retailers, restaurants or takeaways - to reduce the calories by 20% in a range of everyday foods consumed by children by 2024. This will help make sure children and their families are able to buy healthier food. Government will monitor progress against this target closely once the programme begins, and Government will consider what additional steps could be taken if progress is not delivered.

We are also turning our attention to how we make choices about the food we buy, particularly pre-prepared food, whether it is picking up a takeaway or going out to eat. We think it is crucial that parents and individuals are given the information they need to make the most informed decisions about the food they choose for their families. While some parts of the food and drink industry, such as Subway, are leading the way by including calorie labelling on menus, these remain in the minority.

To ensure we continue to drive progress on calorie reduction and transparent information for parents we will:

- Introduce legislation to mandate consistent calorie labelling for the out of home sector (e.g. restaurants, cafes and takeaways) in England, with a consultation before the end of 2018.
- Explore what additional opportunities leaving the European Union presents for food labelling in England that displays world-leading, simple nutritional information as well as information

on origin and welfare standards. We will continue to work with the devolved administrations to explore the potential for common approaches.

## Advertising and promotions

Tackling obesity requires us to look at all factors that influence our food choices. Every day we are presented with constant encouragement and opportunity to eat the least healthy foods. We face numerous decisions about the food we and our children eat created by the advertisements our children see on TV and on-line; the range of foods sold in our local shops or delivered straight to our doors; and the food that is promoted in-store and on-line. All of this is intended to influence the choices we make about the food we buy our children.

In our 2016 plan we committed to updating current marketing restrictions to ensure they reflected the latest dietary advice. This work is underway as Public Health England (PHE) consult on updating the Nutrient Profiling Model, the tool used to define what products can and cannot be shown during children's programming. However, despite strict restrictions around children's TV we know their impact will be limited if they do not reflect their media habits across all the media platforms which they use.

To make more progress to reduce the marketing and promotion of unhealthy food and drink - which we define as products that are high in fat, sugar and salt (HFSS) - we will:

- Consult, before the end of 2018, on introducing a 9pm watershed on TV advertising of HFSS products and similar protection for children viewing adverts online, with the aim of limiting children's exposure to HFSS advertising and driving further reformulation. We will explore options to ensure that any restrictions are proportionate, help to incentivise reformulation in line with the aims of the sugar and calorie reduction programmes, and consider a focus on those products that children consume and most contribute to the problem of childhood obesity.
- Currently online advertising rules are drawn up by the Committee of Advertising Practice, which works alongside the Advertising Standards Authority (ASA), on a self-regulatory basis. We will consider whether this continues to be the right approach for protecting children from the advertising of unhealthy food and drinks, or whether legislation is necessary. We will ensure any further restrictions are designed effectively for the digital space, taking into account how content is consumed online and considering options for enforcement.

Where food is placed in shops and how it is promoted can influence the way we shop and it is more common for HFSS products to be placed in the most prominent places in store and sold on promotion, e.g. with 'buy one get one free' offers. Whilst some retailers have taken the first steps to redressing this by removing confectionary from checkouts or restricting price promotions, we believe that wherever parents shop, they shouldn't be bombarded with promotions for HFSS products. To create this level playing field:

- We intend to ban price promotions, such as buy one get one free and multi-buy offers or unlimited refills of unhealthy foods and drinks in the retail and out of home sector through legislation, consulting before the end of 2018.
- We intend to ban the promotion of unhealthy food and drink by location (at checkouts, the end of aisles and store entrances) in the retail and out of home sector through legislation, consulting before the end of 2018.

## Local areas

Where we live also has a huge role to play in tackling childhood obesity, whether it is the way our towns and cities are designed to ensure greater active travel or safe physical activity, or how many fast food outlets can operate near schools. Each local authority already has a range of powers to find local solutions to their own level of childhood obesity but while some are already taking bold action, others are not. We want to make sure that all local authorities are empowered and confident in finding what works for them, whilst learning from local authorities both here and international examples such as Amsterdam that have tackled the problem. To do this we will:

- Develop a trailblazer programme with local authority partners to show what can be achieved within existing powers and understand “what works” in different communities.
- Develop resources that support local authorities who want to use their powers. We will help set out the economic business case for a healthy food environment and provide up to date guidance and training for planning inspectors.

## Schools

Schools have a fundamental role to play in helping equip children with the knowledge they need to make healthy choices for themselves, and in creating a healthy environment for children to learn and play. We remain committed to delivering the actions in our 2016 plan which set out our commitment to supporting all children with high quality nutrition and at least 30 minutes of physical activity per day while at school. We have already seen the money raised by the Soft Drinks Industry Levy flowing into schools, funding breakfast clubs for the most disadvantaged children and being invested in PE and school sport. We have also invested significant funding in measures to increase cycling and walking to school. To further support schools in their role we will:

- Be bold in our update of the School Food Standards to reduce sugar consumption. The update will be coupled with detailed guidance to caterers and schools so they are well prepared to adapt to the changes.

- Consult, before the end of 2018, on strengthening the nutrition standards in the Government Buying Standards for Food and Catering Services, to bring them into line with the latest scientific dietary advice.
- Review how the least active children are being engaged in physical activity in and around the school day.
- Promote a national ambition for every primary school to adopt an active mile initiative, such as the Daily Mile.
- Invest over £1.6million during 2018/19 to support cycling and walking to school.

In addition:

- We will consult, before the end of 2018, on our plans to use Healthy Start vouchers to provide additional support to children from lower income families.
- Ofsted is developing a new inspection framework for September 2019. This will consider how schools build knowledge across the whole curriculum and how they support pupils' personal development more broadly, including in relation to healthy behaviours.
- Ofsted will undertake research into what a curriculum that supports good physical development in the early years looks like.

## Delivering the national ambition

We are already starting to embed change, and there are many examples of good practice highlighted in this document – from manufacturers leading on voluntary reformulation, to retailers leading the way on location and promotion of unhealthy items, to local authorities taking concerted action, and schools committing to promote healthy lifestyles through active mile initiatives.

However, we are not yet where we need to be. The scale of the challenge means that Government, the food and drink industry, the NHS, local authorities, schools and families all need to play their part in helping to tackle childhood obesity and be ambitious in doing so.

We are confident that the additional actions outlined in this plan will help parents make the best decisions for their families by changing the default in our food environments, so that healthier choices become the easiest choices. Whilst the majority of actions in this plan will relate to England only, we will also continue to work with the devolved administrations to deliver the best outcome for all.

No single action or single plan will help us solve the challenge of childhood obesity on its own. We will continue to review progress made against the measures we have already introduced; the evidence base for action; and the changing face of our food and retail environments.

Alongside this we will continue to invite and listen to views on what actions are needed and why.

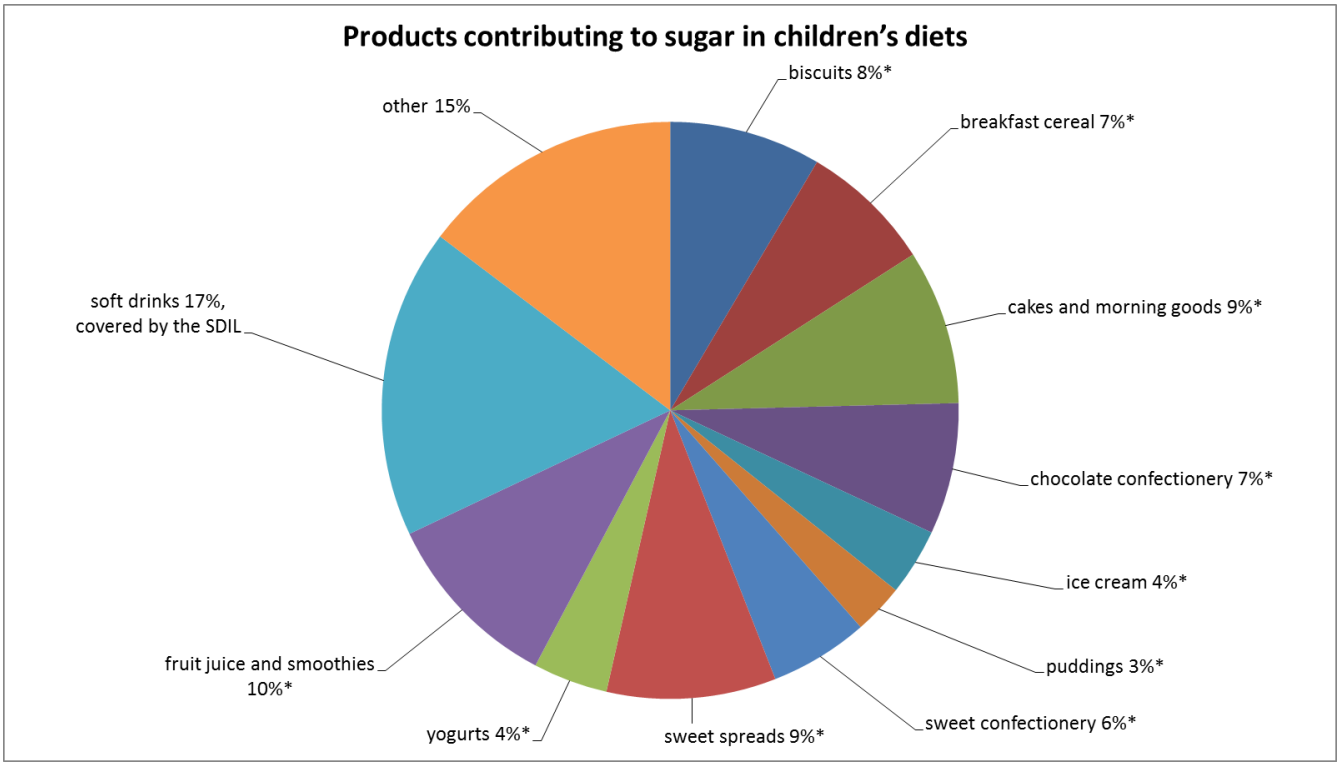
# 1. Sugar reduction

Children are currently consuming up to three times more sugar than is recommended.[15] The need for Government to act to reduce the amount of sugar our children consume is clear and formed the basis of our 2016 plan. The Soft Drinks Industry Levy (SDIL) was designed to tackle the largest contributor of sugar in children's diets by instructing soft drink manufacturers to reduce the sugar in their drinks or pay the Levy - with the drinks highest in sugar being taxed at a higher rate. The early response has been very encouraging, with around half of all drinks that would otherwise have been within scope of the Levy reducing their sugar content before it even came into force. Companies like Lucozade Ribena Suntory cut the sugar in their products by 50%. Overall, soft drinks produced by retailers and manufacturers have reduced their sales weighted average (SWA) for sugar by 11%.

In addition to the SDIL, the sugar reduction programme challenged all sectors of the food and drink industry, including retailers, manufacturers and the out of home sector (e.g. restaurants, cafes and takeaways) to reduce the amount of sugar in the foods most commonly eaten by children by 20% by 2020. The chart below shows the largest contributors of sugar in children's diets. The food and drink industry have three options to help them do this – reformulating foods to reduce sugar levels, providing smaller portions, or encouraging consumers to purchase lower or no sugar products.

Overall, industry has delivered a 2% reduction in sugar content across these foods.[16] This does not meet our 5% year one target, but we are pleased to see that reductions in yogurts and fromage frais, breakfast cereals, and sweet spreads and sauces have all met or exceeded the 5% sugar reduction ambition. We also know that there is more product reformulation in the pipeline that is not yet captured in the data. Overall, we continue to believe that the voluntary approach is the right one to meet the 20% ambition by 2020. However, PHE will continue to monitor sugar levels and the Government will evaluate progress once again in 2019. We will not shy away from further action, including mandatory and fiscal leavers if necessary.

PHE have also published voluntary sugar reduction guidelines for fruit and vegetable juices and milk-based drinks with added sugar. These drinks currently fall outside the scope of the Levy, as unsweetened juices do not contain added sugar and milk based drinks are a source of calcium and other nutrients. However, these drinks are a large contributor of sugar and calories to our children's diets, particularly given some of the larger portion sizes available.




**These categories are included in PHE's sugar reduction programme*

*'Other' consists of: Pasta, rice, pizza and other miscellaneous cereals; White and wholemeal bread; Other milk and cream; Meat and meat products; Vegetables and potatoes; Dry weight beverages; Soup, manufactured/retail and homemade; Savoury sauces, pickles, gravies and condiments.*

*Source: National Diet and Nutrition Survey (NDNS), years 7 and 8 (2014/15 - 2015/16)*

For juices, the drinks industry is expected to reduce the sugar in blended juice based drinks by 5% and cap the serving size of all juice based drinks to 150 calories by 2021. For milk based drinks, industry is expected to reduce the sugar by 20% and cap single servings to 300 calories by 2021, with an initial target of reducing sugar by 10% by 2020. PHE will monitor and report on industry's progress. **HM Treasury will consider the sugar reduction progress achieved in sugary milk drinks as part of its 2020 review of the milk drinks exemption from SDIL. Sugary milk drinks may be included in the SDIL if insufficient progress on reduction has been made.**

As part of the next phase of the sugar reduction programme we will review the scope for reformulation of product ranges aimed exclusively at babies and young children. PHE will review the evidence and publish their approach in 2019.

We may also consider further use of the tax system to promote healthy food if the voluntary sugar reduction programme does not deliver sufficient progress

# Energy drinks

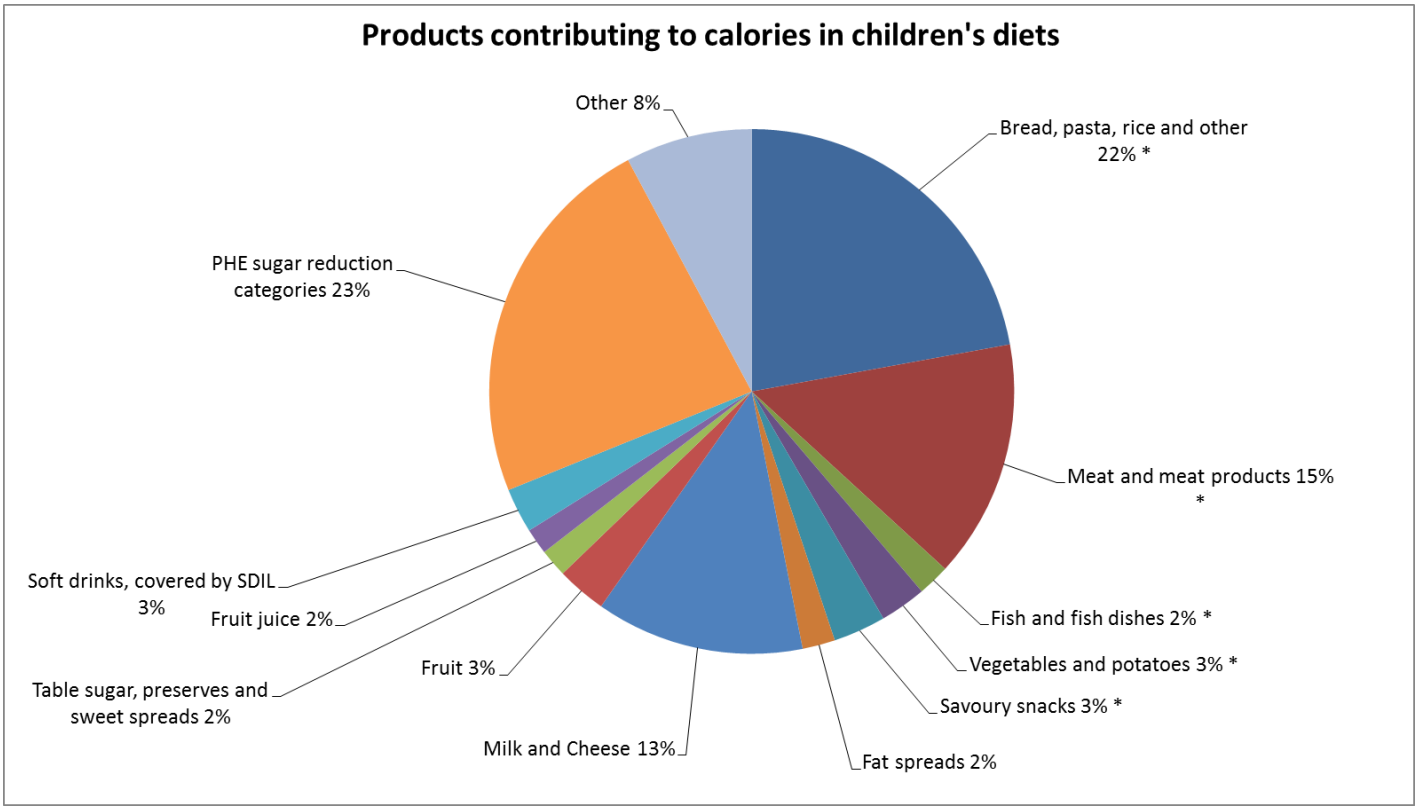
While strong progress has been made as part of the Soft Drinks Industry Levy, we are concerned about the impact that high-caffeine energy drinks are having on the levels of caffeine and sugar that our children consume. Manufacturers currently have to label all energy drinks containing over 150mg of caffeine as 'unsuitable for children.' Regular consumption of caffeinated energy drinks has been linked with adverse health outcomes for children such as headaches, sleeping problems, irritation and tiredness.[17] [18] Energy drinks are often high in sugar as well as caffeine, and may contain more sugar than full-sugar soft drinks,[19] and are therefore a contributor to both obesity in children and dental problems.

Despite growing concern about the effect that consumption of energy drinks has on the health and behaviour of children and young people, research suggests that nearly 70% of UK adolescents (aged 10-17 years old) consume energy drinks, and that those who do so are drinking on average 50% more than the EU average for that age group.[20] Evidence tells us that one of the reasons energy drinks are so appealing to children is that they are often cheaper than other soft drinks; in some outlets it is possible to buy four 250ml cans of energy drink for £1.[21]

Many larger retailers and supermarkets have followed Waitrose in voluntarily introducing a ban on the sale of energy drinks to children. We applaud their positive action in this space. However, there are large numbers of retailers who have not imposed such a restriction. It is important for us to create a level playing field for businesses so that retailers that take action on this issue are not disadvantaged, and to stop children from simply switching from one retail outlet to another to buy energy drinks. **We will therefore consult before the end of 2018 on our intention to introduce legislation to end the sale of energy drinks to children by all retailers.**

# 2. Calorie reduction

While our focus rightly started with sugar, we know that on average overweight and obese children are consuming up to 500 extra calories per day.[22] Therefore to succeed in reducing childhood obesity rates we need to reduce calories from all types of food, not just those that come from sugary products. That is why in 2017 we began to focus on calories. We announced our calorie reduction programme – which challenges the food and drink industry to reduce calories in a range of everyday foods most commonly eaten by children by 20% by 2024. The chart below shows the categories that contribute most to children's calorie intake. Our sugar and calorie reduction programmes will, together, apply to foods which account for around 50% of children's overall calorie intake.




** Some products within these categories are included in PHE's calorie reduction programme but the categories do not map to the product categories used in the National Diet and Nutrition survey.*

*'Other' consists of: Other meat, meat products and dishes; Oily fish; Other potato dishes; Nuts and seeds; Dry weight beverages; Soup, manufactured/retail and homemade; Savoury sauces, pickles, gravies and condiments.*

*Source: National Diet and Nutrition Survey (NDNS), years 7 and 8 (2014/15 - 2015/16)*

To deliver the calorie reduction programme, PHE will carry out in-depth engagement with stakeholders from the food industry, health charities and think-tanks, to develop category specific guidelines, which will be published in mid-2019. PHE will monitor and report on

progress annually so we can assess progress and will continue to support children and families across England to choose healthier meals, snacks and drinks, and to stay within recommended calorie guidelines, through its Change4Life and One You campaigns.

However, we recognise that public understanding of calories can often be limited and information on calories can be hard to understand. Most of the major manufacturers and retailers have now adopted our voluntary front-of-pack nutritional labelling scheme on pre-packaged foods. A recent survey from Diabetes UK found that 'almost nine in ten people agree that the traffic light labelling system helps people make informed decisions about the food they buy.'[23] The UK's ability to introduce changes to our labelling system currently depends on EU legislation; we **therefore remain committed to exploring what additional opportunities leaving the European Union presents for food labelling** in England that displays world-leading, simple nutritional information as well as information on origin and welfare standards. We will continue to work with the devolved administrations to explore the potential for common approaches.

We know that a significant proportion of the food people eat is consumed outside of the home; recent surveys tell us that 96% of people eat out, and 43% do so at least once or twice a week.[24] People are also eating out more often; in 2014, 75% of people said they had eaten out or bought takeaway food in the past week, compared to 69% in 2010.[25] In March 2017, Cancer Research reported that the UK population consumes more than a 100 million takeaways and ready-made meals in a week.[26]

The consumption of fast food and takeaways is particularly prevalent among families; evidence from 2016 indicates that 68% of households with children under 16 had eaten takeaways in the last month, compared with only 49% of adult-only households.[27] We know that overweight and obesity is often caused by consuming a relatively small amount of excess calories on a daily basis.[28] As evidence suggests people dining out consume 200 more calories per day than when eating at home,[29] it is therefore clear that looking at how to reduce the amount people consume when eating food made outside the home needs to be a significant part of efforts to tackle childhood obesity.

**Reported eating out behaviour of individuals over 16 years 2016**


*Source: Food Standards Agency. (2017) Food and You survey, Wave 4.*

Many businesses, such as Caffé Nero and Pizza Express, already provide nutritional information on their websites to help consumers make informed choices about the food they buy. However, only a few, for example JD Wetherspoon, provide this information at the point of choice (e.g. on menus or menu boards). It is estimated that only one quarter of the food we purchase to eat outside the home has calorie labelling at the point of choice.[30] Where this information is present, it is often provided in inconsistent ways.

There is strong public demand for this to change. A large majority (79%) of people agree that menus should include the number of calories in food and drinks.[31] A recent survey from Diabetes UK showed that around 60% of the public said that calorie labelling on food menus would make it more likely that they would buy food from a restaurant, café or takeaway.[32]

To provide the public with the nutritional information they need to make healthier choices wherever they choose to eat **we will introduce legislation to mandate consistent calorie labelling in England for the out of home sector**. Evidence suggests[33] that contextual information, for example displaying the calorie content as a percentage of daily calorie requirements, using colour coding, or including information on sugar, fat and salt content, may further help consumers make healthier choices. Therefore, we will consult, before the end of 2018, on the best way of implementing calorie labelling, including opportunities to display additional contextual information to help consumers understand calories and make healthier choices when eating food prepared outside the home. We recognise that the compliance burden associated with this policy may be disproportionately high for micro-businesses. Therefore, we will consult on whether micro-businesses should be excluded or given a longer implementation period. We also intend to provide guidance and methodology to help businesses calculate calorie information.

Labelling is just one part of the product packaging. Emerging evidence suggests that using other forms of marketing and promotion such as brand equity and licensed characters and

celebrities on product packaging can influence children's food choices and children's intake and preference for high sugar foods.[34] [35] [36]

There are no current plans to place a ban on using brand equity and licensed characters, cartoon characters and celebrities to promote HFSS products. The NIHR Obesity Policy Research Unit will continue to review the evidence base of the effect of marketing and advertising on children, including in these areas.

As well as capturing products that contribute to high sugar and calorie intake, over consumption of salt increases the risk of high blood pressure which in turn increases the risk of cardiovascular disease. Later this year, we will review the latest industry progress on salt reformulation to see if more can be done to reduce salt intakes in future years.

# 3. Advertising and promotions

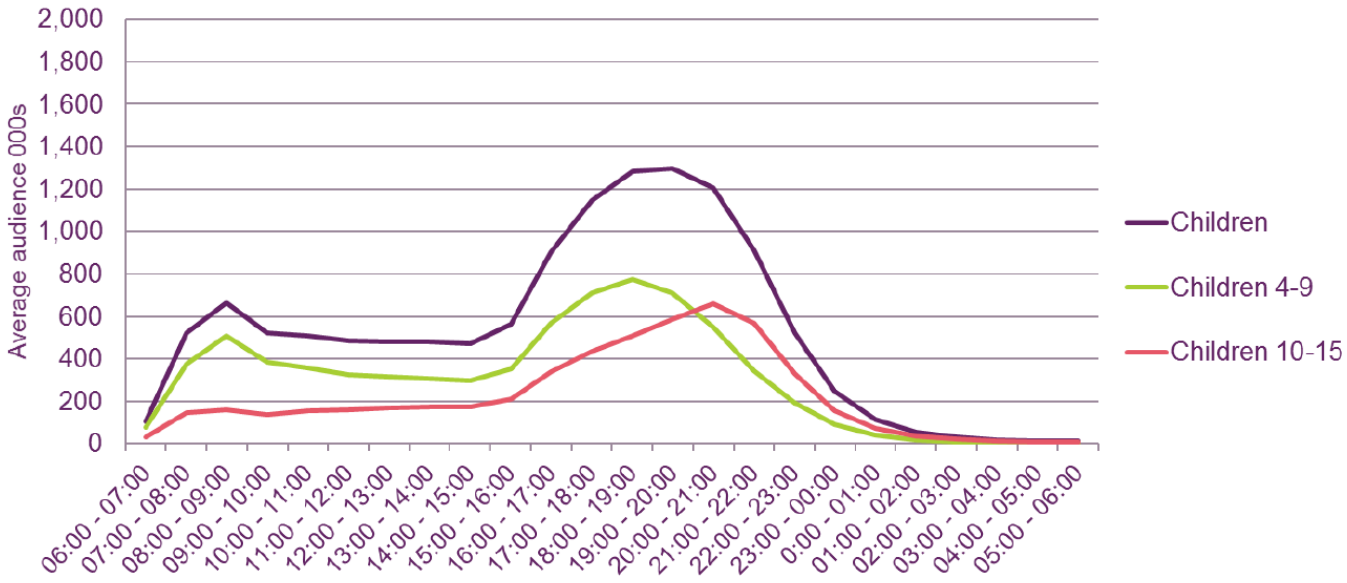
## Advertising

The evidence shows that exposure to food advertising can have both an immediate and longer-term impact on children's health, by encouraging greater consumption immediately after watching the advert and altering children's food preferences.[37] [38] [39] [40] Furthermore, several reviews have concluded that these effects are significant and independent of other influences.[41] [42] Over time we know that small daily increases in children's calorie intakes will lead to weight gain, obesity and future ill health.

To protect children from this exposure the UK currently places strong restrictions on the advertising of high fat, salt or sugar (HFSS) products. Strict new rules came into effect in July 2017 banning the advertising of HFSS food or drink products in children's media - content that is directed to, or likely to appeal to children. These restrictions complement similar measures already in place for broadcast media (television and radio) where advertising of HFSS products is prohibited during, before and after programmes commissioned for, principally directed at, or likely particularly to appeal to children (children's programming). This is in addition to rules that apply across broadcast media that adverts must not be used to condone or encourage poor nutritional habits, unhealthy lifestyles or use of pester power. There are also specific content restrictions on adverts for HFSS foods. Together, these restrictions mean that irrespective of the time shown, HFSS products cannot be deliberately targeted at children; limiting marketing tactics such as the use of character or celebrity endorsements, promotional offers with appeal to children, or nutritional claims.

TV remains our children's main form of media. They watch on average 14 hours of TV each week.[43] However, children do not just watch programming aimed at them. Half of children's viewing takes place during adult commercial programming where restrictions are weaker.[44] Recent data shows that the number of children watching TV peaks between 6-9pm, when popular family programmes typically dominate, leaving children exposed to HFSS advertising.

**Average 2016 audience, by day part and age: total TV**




Source: BARB, 2016. Live viewing. Sourced from Ofcom (2017). Children and Parents: media use and attitudes report.

We also know that, despite TV's continued popularity, many more children are spending more time online, through devices including smartphones and tablets. We think it is important to consider giving children the same level of protection against HFSS adverts regardless of the media platform with which they are engaging.

We think more could be done to build on current restrictions to deliver this protection. Our ambition is to see further advertising restrictions applied which limit children's exposure to HFSS advertising, incentivise reformulation, and ensure that the healthiest of products are advertised freely across all programming. We also want to put control back into parents' hands by making it clearer for them when and where HFSS adverts can and cannot be shown, so that they can make the best choices for their children.

**We will consult, before the end of 2018, on introducing a 9pm watershed on TV advertising of HFSS products and similar protection for children viewing adverts online, with the aim of limiting children's exposure to HFSS advertising and driving further reformulation**. We will explore options to ensure that any restrictions are proportionate, help to incentivise reformulation in line with the aims of the sugar and calorie reduction programmes, and consider a focus on those products that children consume and most contribute to the problem of childhood obesity.

Currently online advertising rules are drawn up by the Committee of Advertising Practice, which works alongside the Advertising Standards Authority (ASA), on a self-regulatory basis. We will consider whether this continues to be the right approach to protect children from advertising of

unhealthy food and drinks, or whether legislation is necessary. We will ensure any further restrictions are designed effectively for the digital space, taking into account how content is consumed online and considering options for enforcement.

## Promotions

Marketing goes beyond the advertisements that children and their families see on TV and online. How food and drink is promoted to us when we are buying food – whether doing our weekly shop in a supermarket, picking up a few bits from a local corner shop or shopping on-line can lead us to purchase more than we need. This is a particular problem when it comes to the promotion of unhealthy food. We have the highest level of promotions in Europe and 40% of what we spend on food and drink is on promotion.[45]

Promotions, both by price and location, can impact on the food purchases we make whether online or in a shop. Evidence from PHE shows us that we are more likely to see price promotions such as 'buy one get one free' (BOGOFs) and multi-buy offers for unhealthy food products compared to other food.[46] Such promotions increase the amount of food and drink people buy by around one fifth.[47] This can lead to stockpiling and overconsumption of unhealthy products.

Where this food is located within shops can have a significant impact on what we purchase.[48] [49] Locations such as end-of-aisle displays and checkouts are used to promote unhealthy food items. Evidence shows us that this can increase sales. For example, end-of-aisle displays can increase sales of carbonated drinks by over 50%.[50] This type of promotion can particularly impact on parents through 'pester power'.[51] Parents may not realise the extent to which their purchases are driven by prompts from children, but evidence suggests that twice as many purchases are triggered by children than parents are aware of.[52] Furthermore, most of the items requested by children tend to be unhealthy foods and 70% of parents purchased at least one food item requested by a child during a shopping trip.[53] We must act to support parents.

Some retailers, such as Lidl and Aldi, have changed the way that unhealthy food and drink items are located or sold on promotion in their stores, but few retailers take this responsible approach. The approach needs to apply across the whole retail sector, to ensure that all are operating to the same rules and that shoppers are able to access healthier food on promotion, wherever they shop.

**We intend to ban price promotions, such as buy one get one free and multi-buy offers (BOGOFs) or unlimited refills of unhealthy foods and drinks in the retail and out of home sector through legislation.** In doing so, we aim to stop promotions that encourage bulk buying and over consumption of unhealthy products. It is not our intention to make food for families eating out as a treat more expensive so offers such as 'kids eat free' are not withinscope.

### Advertising and promotions

**We intend to ban the promotion of unhealthy food and drink by location (at checkouts and the end of aisles and store entrances) in the retail and out of home sector through legislation**. We will seek to extend a similar approach to online shopping and the out of home sector ahead of checkout.

We will consult on both proposals before the end of 2018 to address the best way to implement these policies and whether there should be exclusions for small businesses, shops with limited space, and specialist retailers. We will also consider how the restrictions on price promotions will apply in the out of home sector to target children's over consumption.

# 4. Local areas

As well as addressing the content, advertising and promotion of food at national level, we want to ensure that the places our children live, learn and play are promoting a healthy lifestyle. Across England, there are excellent examples of ambitious local approaches to tackling childhood obesity, including in Southwark, Manchester, Lambeth and Blackpool. But many local authorities are struggling to tackle the complexity of the childhood obesity challenge.

Challenges vary across local areas but many local authorities face common issues, including a proliferation of fast food outlets on high streets and near schools;[54] less active travel;[55] limited access to green spaces[56] and physical activity; and unhealthy food marketing dominating many public spaces.[57] These factors create an environment that makes it harder for children and their families to make healthy choices, particularly in some of our most deprived areas.

Local authorities have a range of powers and opportunities to create healthier environments. They have the power to develop planning policies to limit the opening of additional fast food outlets close to schools and in areas of over-concentration; prioritise active travel in transport plans and deliver walking and cycling infrastructure through Local Cycling and Walking Infrastructure Plans; and ensure access to quality green space to promote physical activity. They can also offer professional training, parenting support, social marketing campaigns and weight management services. They can partner with leisure and sport facilities to offer accessible physical activity opportunities.

## Case study: Blackpool Council

*In partnership with Food Active, Blackpool developed the Local Authority Declaration on Healthy Weight, a strategic commitment across the council to reduce unhealthy weight and protect health, which was adopted in 2016.*

*Blackpool has since held a Healthy Weight Summit resulting in over 20 pledges of action across public, voluntary and private sectors.*

*The city also offered healthier food choices by introducing healthier vending and catering guidelines and a Healthier Choices award which over 100 establishments have achieved.*

*It also delivered family weight management service Making Changes and a healthy lifestyles programme for all Year 4 children Fit2Go and encouraging active travel in partnership with Living Streets.*

*Blackpool also works closely with schools, developing healthy lunchbox guidance and delivering Food Active's GULP (Give up loving pop) campaign, challenging schools to reduce children's sugary drink intake. Running since 2015, this year's 21-day challenge will reach 3,000 Year 4 & 5 children.*

## Case study: Derbyshire County Council

*Derbyshire has a range of measures to tackle child obesity and aim to make the healthier choice, the easier choice.*

*Through the HENRY programme for pre-school children; the Forest Schools programme promoting outdoor activity; weight management services for over 16s and additional support for Looked After Children to get physically active, Derbyshire offers support throughout childhood.*

*The council also works with Active Derbyshire which offers opportunities to get active including free health walks and Jog Derbyshire which has 6,500 participants.*

*To improve the local food offer, Derbyshire developed the Heart of Derbyshire scheme with a set of pledges, including use of healthier ingredients and controlling portion sizes. So far 197 takeaways have signed up while all council catered schools and nurseries have achieved a Gold Award.*

*In 2015, the Be Portion Size Wise campaign was introduced, challenging locals to reduce their portions. Residents were supported with resources including tips on dining out and had the chance to win healthy eating prizes.*

We understand there is real ambition among local authorities to tackle childhood obesity but there are very real obstacles. While there are a number of pioneering local authorities taking bold action, many are not, with existing powers not being fully realised and disparities in action across different areas.

To help address these challenges, **we will develop a trailblazer programme with local authority partners to show what can be achieved within existing powers and understand "what works" in different communities.** This three year programme will involve a small number of local authorities working intensively with a delivery partner and with central Government support to be ambitious in addressing childhood obesity. We will look to the experience of pioneering local authorities and international examples such as Amsterdam to identify key areas of learning.[58] Participating local authorities will focus on inequalities and ethnic disparities and will share this learning and best practice to support all local authorities to take action. We aim to significantly increase the proportion of local authorities actively combatting childhood obesity over the next five years.

We recognise that national resources and interventions will also help local authorities to use their powers. In 2017 the National Planning Practice Guidance was updated to outline the role that planning can have in reducing obesity by limiting over-concentration of fast food takeaways, particularly around schools.[59] Local authorities want to use these powers[60] and have a range of tools to support them but local leaders have told us it is difficult to put these powers into practice. For example, the evidence they need to support their planning decisions and make them resilient to appeals can be difficult and expensive to obtain. We want to see more local authorities using these powers. So we will **develop resources that support local authorities who want to use their powers. We will help set out the economic business case for a healthy food environment and provide up to date guidance and training for planning inspectors.**

Exposure to the natural environment and green space is associated with lower levels of obesity and higher levels of physical activity,[61] but there is unequal access across the population, with those living in the most deprived areas less likely to live in the greenest areas.[62] The Government's 25 Year Environment Plan[63] promotes a sustainable natural environment as a pathway to good health and wellbeing. **In 2019 we will define a set of standards to demonstrate what "good" green infrastructure looks like.**

As part of their responsibility for public health, local authorities deliver the National Child Measurement Programme (NCMP), which measures the height and weight of Reception and Year 6 children at all mainstream state-maintained schools (including academies) in England. The NCMP provides robust data to inform national and local policy and commissioning decisions, presents the opportunity to engage parents of overweight and obese children and provides Government with a national picture of childhood obesity over the long term which is an invaluable resource to measure progress. Evidence shows us that while parents find it difficult to recognise when their children are overweight or obese, the majority (87%)[64] appreciate being given feedback on the weight status of their children, which the NCMP provides. **Therefore, we will continue the NCMP for children in Reception and Year 6.**

The NCMP also gives local authorities the opportunity to connect parents with health and care professionals and local weight management services to help them support their children to achieve and maintain a healthy weight. We know the confidence of health and care professionals in supporting children with their weight is vital. Therefore **we will provide health and care professionals with the latest training and tools to better support children, young people and families to reduce obesity, including a digital family weight management service.**

The NHS has an important role in tackling childhood obesity at both a local and national level. This includes preventative initiatives such as NHS England's Heathy New Towns programme which involves over 50,000 homes and is using the environment to incentivise physical activity for children, through digital innovation and healthy routes for walking and cycling. It also includes action to create healthier environments in NHS premises by curbing the sale of unhealthy foods and drink which has seen positive results including a 45% reduction of sugary drink sales in 2017.

This tracks wider than the NHS and all of the public sector should be leading by example in ensuring a healthy food environment for children and parents on their premises. To offer healthier food and drink options, many public sector buildings apply the Government Buying Standards for Food and Catering Services (GBSF). The standards are mandatory for central Government buildings and hospitals, with the wider public sector, such as leisure centres and schools, being encouraged to use them. We will support local authorities, schools and hospitals, to adopt the GBSF to help ensure that children have the healthiest food available throughout the public sector. **We plan to consult, before the end of 2018, on strengthening the nutrition standards in the GBSF, to bring them into line with the latest scientific dietary advice.**

# 5. Schools

Schools have an important role in defining habits and helping their pupils make healthier choices. We know that obesity rates double during the primary school years[65] and increase further in secondary school.[66] We must ensure that schools are equipping children with the knowledge they need to lead healthy lifestyles and creating environments which encourage their pupils to eat healthily and be physically active.

A healthy, balanced diet is important for a child's development. The School Food Standards were introduced to make sure food provided to pupils is nutritious and of high quality, by setting requirements for all food and drink provided in schools. Compliance with the School Food Standards is a legal requirement for the majority of schools, including all maintained schools. Academies and free schools are required to comply with the Standards by virtue of their funding agreements, with the exception of a proportion that we expect to comply voluntarily. Government will ensure all schools are aware of their responsibility for quality nutrition.

In 2016, we committed to update the School Food Standards in light of the latest advice on nutrition which revised the recommended daily intake of sugar and fibre. **Our update to the standards will be bold on reducing sugar consumption and will be coupled with detailed guidance to caterers and schools so they are well prepared to adapt to the changes**.

With children in lower income households more likely to be obese, we have considered how the Government can continue to help families that sometimes struggle to give their children a healthy diet. The Government currently delivers the Healthy Food Schemes - Healthy Start, School Fruit and Vegetable and the Nursery Milk schemes - which aim to provide children with nutritional support and to encourage good eating habits from an early age. But we think we can make these schemes work even better. To do this **we will consult, before the end of 2018, on our plans to use Healthy Start vouchers to provide additional support to children from lower income families, who are at greater risk of obesity.** Healthy Start vouchers can be exchanged for fruit, vegetables and milk and are accepted by a wide range of retailers.

Regular physical activity has been linked not only to improved physical health but also improved mental wellbeing and academic attainment.[67] The Chief Medical Officer recommends all school-aged children get at least 60 minutes of physical activity every day – but we know only approximately one in five achieve this.[68] The Government's Sporting Future strategy[69] set out a new approach to sport and physical activity, with a clear focus on engaging the least active. This direction has been supported by key investments announced in our 2016 plan using revenue from the Soft Drinks Industry Levy and Sport England's 'Towards an Active Nation.' While we can be proud of this significant investment, we need to ensure that it is reaching the least active children. We want to do more to support schools in this regard. Therefore we will work across Government to review how the least active children are being engaged in physical activity in and around the school day. The review will consider how the Primary PE and Sport Premium is being used, to help ensure that our investment contributes towards helping all children to lead active lives.

We recommend that during the school day, schools should be responsible for delivering at least 30 minutes of the total recommended 60 daily minutes of moderate to vigorous physical activity for children and young people.[70] For many schools it can be difficult to identify the right opportunities to meet this recommendation. Active mile initiatives provide a simple means of significantly contributing to this recommendation and early research has suggested such schemes can deliver on well-established links between physical activity, and improved wellbeing and educational attainment.[71] Therefore **we will promote a national ambition for every primary school to adopt an active mile initiative, such as the Daily Mile**. Schools will have the flexibility to do so in a way that best suits their facilities and students and we will review how the Primary PE and Sport Premium can be used to support it.

## Case study: Active Mile

*Using increased physical activity to improve pupil fitness, increase concentration and improve levels of attainment was the catalyst for Thornhill Primary to implement an active mile into the school day. The school was keen for the active mile to be inclusive for all pupils, in particular, pupils with wheelchairs and walking frames. The school playground already had a heart line marked out and pupils and staff walk, jog or run a route around the heart equivalent to a mile every day. Teachers have discretion on when to complete the active mile and often use it to combat lack of attention or concentration in class.*

*Since implementing this initiative, the pupils are engaging in increased daily physical activity and improvements have been noted in levels of fitness, classroom behaviour and attendance levels.*

*"Pupils, staff and parents recognise the positive impact it has on the whole school." Mrs Amanda Benton, Head teacher*

Our plans to introduce a healthy rating scheme for schools, outlined in the 2016 Childhood Obesity plan, will ensure that schools have a framework for self-evaluation for promoting healthy eating and physical activity during the school day.

As well as encouraging children to be active while in school, travel to and from school can also be used as an opportunity to increase children's physical activity levels. During 2018/19 the Government will be investing an additional £620,000 of funding in the Walk to School project, a highly successful programme[72] delivered by Living Streets which aims to increase the number of children walking to school. The funding will support the delivery of the Government's Cycling and Walking Investment Strategy target to increase the percentage of children aged 5 to 10 years old that usually walk to school to 55% in 2025. The Government will also invest an additional £1 million during 2018/19 to expand Bikeability, the national cycling training programme for schoolchildren, in order to support secondary school children to cycle safely and confidently on local roads.

A broad and balanced school curriculum should provide opportunities for pupils to develop knowledge and understanding of a range of health related matters. For example, as part of the national science curriculum, pupils learn how eating food and getting exercise keeps them healthy; as part of the Design and Technology curriculum pupils learn how to cook, and how to

feed themselves a varied and balanced diet; and in PE, pupils not only participate in sports and physical activity, but are taught the long term health benefits of physical activity.

As part of Ofsted school inspections, inspectors currently evaluate how well schools support pupils so that children are able to explain accurately and confidently how to keep themselves healthy, including through making informed choices about healthy eating and physical fitness. This evaluation contributes to a graded judgement on pupils' personal development, behaviour and welfare. **Ofsted is developing a new framework for September 2019. This will consider how schools build knowledge across the whole curriculum and how they support pupils' personal development more broadly, including in relation to healthy behaviours.**

Addressing the increase in obesity amongst school age children is important, but for some children, the habits and behaviours that result in obesity are embedded in the early years. To help address this, **Ofsted will undertake research into what a curriculum that supports good physical development in the early years looks like**. This will explore the full range of development, including what children are taught about their bodies - for example the importance of sleep and healthy eating.

# 6. Conclusion

Our ambition is a bold but simple one. We will halve childhood obesity and significantly reduce the gap in obesity between children from the most and least deprived areas by 2030. We all have a lot to gain by beating obesity and it is vital for us all to work together to achieve this, particularly to support parents, especially in the most deprived families and areas, to help their children have the best start in life. We believe that the evidence-based actions we propose will do this by encouraging healthier choices and making these more readily available and identifiable to parents.

Taken together, the actions in this plan and the ones we already have in train from 2016, are world leading. However, we remain committed to reviewing what more can be done to make sure we meet our ambition of halving childhood obesity and will continue to monitor progress and emerging evidence carefully. Where progress is not being delivered, we will consider what further action can be taken to help us to achieve what no other country in the world has yet achieved: success in tackling childhood obesity.

[1] NHS Digital. (2017). National Child Measurement Programme 2016/17
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# HEALTH AND WELLBEING BOARD

**14 September 2018**

HARTLEPOOL BOROUGH COUNCIL

**Report of:** Interim Director of Public Health and Director

**Subject:** JOINT HEALTH AND WELLBEING STRATEGY (2018-2025) – IMPLEMENTATION AND MONITORING UPDATE

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## 1. PURPOSE OF REPORT

1.1 To update the Board on progress in relation to the implementation of the Joint Health and Wellbeing Strategy (2018-2025) (JHWS), with specific reference to the following deep dive areas:-

i) Reducing Drug and Alcohol Harm; and
ii) Improving Mental Health and Wellbeing.

## 2. BACKGROUND

2.1 The Health and Wellbeing Board (HWB), at its meeting on the 25 June 2018 agreed the process and timetable for the implementation of the 'Reducing Drug and Alcohol Harm' deep dive during 2018/19. Nominations were sought to lead aspects of the implementation process and details of those received have been added to **Appendix A**, with lead officers still required in relation to the following children and young people's health actions.

**Table 1**

| **Children and young people's health** | |
|---|---|
| • Develop local CYP workforce (to help make every contact count) to provide parental and CYP education and to identify Drug and Alcohol misuse issues and intervene early; and to support schools and colleges to play a lead role. | Children's Strategic Partnership (CSP)<br><br>Lead Officer Nomination required. |

| | |
|---|---|
| • Design and implement a multi-agency model that will support early identification of 'hidden harm' and intervention in order to minimise the impact of drugs and alcohol on children and young people.<br><br>• Build and provide multi-agency integrated early help services for 'hidden harm'. | Hartlepool Safeguarding Children's Board (HSCB)<br><br>Lead Officer Nomination required. |

2.2 It was also agreed that the submission of a report to the Finance and Policy Committee in relation to the wider provision of drug and alcohol preventative services[1] would be deferred until October 2018, to allow completion of a needs assessment and the development of proposals for future service delivery. This work has now been completed and was considered by the HWB earlier on this agenda.

2.3 The needs assessment, considered earlier in the meeting, provides the output and outcome data identified by the HWB, at its meeting on the 25th June 2018. It also, together with the proposals for future service delivery, responds to the actions identified in the JHWS Action Plan.

## 3. 2019/2020 DEEP DIVE AREA - IMPROVING MENTAL HEALTH AND WELLBEING

3.1 In preparing for the 'mental health and wellbeing' deep dive in 2019/2020, the HWB is asked to confirm the proposed lead committees, officers and partners outlined in Table 2 below (some of which were already identified in the JHWS Action Plan), and to fill in the remaining gaps.

**Table 2**

| **Improve Mental Health and Wellbeing (summarised from the JHWS Action Plan – pages 16-17)** | | |
|---|---|---|
| Action to be addressed | **Lead Committee (currently in Action Plan)** | **Proposed Lead Committee / Body; Lead Officer and Partner Representatives** |
| **Understanding needs and demand**<br>• Utilise multi-agency data, information and demographics across Hartlepool to provide a better overview of need to help | **To be added**<br><br>**Mental Health Forum??** | **To be added** |

[1] Report requested by the Safer Hartlepool Partnership

| | | |
|---|---|---|
| redirect action through the JSNA.<br>• Map current activity to help re-direct action to areas of most need through the development and make the links to the Drugs and Alcohol Needs Assessment. | | |
| **Targeted awareness and social marketing**<br>• Design and launch a '**Hartlepool Big Conversation**' programme that will support multi-agency and town wide social marketing on mental health and wellbeing – use physical and creative activities, including volunteering and using local resources as an engagement tool for prevention and recovery. | **To be added** | **To be added** |
| **Promoting behaviour change**<br>• Pilot a behaviour insight project to help understand behavioural barriers to assessing interventions and implement appropriate ethnographic interventions in response in order to improve uptake of services. | **To be added** | **To be added** |
| **Access to mental health services**<br>• Redesign care pathways to improve access to interventions for those people who fall below the specialist services threshold but require interventions other than universal programmes | Hartlepool Matters Working Group | **To be added** |
| **Children and young people's health**<br>• Develop local CYP workforce (to help make every contact count) to identify emotional health issues and intervene early<br>• Continue to develop and implement a multi-agency intervention model that incorporates the five ways to wellbeing and aligned with CAMHS and Future in Mind<br>• Continue to develop intervention to address the | Children's Strategic Partnership (CSP) | **To be added** |

| | | |
|---|---|---|
| needs of young carers with a focus on social isolation | | |
| **Employee health**<br>• Utilise the North East Better Health at Work Award to facilitate improved employer support for emotional wellbeing of employees | **Public Health Lead** | **To be added** |
| **Older people's health**<br>• Continue to strengthen ongoing multi-agency work (e.g. Befriending Network, Project 65 etc) to tackle social isolation for older people. To include peer networks to facilitate improved access to community based activities. | Adult Services Committee | **To be added** |

3.2 The Council's Audit and Governance Committee, as part of its statutory health scrutiny responsibilities, is undertaking an investigation into the provision of preventative mental health services in Hartlepool. This will be helpful evidence for the mental health 'deep dive' exercise.

## 4. RISK IMPLICATIONS

4.1 Failure to monitor the implementation of the Joint Health and Wellbeing Strategy.

## 5. FINANCIAL CONSIDERATIONS

5.1 Whilst there may be implications associated with specific actions required to implement the JHWS, none relate to the content of this overarching report.

## 6. LEGAL CONSIDERATIONS

6.1 None

## 7. EQUALITY AND DIVERSITY CONSIDERATIONS

7.1 None

## 8. STAFF CONSIDERATIONS

8.1 None

## 9. RECOMMENDATIONS

9.1 In relation to the 'Reducing Drug and Alcohol Harm' deep dive (referenced in Section 2 of this report) the HWB agreed that:-

i) The drug and alcohol service needs assessment, and proposals for future service delivery, considered earlier in the agenda be noted.

ii) Nominations be sought for the two remaining lead officer positions (as detailed in Table 1) to progress the outcome and output measures though the agreed lead committees.

9.2 In relation to preparation for the Mental Health and Wellbeing 'deep dive' the HWB agreed that:-

i) The steps identified in Table 2 be approved.

ii) Nominations be put forward following the meeting for appropriate lead committees and bodies, lead officer(s) and partner representatives to progress the steps outlined.

## 10. REASONS FOR RECOMMENDATIONS

10.1 To facilitate monitoring and implementation of the JHWS.

## 11. BACKGROUND PAPERS

Health and Social Care Act 2012

Hartlepool's Joint Health and Wellbeing Strategy (2018-2025)
(Link to document Joint Health and Wellbeing Strategy | Joint Health and Wellbeing Strategy | Hartlepool Borough Council)

Health and Wellbeing Board Report and Minutes – 25th June 2018

## 12. CONTACT OFFICER

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**Appendix A**

| **Reduce Drug And Alcohol Harm** | | |
|---|---|---|
| Actions (JHWS Action Plan – pages 16-17) | With reference to the report considered earlier in the meeting entitled 'Drug and Alcohol Service Needs Assessment – Next Steps for Delivery' the following actions are:- | Lead Committee / Body; Lead Officer and Partner Representatives to progress where required. |
| **Understanding needs and demand**<br>• Utilise multi-agency data, information and demographics across Hartlepool to provide a better overview of need to help redirect action through the JSNA.<br>• Map current activity to help re-direct action to areas of most need through the development and implementation of a multi-agency Drug &Alcohol Harm Reduction delivery framework and to improve access to interventions – to include a focus on CYP misuse and parental impact. | Complete<br><br>Complete | Lead Committee / Body: **SHP - Drug and Alcohol Harm Reduction Group**<br><br>Lead Officer: **Director of Public Health**<br><br>Partner Representative(s):<br>**FT** – Dr R Thomas<br>**A&CBS** – John Lovatt (or deputy)<br>**Police –** Chief Inspector Burnell |
| **Targeted awareness and social marketing**<br>• Design and launch a '**Hartlepool Big Conversation**' programme that will support multi-agency and town wide social marketing on drugs and alcohol harm (to include medicines waste) – use physical and creative activities, including volunteering and using local resources as an engagement tool for prevention and recovery. | Complete | Lead Committee / Body: **SHP – Drug and Alcohol Harm Reduction Group**<br><br>Lead Officer: **Director of Public Health**<br><br>Partner Representative(s):<br>**FT** – Dr J Metcalf<br>**A&CBS** – Gemma Ptak (or deputy)<br>**Police** – Chief Inspector Burnell |
| **Promoting behaviour change**<br>• Pilot a behaviour insight project to help understand behavioural barriers to | Complete | Lead Committee / Body: **SHP – Drug and Alcohol Harm Reduction Group** |

| | | |
|---|---|---|
| assessing interventions and implement appropriate ethnographic interventions in response in order to improve uptake of services. | | Lead Officer: **Director of Public Health**<br><br>Partner Representative(s):<br>**A&CBS** – Sarah Wood and Gemma Ptak (or deputy)<br>**Police** – Chief Inspector Burnell |
| **Children and young people's health**<br>• Develop local CYP workforce (to help make every contact count) to provide parental and CYP education and to identify Drug and Alcohol misuse issues and intervene early; and to support schools and colleges to play a lead role. | Complete | Lead Committee / Body: **Children's Strategic Partnership (CSP)**<br><br>Lead Officer: **Nomination still required**<br><br>Partner Representative(s): **FT – Dr A Koshy** |
| • Design and implement a multi-agency model that will support early identification of 'hidden harm' and intervention in order to minimise the impact of drugs and alcohol on children and young people.<br><br>• Build and provide multi-agency integrated early help services for 'hidden harm'. | Complete<br><br>Complete | Lead Committee / Body: **Hartlepool Safeguarding Children's Board (HSCB)**<br><br>Lead Officer: **Nomination still required**<br><br>Partner Representative(s):<br><br>**FT** – Dr S Puthuval<br>**Police** – TBC |

# HEALTH AND WELLBEING BOARD

**14 September 2018**

**Report of:** Statutory Scrutiny Officer

**Subject:** AUDIT AND GOVERNANCE COMMITTEE WORK PROGRAMME 2018/19 – INVESTIGATION IN TO THE PROVISION OF PREVENTATIVE MENTAL HEALTH SERVICES IN HARTLEPOOL

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## 1. PURPOSE OF REPORT

1.1 To advise the Health and Board of the selection of 'The Provision of Preventative Mental Health Services in Hartlepool' as the topic for investigation by the Audit and Governance Wellbeing Committee during 2018/19.

## 2. BACKGROUND

2.1 In fulfilling the requirements of the Health and Social Care Act 2012, the Council has a statutory responsibility to review and scrutinise matters relating to the planning, provision and operation of health services at both local and regional levels. In doing this, local authorities not only look at themselves (i.e. in relation to public health), but also at all health service providers and any other factors that affect people's health.

2.2 This function is fulfilled through the Audit and Governance Committee, which reviews / scrutinises and makes reports with recommendations to the Council, a 'responsible person' (that being relevant NHS body or health service provider) and other relevant agencies about possible service improvements in the following areas:-

(i) health issues identified by, or of concern to, the local population;
(ii) proposed substantial development or variation in the provision of health services in the local authority area (except where a decision has been taken as a result of a risk to safety or welfare of patients or staff);
(iii) the impact of interventions on the health of local inhabitants;
(iv) an overview of delivery against key national and local targets, particularly those which improve the public's health;
(v) the development of integrated strategies for health improvement; and
(vi) the accessibility of services that impact on the health of local people to all parts of the local community.

2.3 The Audit and Governance Committee set its annual work programme for 2018/19 on the 28 June 2018 and, in identifying an appropriate topic, gave due regard to:

- The identification of 'Improving Mental Health and Emotional Wellbeing' as a deep dive area within Hartlepool's Joint Health and Wellbeing Strategy (JHWS) (2018-2025) and opportunity for the Committee's investigation to feed into the Health and Wellbeing Boards review of the area in 2020/21.

- The identification of 'ensuring mental health receives the same priority as physical health' as a Healthwatch priority for 2018/19 and the opportunity for the Committee to contribute towards achieving this.

2.4 The Committee subsequently agreed that it would focus its investigation for 2018/19 on 'The Provision of Preventative Mental Health Services in Hartlepool', coordinating its activities alongside that of its partner organisations to prevent duplication and ensure that the most effective / worthwhile outcome is achieved. The Committee also agreed that in gaining an understanding of the services provided in Hartlepool, and exploring where or how improvements could be made, it would divide its investigation to three separate areas (children and young people's services, working age services and older people's services). In addition to allowing the Committee to effectively focus it activities, this also reflects the priority outcomes identified in the JHWS.

## 3. EQUALITY AND DIVERSITY CONSIDERATIONS

3.1 There are no equality of diversity implications.

## 4. RECOMMENDATIONS

4.1 That that selection of preventative mental health services as the health topic for investigation by the Audit and Governance Committee in 2018/19 be noted.

## 5. REASONS FOR RECOMMENDATIONS

5.1 To ensure that the Health and Wellbeing Board is kept fully informed and updated.

## 6. BACKGROUND PAPERS

Audit and Governance Committee (28 June 2018):

- Report of the Statutory Scrutiny Officer entitled 'Selection of Potential Topics for Inclusion in the 2018/19 Statutory Scrutiny Work Programme'
- Minutes

Audit and Governance Committee (25 July 2018):

- Report of the Statutory Scrutiny Officer entitled 'Mental Health (Prevention) Scrutiny Investigation – Scoping'
- Minutes

## 7. CONTACT OFFICER

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# HEALTH AND WELLBEING BOARD

**14 September 2018**

**Report of:** Director, Children's and Joint Commissioning Services

**Subject:** DEPARTMENTAL RESTRUCTURE

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## 1. PURPOSE OF REPORT

1.1 To inform the Health and Wellbeing Board of a departmental restructure of Hartlepool Borough Council's Children's and Joint Commissioning Services and request that Danielle Swainston, Assistant Director, Joint Commissioning be invited to join the Board.

## 2. BACKGROUND

2.1 In August 2017, the Council's Finance and Policy Committee approved proposals for a corporate restructure following a review the functional groupings of the Council's departments. The aim of the restructure was to ensure that there was a senior leadership team clearly focused on the challenges the Council faced, made best use of the expertise within the authority and delivered excellent and consistent services. The proposal created two new departments: Children and Joint Commissioning Services covering the functions and responsibilities of children's services, education, children and adult services commissioning and public health; and Adults and Community Based Services covering the functions and responsibilities of adult services, community based public health and preventative services, Community Hubs, Sport and Leisure services, and well being and physical activity programmes.

2.2 In January 2018, the Council commenced the process to recruit a permanent Director of Public Health/Assistant Director Joint Commissioning and a Public Heath Consultant/Head of Business Intelligence. Unfortunately despite a national campaign, the Council was unable to recruit to these posts and therefore the Chair of the Appointments Panel asked the Chief Executive and Director of Children and Joint Commissioning Services to review the senior management structure of the department and any alternative models that could be considered to enable the Council to successfully recruit to the vacant posts.

## 3. PROPOSALS

3.1 A further report was taken to the Council's Finance and Policy Committee in July 2018 outlining an alternative structure which maintained the integrity of the original proposals and further strengthened these with the creation of an Assistant Director, Joint Commissioning post and a reconfiguration of existing Chief Officer responsibilities to achieve this. The revised structure is attached at **Appendix 1** to this report.

3.2 The proposed restructure was approved by Finance and Policy Committee and came into effect on 16 July 2018. The new structure reflects the continuing operational and financial demands facing both adult and children's services by ensuring the Council has sufficient capacity at Assistant Director level to address the significant challenges facing these service areas. The Assistant Director Joint Commissioning although managed by the Director, Children's and Joint Commissioning Services, will work closely with the Director of Adults and Community Based Services and the Director and Deputy Director of Public Health to deliver the Council's commissioning priorities and ensure these are informed by robust business intelligence and a strategic needs analysis.

3.3 The work of the Assistant Director Joint Commissioning will be cross cutting, including taking a leadership role in delivering aspects of the Health and Wellbeing Strategy. The council envisages that this post will work closely and collaboratively with partner organisations to the collective benefit of all. For these reasons, it would be beneficial if the Council's Assistant Director Joint Commissioning was a member of the Health and Wellbeing Board. This role would also be the nominated substitute for the Director, Children's and Joint Commissioning Services and Director, Adults and Community Based Services in the event these prescribed officers were unable to attend a meeting.

## 4. RECOMMENDATIONS

4.1 For members of the Health and Wellbeing Board to note the restructure of Children's and Joint Commissioning Services as shown at **Appendix 1**.

4.2 For members of the Health and Wellbeing Board to approve the Assistant Director, Joint Commissioning as a non prescribed member of the Board.

## 5. BACKGROUND PAPERS

None

## 6. CONTACT OFFICER

Sally Robinson, Director, Children's and Joint Commissioning Services
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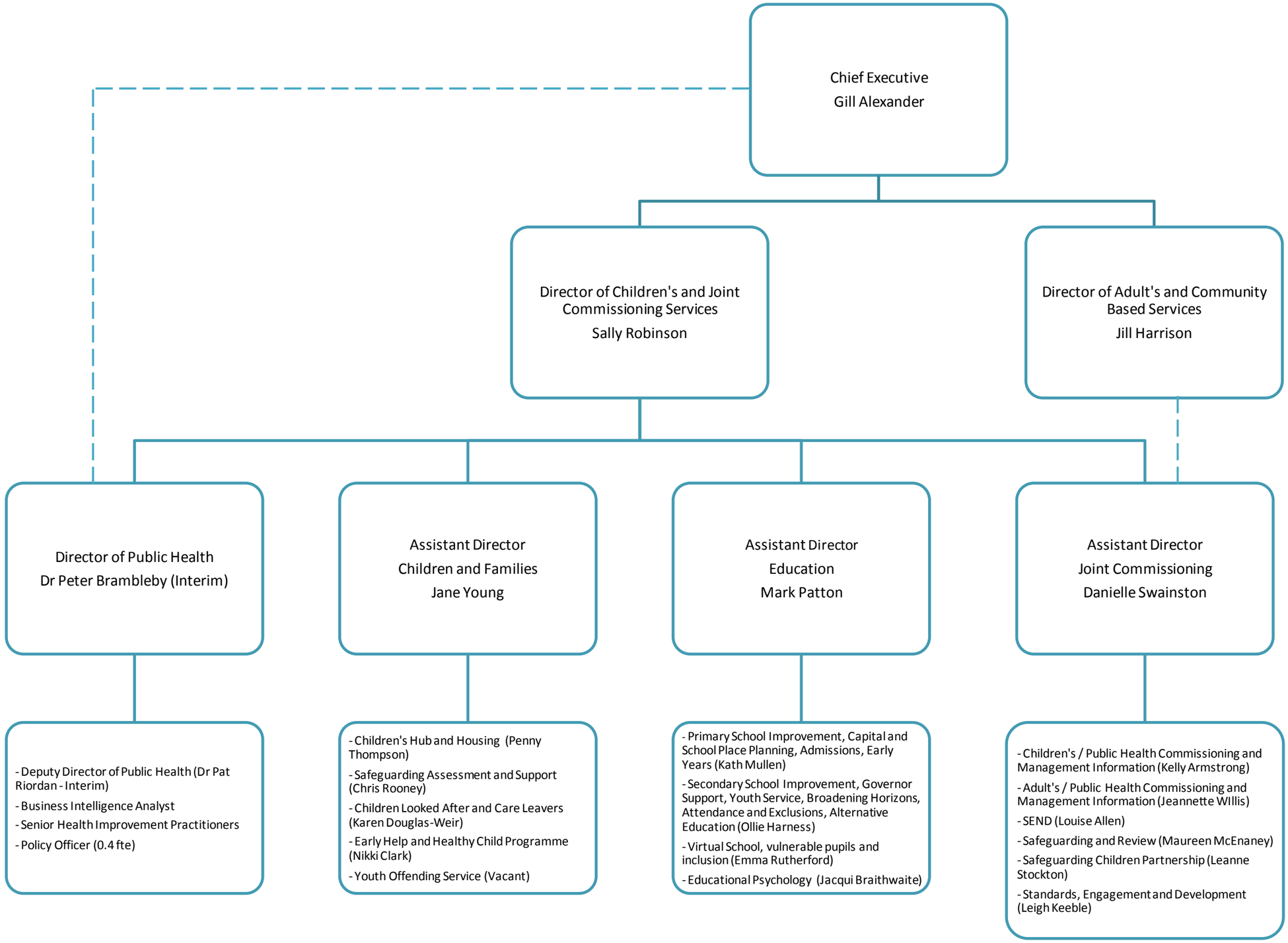
# Structure Chart – Children's & Joint Commissioning July 2018



# HEALTH AND WELLBEING BOARD

**14 September 2018**

**Report of:** Director of Adult & Community Based Services

**Subject:** Better Care Fund 2018/19: Q1 Performance Update

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## 1. PURPOSE OF REPORT

1.1 To update the Health and Wellbeing Board on 2018/19 Q1 performance against the indicators in the Hartlepool Better Care Fund Plan.

## 2. BACKGROUND

2.1 The Better Care Fund has been in place since 2015/16 and provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets into a single pooled budget that is focused on integration.

2.2 The 2017 policy framework introduced two key changes requiring plans to be developed for the two year period 2017-2019 rather than a single year and reducing the number of national conditions from eight to four.

2.3 The four national conditions are:

1. That a BCF Plan, including at least the minimum contribution to the pooled fund specified in the BCF allocations, must be signed off by the H&WB and by the constituent LAs and CCGs;
2. A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution to the fund in line with inflation;
3. That a specific proportion of the area's allocation is invested in NHS-commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and
4. Implementation of the High Impact Change Model for Managing Transfer of Care to support system-wide improvements in transfers of care.

2.4 The reduction in national conditions does not diminish the importance of the issues that were previously subject to conditions as these remain key

enablers of integration. The Hartlepool plan describes how partners continue to build on improvements against these former conditions which relate to seven day services across, improved data sharing between health and social care and a joint approach to assessments and care planning.

2.5 In addition, local authorities now benefit from the additional funding for social care announced in the Spring Budget 2017 which must be pooled within the BCF Pooled Budget. This is a Direct Grant to Local Government for the purposes of:

- Meeting adult social care needs;
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and
- Ensuring that the local social care provider market is supported.

2.6 The 2015 Spending Review set out the Government's intention that, by 2020, health and social care will be more fully integrated across England. BCF plans set out how CCGs and local authorities are working towards fuller integration and better co-ordinated care, both within the BCF and in wider services. Narrative plans set out the joint vision and approach for integration, including how the work in the BCF plan complements the direction set in the Next Steps on the NHS Five Year Forward View, the development of Sustainability and Transformation Partnerships (STPs), the requirements of the Care Act (2014) and wider local government transformation in the area covered by the plan.

2.7 The Hartlepool BCF Plan 2017-2019 was approved in October 2017, as reported to the Health & Wellbeing Board in December 2017.

## 3. PERFORMANCE UPDATE

3.1 BCF performance reports are submitted to NHS England on a quarterly basis. The Q1 return (covering the period April – June 2018) was submitted in July 2018 and confirms that all national conditions continue to be achieved, as well as providing analysis of performance data, which is summarised below.

3.2 In relation to performance measures:

3.2.1 <u>Permanent Admissions to Residential and Nursing Care Homes</u>
The 2017/18 target for permanent admissions to care homes was achieved, which is a considerable achievement in the context on an ageing population and increased prevalence of dementia, and evidences that people are being supported in their own homes effectively for as long as possible. Based on performance in Q1 it is expected that the target will be achieved again in 2018/19.

Key actions:

- Continue to promote services that offer alternatives to 24hr care, which include assistive technology, housing related support, extra care, domiciliary care, personal budgets and support for carers.

- Continue to monitor occupancy levels, average age at admission and average length of stay which provide further information about the use of 24hr care.
- Continue to monitor on a monthly basis.

3.2.3 Proportion of older people still at home 91 days after discharge from hospital into reablement / rehabilitation services

The percentage of older people still at home 91 days after discharge into reablement / rehabilitation services was 80% in 2017/18, which was the target set for the year. Q1 performance for 2018/19 is 87% and it is anticipated that the target will be achieved in 2018/19.

It should be noted that this measure of the effectiveness of reablement only captures a small subset of the total number of people accessing the service, with many people accessing reablement from the community as a preventative measure. Data indicates that approximately 75% of people continue to have no ongoing social care needs after a reablement intervention, and over 95% of reablement goals continue to be achieved at the end of a period of reablement.

Key actions:

- Continue to monitor on a monthly basis and undertake further audit work if the position changes
- Continue to monitor other measures that demonstrate the effectiveness of reablement services.

3.2.4 Delayed transfers of care (DToC) from hospital per 100,000 population (days delayed)

Delayed transfers of care reduced significantly in 2017/18 compared to previous years and targets were achieved in Q1 and Q2. Unfortunately the nationally set trajectory to deliver and maintain reductions by November 2017 resulted in very challenging targets for Q3 and Q4 which were not met, meaning that the overall target for the year was not achieved.

Data is not yet finalised for Q1 but performance in April and May 2018 show that the target will not be achieved. It is anticipated that achievement of this indicator will continue to be very challenging throughout 2018/19.

Recently released National Guidance confirmed that new DToC targets will be imposed on all localities from October 2018. The baseline for these targets was taken from actual performance in Quarter 3 17/18. For Hartlepool this sees an increase in the target from the previous year and gives a more realistic but still ambitious target to aim for.

Key actions:

- Build on the success of the Integrated Discharge Team.
- Further development of Trusted Assessor approaches following the successful pilot for the elective orthopaedic pathway.
- Continued support for care homes to ensure sustainability of the local care market.

3.2.5 Total non-elective (NEL) admissions

In 2017/18 the annual target was achieved with 13,014 non-elective admissions against a target of 13,234. As with other indicators, this is a notable achievement in the context of an ageing population. The 2018/19 target is taken directly from the CCG Annual Plans. Actual data is not yet available for Q1 but it is anticipated that the target will be achieved again in 2018/19.

It is particularly positive to note that there was a reduction in NEL admissions from care homes in 2017/18, reflecting the impact of a range of BCF funded services commissioned to support care homes, including enhanced pharmacy support and a training and education programme. There has also been a reduction in admissions linked to falls, which again evidences that initiatives introduced to prevent and more proactively manage people at risk of falls are having a positive impact.

Key actions:

- Continue to monitor the NEL position monthly.
- Build on the successes of interventions in 2017/18 such as the training and education programme for care homes, which will now be funded for a further two years following a successful evaluation.

## 4. RISK IMPLICATIONS

4.1 A risk register was completed as part of the original BCF plan with mitigating actions identified. This was reviewed and updated for the 2017-2019 plan.

## 5. FINANCIAL CONSIDERATIONS

5.1 The BCF Pooled Budget is made up of a number of elements, some of which have mandatory funding requirements, and the Hartlepool plan demonstrates that these minimum contributions are being maintained.

Confirmed allocations for Hartlepool for 2018/19 are as follows:

| **Funding** | **2018/19** |
|---|---:|
| CCG Minimum Contribution | £6,948,854 |
| Disabled Facilities Grant | £997,971 |
| IBCF Allocation | £3,737,159 |
| **TOTAL** | **£11,683,984** |

5.2 The BCF Pooled Budget is hosted by Hartlepool Borough Council and governed through the Pooled Budget Partnership Board.

## 6. LEGAL CONSIDERATIONS

6.1 The legal framework for the pooled budget is a Section 75 Partnership Agreement.

## 7. CHILD AND FAMILY POVERTY CONSIDERATIONS

7.1 None identified.

## 8. EQUALITY AND DIVERSITY CONSIDERATIONS

8.1 None identified.

## 9. STAFF CONSIDERATIONS

9.1 No staff considerations have been identified.

## 10. ASSET MANAGEMENT CONSIDERATIONS

10.1 No asset management considerations have been identified.

## 11. RECOMMENDATION

11.1 It is recommended that the Health and Wellbeing Board retrospectively approves the Hartlepool Better Care Fund Q1 return and notes the current position in relation to performance.

## 12. REASON FOR RECOMMENDATION

12.1 It is a requirement that Health & Wellbeing Boards approve performance reports in relation to the BCF.

## 13. CONTACT OFFICER

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# HEALTH AND WELLBEING BOARD

14th September 2018

**Report of:** HealthWatch Hartlepool and Hartlepool Deaf Cente

**Subject:** HealthWatch Hartlepool and Hartlepool Deaf Centre Joint Investigation of Deaf Patient Experience of Local GP and Hospital Services - Update

## 1. PURPOSE OF REPORT

1.1 To update the Health & Wellbeing Board of progress made in the implementation of recommendation from the May 2017 report on Deaf Patient Experience of Local GP and Hospital Services. http://www.healthwatchhartlepool.co.uk/sites/default/files/deaf_patient_experience_report.pdf

## 2. BACKGROUND

2.1 HealthWatch Hartlepool is the independent consumer champion for patients and users of health & social care services in Hartlepool. To support our work we have appointed an Executive committee, which enables us to feed information collated through our communication & engagement plan to form the strategic vision. This ultimately should lead to influence of all services within the borough. Further information relating to the work of Healthwatch can be viewed via www.healthwatchhartlepool.co.uk

2.2 The Deaf patient experience consultation was included in the 2016/17 work programme of Healthwatch Hartlepool as a result of concerns raised with us regarding access to and subsequent provision of health related services from members of the Deaf community.

2.3 The presentation which will accompany this report identifies progress made against recommendations contained within the report and areas in which further action is still required.

## 3. PROPOSALS

3.1 Established under the Health and Social Care Act 2012, the requirements set out in the legislation mean HealthWatch Hartlepool will be expected to:

- Obtain the views of the wider community about their needs for and experience of local health and social care services and make those views known to those involved in the commissioning, provision and scrutiny of health and social care services.
- Promote and support the involvement of a diverse range of people in the monitoring, commissioning and provision of local health and social care services through membership of local residents and service users.
- Make reports and recommendations about how those services could or should be improved.
- Provide information to the public about accessing health and social care services together with choice in relation to aspects of those services.
- Represent the views of the whole community, patients and service users on the Health & Wellbeing Board and the Hartlepool Clinical Commissioning Group (locality) Board.
- Make the views and experiences of the broad range of people and communities known to Healthwatch England helping it to carry out its role as national champion.
- Make recommendations to Healthwatch England to advise the Care Quality Commission (CQC) to carry out special reviews or investigations into areas of concern (or, if the circumstances justify it, go direct to the CQC with recommendations, if for example urgent action were required by the CQC).
- This report will be made available to all partner organisations and will be available to the wider public through the Healthwatch Hartlepool web site.

## 4. EQUALITY & DIVERSITY CONSIDERATIONS

4.1 HealthWatch Hartlepool is for adults, children and young people who live in or access health and/or social care services in the Borough of Hartlepool. HealthWatch Hartlepool aims to be accessible to all sections of the community. The Executive committee will review performance against the work programme on a quarterly basis and report progress to our membership through the 'Update' newsletter and an Annual Report. The full Healthwatch Hartlepool work programme will be available from www.healthwatchhartlepool.co.uk

## 5. RECOMMENDATIONS

5.1 That the Health and Wellbeing Board note the contents of the presentation and the service developments which have taken place since the publication of the Deaf Patient Experience report in 2017.

## 6. REASONS FOR RECOMMENDATIONS

6.1 The recommendations are based on findings from the consultation events and subsequent discussions.

## 7. BACKGROUND PAPERS

7.1 None

## 8. CONTACT OFFICER

Stephen Thomas - HealthWatch Development Officer
Hartlepool Voluntary Development Agency
'Rockhaven'
36 Victoria Road
HARTLEPOOL. TS24 8DD

# HEALTH AND WELLBEING BOARD

14th September 2018

**Report of:** HealthWatch Hartlepool

**Subject:** HealthWatch Hartlepool and Hartlepool Carers Joint Health Care Experience Consultation

## 1. PURPOSE OF REPORT

1.1 To inform the Health & Wellbeing Board of the outcomes of the recent Health focused consultation events undertaken by Healthwatch Hartlepool and Hartlepool Carers with carers in Hartlepool.

## 2. BACKGROUND

2.1 HealthWatch Hartlepool is the independent consumer champion for patients and users of health & social care services in Hartlepool. To support our work we have appointed an Executive committee, which enables us to feed information collated through our communication & engagement plan to form the strategic vision. This ultimately should lead to influence of all services within the borough. Further information relating to the work of Healthwatch can be viewed via www.healthwatchhartlepool.co.uk

2.2 The Carer consultation was included in the 2017/18 work programme of Healthwatch Hartlepool as a result of concerns raised with us regarding access to and provision of health related services to those receiving and providing care in communities in Hartlepool.

## 3. PROPOSALS

3.1 Established under the Health and Social Care Act 2012, the requirements set out in the legislation mean HealthWatch Hartlepool will be expected to:

- Obtain the views of the wider community about their needs for and experience of local health and social care services and make those

views known to those involved in the commissioning, provision and scrutiny of health and social care services.
- Promote and support the involvement of a diverse range of people in the monitoring, commissioning and provision of local health and social care services through membership of local residents and service users.
- Make reports and recommendations about how those services could or should be improved.
- Provide information to the public about accessing health and social care services together with choice in relation to aspects of those services.
- Represent the views of the whole community, patients and service users on the Health & Wellbeing Board and the Hartlepool Clinical Commissioning Group (locality) Board.
- Make the views and experiences of the broad range of people and communities known to Healthwatch England helping it to carry out its role as national champion.
- Make recommendations to Healthwatch England to advise the Care Quality Commission (CQC) to carry out special reviews or investigations into areas of concern (or, if the circumstances justify it, go direct to the CQC with recommendations, if for example urgent action were required by the CQC).
- This report will be made available to all partner organisations and will be available to the wider public through the Healthwatch Hartlepool web site.

## 4. EQUALITY & DIVERSITY CONSIDERATIONS

4.1 HealthWatch Hartlepool is for adults, children and young people who live in or access health and/or social care services in the Borough of Hartlepool. HealthWatch Hartlepool aims to be accessible to all sections of the community. The Executive committee will review performance against the work programme on a quarterly basis and report progress to our membership through the 'Update' newsletter and an Annual Report. The full Healthwatch Hartlepool work programme will be available from www.healthwatchhartlepool.co.uk

## 5. RECOMMENDATIONS

5.1 That the Health and Wellbeing Board note the contents the Healthwatch Hartlepool/Hartlepool carers Health Care Experience Consultation and consideration is given to recommendations contained within.

## 6. REASONS FOR RECOMMENDATIONS

6.1 The recommendations are based on findings from the consultation events and subsequent discussions.

## 7. BACKGROUND PAPERS

7.1 None

## 8. CONTACT OFFICER

Stephen Thomas - HealthWatch Development Officer
Hartlepool Voluntary Development Agency
'Rockhaven'
36 Victoria Road
HARTLEPOOL. TS24 8DD

Charity Number: 1132951
Company Registration Number:



# Healthwatch Hartlepool/Hartlepool Carers
# Health Care Experience Consultation

# Final Publication

## May 2018

### MISSION STATEMENT

**"Healthwatch Hartlepool has been established in a way that is inclusive and enables involvement from all areas of the local community. We wish to involve those who are seldom heard."**

## Contents of the Report



## 1. Background and Methodology

**1.1** In December 2017 the Healthwatch Development Officer met with representatives of Hartlepool Carers to discuss a range of health

and social care related issues which impact upon the wellbeing of carers and the people they care for. Discussions touched upon a wide range of issues but it soon became apparent that there was a need to engage directly with carers to obtain first hand experiences of the effectiveness of local health services.

**1.2** During our initial discussions a theme around Personal Health Budgets and Continuing Health Care had emerged. It was felt that carers were experiencing increasing difficulties and inconsistent application on the part of health professionals when applying for funding from both sources.

**1.3** Consequently, it was agreed that a series of focus groups would be held, to which carers would be invited. The initial area of discussion at the meetings would focus on experiences of applying for Personal Budgets and Continuing Health Care, but it was agreed that there would also be opportunities to raise wider health related issues and experiences during the sessions.

**1.4** Arrangements were then made to run five differently themed half day carer focus groups-

**February 5th**

Children and Young People (10am-12pm)

Transition and Adults (1pm – 3pm)

**February 12th**

Older People (10am -12pm)

Young Carers (8-11) (1pm – 3pm)

Young Carers (11-18) (1pm – 3pm)

The first three sessions were held at "The Place in the Park", with the Young Carers sessions taking place at Hartlepool Carers offices on York Road.

**1.5** The three sessions at the Place In the Park were attended by approximately 20 carers with a similar number of young carers attending the two sessions held at York Road.

**1.6** Finally, it was agreed that a short report would be produced by Healthwatch Hartlepool which would outline key findings and make recommendations as appropriate. All information would be shared in full with key partner organisations including Hartlepool Borough Council but individual input and comments would be presented anonymously.

## 2. Findings

### Continuing Health Care

**2.1** NHS Continuing Healthcare is the name given to a package of care that is arranged and funded solely by the NHS for individuals who are not in hospital and have been assessed as having a primary health need.

**2.2** There is a two stage process by which eligibility for NHS Continuing Healthcare is assessed. Firstly, the patient has an assessment with a health or social care professional using a screening tool called the Checklist Tool. If after completing this tool it looks like the individual may be eligible for NHS Continuing Healthcare, the second stage is a full assessment using a tool called the Decision Support Tool. Guidance states that the individual should be fully involved in the assessment and decision making processes. Their views about their care and support needs must be taken into account. If the individual is struggling to explain their views, or would like help doing this, a friend, relative or advocate can help.

**2.3** A separate process of NHS Continuing Healthcare operates for children and young people. This applies when the child or young person has needs or challenging behaviour arising from disability, accident or illness that cannot be met by existing universal or specialist services alone.

**2.4** Some children and young people (up to 18 years old) may have very complex health needs. These may be the result of congenital conditions, long-term or life-limiting or life-threatening conditions, disability, or the after effects of other serious illness or injury. Eligibility for such a package of health funded care is assessed following the same process to that illustrated in 2.1 above.

**2.5** Feedback received from carers of both adults and children was remarkably similar regarding experiences of trying to access both types of Continuing Healthcare. Everyone who had been through either of the processes felt that it had been a complex, difficult and emotionally draining experience.
"It felt like the process and procedures took priority over the needs of my child"
"Everything was a fight, it felt like we had to battle for everything!"
"Services are not joined up, so you end up repeating things over and over again."

**2.6** Carers with children reported that having a full diagnosis of the child's condition could be a major barrier to accessing support through Continuing Health Care.
"They haven't been able to come up with a diagnosis yet, but my child's care needs are still there and not being met."
"The system fails if a clear diagnosis is not in place. The whole process is diagnosis led and not patient centred"

**2.7** Clear information on how both processes work, with clear explanations of eligibility criteria were said to be very hard to find.
"Information on Continuing Healthcare is hard to find and when you do find it, it's very unclear and difficult to understand."
"The whole process is very poorly explained and information that you have a right to is not always forthcoming."
"I am still unclear on what Continuing Health Care is. It was not explained well and appears to be inconsistently applied."

**2.8** All carers reported inconsistencies in the interpretation of eligibility for Continuing Health Care that was received from different health professionals involved in the assessment process.
"Professionals do not appear to fully understand them (Continuing Health Care processes and eligibility criteria) and sometimes give contradictory advice"
"Input from social workers is very inconsistent, some cases are fast tracked and others aren't but no explanation is given."
"Staff need better training so they are able to fully understand and explain how the pathways and processes associated with Continuing Healthcare work."

**2.9** Many carers reported feeling that the process was finance driven and that it was becoming harder to access Continuing Health Care support.

"The system is dishonest, it pretends that it isn't financially driven when in reality we all know that it is!"

"Carer experience is that applications are usually declined and criteria is getting tougher."

"The person I care for has significant needs but still does not qualify for support."

**2.10** Experience of service delivery was reported to be inconsistent when dealing with transition from child to adult services.

"There were variations and inconsistencies in transition dates and although treatment was received through paediatric services it does not always mean services and support will continue into adulthood."

## Personal Health Budgets

**2.11** A Personal Health Budget is an amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between an individual, or their representative and the local Clinical Commissioning Group (Hartlepool and Stockton CCG).

**2.12** The aim of a Personal Health Budget is to give people with long term health conditions and disabilities more choice and control over the money spent on meeting their health and wellbeing needs. It may be used for a range of things to meet agreed health and wellbeing outcomes. This can include therapies, personal care and equipment within defined parameters.

**2.13** Feedback received from carers largely reflected the experiences outlined above regarding Continuing Health Care. Once again carers generally reported the Personal Health Budget process to be both stressful and difficult to navigate.

"No one really knows about Personal Health Budgets, they aren't publicised and kept quiet"

"The process of applying for a budget is complicated and doesn't include cognition (Learning disability)."

The process for both (Personal Health Budgets and Continuing Health Care) is very complicated and feedback on decisions is poor or none existent."

**2.14** Difficulties were reported in the way in which Personal Health Budgets are administered and the application process.
"The budget was driven by process and didn't accommodate the needs of the carer. This restricted what could be done and consequently the benefits were limited."
"I found the health budget to be inflexible and it didn't match up with individual and carer needs and circumstances, it wasn't person centred."

**2.15** Some parent carers said that their personal knowledge and experience of the individuals condition was not fully taken on board.
"Carers are often not involved in the process and their knowledge and understanding of the persons condition and needs are not fully taken into account"

**2.16** Certain types of rare condition, and conditions for which there was no full diagnosis were also seen as barriers to being able to access a Personal health Budget.
"People with rare conditions, where normal care provision doesn't fit could really benefit from having a Personal Health Budget but they are not made aware."

**2.17** A more positive experience of the process was identified in cases in which support had been made available during the application process.
"The Personal Health Budget process has improved since a nurse at my GP practice became involved in the assessment process. This has led to better communication and a more informed process."

**2.18** Several carers reported that the process was financially driven and that in recent years Budgets had been reduced despite needs either staying the same or increasing.
"Last year x received £1500 for a full year gym membership, but this year only assessed at £750 despite having a degenerative condition."
"Everything is driven by money and they are always looking for ways to say no!"

**2.19** The length of time it takes to get a decision on an application was also given as a reason why people choose not to apply for a Personal Health Budget.
"I know about them but didn't bother to apply, too much hassle and too slow, I would rather self-fund."
"From putting in my application it took three years to get it approved"
"I applied for a swimming pass over a year ago but have had no response, the waiting times and patient service are completely unacceptable."

**Continence Services**
**2.20** Carers highlighted several issues regarding support for continence issues. Carers of children with continence issues said that the service provision felt fragmented and unresponsive.
"It is difficult to get nappies from the Continence Service, School Nursing and the Continence Service seem to work separately"
"The service does not feel carer or people friendly and there is very little continuity"
"The service is now very adult focused, difficult to access and outcomes are poor"

**2.21** Carers for both older people and children commented that very often they were provided with inappropriate products which failed.
"The range of products available is limited and do not always meet individual needs"
"Often the nappies you receive are not the right size and can't be used which has led to a nappy black market."

**2.22** A consistent theme amongst those caring for older adults was the lack of availability of "pull ups".
"The person I care for needs pull ups, anything else just doesn't work. They provide them in Durham, so why won't they provide them here?"
"The pads that we get are not always right and don't work. We need pull ups and can't understand why they don't provide them. Guess it will be money before the needs of the patient."

**2.23** Several carers also said that they often experienced long waits for products and consequently they often end up buying a lot of products for the person they care for.
"We experience very long waits for pads and services."
"Lots and lots of problems. I have to buy a lot of products as the ones the person I care for needs are not available."

## GP Services

**2.24** All focus groups commented on GP services. Many carers felt that their GP was unaware or unappreciative of the needs of carers and consequently felt poorly supported.
"GP's appear to have a low level of understanding of carer needs, and cutting the Carer/GP liaison service is a big loss"
"As a carer I am often left feeling let down by my GP".
"GP's need to have a better understanding of the needs of carers and the role carers play in supporting someone."
"My experience of GP's hasn't been good. I have had problems with getting a diagnosis and prescribing."

**2.25** Problems were highlighted around communication between the GP, the practice and the patient. Concerns were also raised about poor communication between practices and other health providers.
"Please communicate, explain decisions and talk to patients!"
"Communication between GP's and other health agencies can be problematic. My medication was changed in hospital but my GP didn't know."

**2.26** The most frequently raised issue by all focus groups related to difficulties carers experienced in accessing appointments with their GP. Most carers are fully engaged in providing care to loved ones between 7.30am and 9.30am. Consequently, they find it extremely difficult contacting their GP practice between these hours to book appointments. When they are finally able to phone the practice, appointments have usually all been taken. This has a significant impact on the ability of carers to access primary care in a timely and convenient manner.
"It is really difficult getting an appointment at my surgery. It is hard to phone between 8am and 9am as it is a really busy time for me and you are just left on hold. When you finally get through all of the appointments are gone."

"I have real difficulties getting an appointment to see a GP. You have to phone between 8am and 9am which is really hard to do for carers. By the time I get through all of the appointments are gone."
"There needs to be better access to GP surgeries for carers."
"I always have problems with appointments, last time it took 100 calls to get an appointment."
"Care is not patient centred, and don't get me started on the appointment system!"

**2.27** Finally, concerns were raised about medication reviews, with several participants expressing concerns that they are cost driven, rather than for the benefit of the patient.
"Medication reviews are all about cost."
"My GP has stopped prescribing some drugs which are an important part of my treatment. This is down to cost and not what is best for me."

**Hospital Services**
**2.28** Generally, carers were positive about experiences of care at Hartlepool and James Cook Hospitals.
"Really good experience of Urgent care at Hartlepool Hospital, it is an excellent service."
"We have used Orthopaedics, Phlebotomy and Haematology at Hartlepool Hospital, they are all excellent and the staff very caring."
"The volunteers at James Cook provide a wonderful service."

**2.29** However some concerns were expressed about North Tees Hospital and the care received by patients with a learning disability.
"Patient experience in hospital can be poor, particularly North Tees. A course of antibiotics was missed, I was cold and waited four hours to be taken to the toilet. But they don't have enough staff."
"Hospital experience for people with learning disability is not so good, understanding and empathy from some staff can be poor. Also, being on a ward can be a scary experience."

**2.30** Difficulties getting to and from hospital appointments at North Tees and James Cook were highlighted by all groups particularly by those carers who relied on public transport.

"I have to go to North Tees for check-ups every few months. It costs me a fortune for a taxi or takes ages by bus and I have to get someone to stay with him while I am away."

**Community Services**

**2.31** Concerns were expressed about some aspects of wheelchair services. Several people stated that the person was expected to fit around the wheelchair, and the size, mobility and needs of the individual were not properly considered.

"I had a difficult experience with wheelchair services, they weren't very helpful. Patient and carer needs are made to fit around big contract services rather than being about the individual."

"They didn't have the correct understanding of the needs of the wheelchair user. I had to pick a wheelchair from internet pictures."

"With a wheelchair you have to get it right, otherwise it is a waste of money and it has a big impact on the quality of life of the person in the wheelchair and their carer.

**2.32** Several carers raised concerns about physiotherapy and in particular services for children. It was reported that in some instances parents were paying privately for physiotherapy services for children as school based services were not meeting individual needs.

"Children in main stream schools are getting a poor inadequate service and often needs are not being fully identified and met. Families often end up having to pay for private physiotherapy services for their child."

"The service is not working for many children, it is under resourced and health plans often do not fully meet the needs of children."

**Mental Health**

**2.33** Carer mental health was raised in the discussions of all focus groups. Caring can be a physically and emotionally draining experience and have a massive impact on the health and wellbeing of the carer.

"Being a carer has a big impact emotionally and psychologically and can have a big impact on your mental wellbeing".

"Caring for someone 24/7 can leave you feeling drained, emotionally and physically, you have to live it to really understand."
"I have felt stressed and depressed but caring for my child must come first."

**2.34** Overall, carer experience of mental health support services was mixed. Some reported positive and supportive inputs which had been helpful, others felt that they had wasted their time and had not benefited from their uptake of services.
"I went for one session at MIND, the counsellor was not very good and I did not find the experience helpful. I did not go back."
"Crisis support is inconsistent, you get a mixed response."

**2.35** Concerns were raised about Children and Adolescent Mental Health services (CAMHS). A recurrent theme across all focus groups was the time it takes to access CAMHS services and difficulties accessing sensory assessments. Consequently, there was a really strong feeling that all too often support was not made available at an early stage and consequently small manageable problems often became bigger and much harder to address.
"It takes too long to access CAMHS and once you do it is too complicated."
"My child had major difficulties accessing a sensory assessment. This had a massive knock on effect for the whole family. Eventually they did get a diagnosis of autism, but there is a lot of missed diagnosis and under diagnosis which has massive implications for children and carers."

**2.36** Many carers felt that the peer support they received through Hartlepool Carers was far more effective than the support that was available from other mental health specific organisations.
"Hartlepool Carers gives me an opportunity to share how I am feeling with people who understand."
"Being a carer can be really stressful, if you don't care for someone yourself, you don't really understand. At Hartlepool Carers there are people who have been through what you are experiencing and understand how you are feeling."

## 3. Conclusions

**3.1** Carer experience of Personal Health Budgets and Continuing Health Care is generally not positive and can be extremely stressful and cause considerable anxiety for the applicant and carer. In both areas understanding and interpretation of criteria is vague and can vary depending on the personal knowledge and awareness of the health professional spoken to. Clear, easy to understand information appears to be hard to find and both processes appear to focus primarily on cost rather than the needs of the individual.

**3.2** Carers of both adults and children are experiencing significant difficulties in accessing suitable continence products from the Continence Service. Consequently, those who rely on the products are suffering both in terms of dignity and wellbeing, and carers are having to access appropriate products elsewhere at significant cost to themselves.

**3.3** Carers across the town are experiencing major difficulties accessing GP appointments. Appointment systems at many surgeries are based around patients phoning the practice between the hours of 8am and 10am which for many carers is one of their busiest and most intense periods of the day.

**3.4** Experience of hospital services was generally quite positive although some concerns were raised regarding the experiences of patients with a learning disability and transport.

**3.5** The individual needs of the cared for person and carer are not always being fully addressed in the areas of wheelchair services and children's physiotherapy. Consequently, the wheelchair provided may be inappropriate or the physiotherapy package inadequate in order to address identified need.

**3.6** A significant number of people were unaware of complaints/compliments procedures and where to find instruction on what to do. This indicates that on some occasions new care service users are not being told about where to find them, or that current methods of passing on information are failing in some cases.

**3.7** Mental health is a significant issue for carers and those they care for. Access to timely mental health interventions appears to be

problematic both for adults and children. Consequently, this has led to low levels of confidence in mental health service providers amongst some carers and some unmet/undiagnosed mental health care needs amongst both carers and those they care for.

## 4. Recommendations

### Continuing Health Care

**4.1** That as a matter of urgency, the processes and procedures associated with applications for Continuing Health Care for both children and adults is reviewed with a view to making the process more transparent, consistent in application and understandable to those who apply for it.

**4.2** All staff involved in facilitating Continuing Health Care applications should be trained to a consistent level of awareness and understanding and joint training/development of health and social care professionals should be considered to maximise consistency in approach and interpretation.

**4.3** A specific review of transitional arrangements should be undertaken in order to ensure consistency of approach to transition from children to adult CHC arrangements and that parents and carers are kept fully informed and involved at all stages during this time.

**4.4** In all cases, the needs of the individual and not financial implications must be the key focus in applications for Continuing Health Care.

### Personal Health Budgets

**4.5** As a matter of urgency, the process and procedures associated with applications for Personal Health Budgets should be reviewed with a view to ensuring transparency and consistency in application.

**4.6** Hartlepool and Stockton CCG should look to raise awareness of the purpose and availability of Personal Health Budgets amongst patient groups in Hartlepool who may potentially benefit from accessing a Personal Health Budget.

**4.7** All staff involved in facilitating Personal Health Budget applications should be trained to a consistent level of awareness and

understanding and joint training/development of health and social care professionals should be considered to maximise consistency in approach and interpretation.

**4.8** Efforts are made to ensure that applications for Personal Health Budgets are turned around in a timely manner and that at all stages applicants are kept informed of progress in clear, concise and understandable language.

**Continence Services**

**4.9** The Continence Service undertakes a full consultation with service users and carers regarding the appropriateness of current service provision and product types which are available and that the outcomes of the consultation are acted upon and implemented at the earliest opportunity.

**GP Services**

**4.10** As a matter of urgency, GP practices across Hartlepool consult with carers and carer organisations to identify ways by which carer access to GP appointments can be improved.

**4.11** GP practices provide detailed information to patients and carers which describes the various ways in which GP appointments can be booked, including on-line and via the 111 service.

**4.12** Hartlepool and Stockton CCG give serious consideration to ways in which awareness of carer needs and circumstances can be improved in GP practices within Hartlepool including the reintroduction of a Carer/GP Liaison officer.

**Hospital Services**

**4.13** North Tees and Hartlepool Foundation Trust should engage with Hartlepool Carers to ensure that carers are fully aware of shuttle bus times, the volunteer driver scheme, subsidised taxi scheme and reduced cost hospital carparking availability.

**Mental Health**

**4.14** Efforts should be made to ensure that funding streams are secured to enable Hartlepool Carers to provide support to carers in the areas of mental wellbeing and resilience on a permanent basis.

**4.15** Mental health service providers including CAMHS and TEWV should examine ways of working more closely with Hartlepool Carers to ensure that mental health services are responsive to the specific needs of carers in a timely and effective manner.


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