PLEASE NOTE CHANGE OF TIME

AUDIT AND GOVERNANCE COMMITTEE

AGENDA

Thursday 17 January 2019

at 10.30 am

in Committee Room B
Civic Centre, Hartlepool

MEMBERS: AUDIT AND GOVERNANCE COMMITTEE

Councillors Belcher, Cook, Hall, Hamilton, Lindridge, Loynes and Tennant.

Standards Co-opted Members; Mr Stan Cronin, Mr Norman Rollo and Ms Clare Wilson.

Parish Council Representatives: Parish Councillor John Littlefair (Hart) and Parish Councillor Don Cameron (Greatham).

Local Police Representative: Superintendent Alison Jackson.

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 22 November 2018

   3.2 To confirm the minutes of the meeting held on 13 December 2018 (to follow)

4. **AUDIT ITEMS**

   None

5. **STANDARDS ITEMS**

   None.

PLEASE NOTE CHANGE OF TIME

6. **STATUTORY SCRUTINY ITEMS**

Health Scrutiny

6.1 Preventative Mental Health (Working Age Services) - *Statutory Scrutiny Manager*

(a) Covering Report – *Statutory Scrutiny Manager*
(b) Evidence from service providers:

- Hartlepool Borough Council
- Hartlepool and Stockton NHS Clinical Commissioning Group
- North Tees and Hartlepool NHS Foundation Trust
- Tees Esk and Wear Valley NHS Foundation Trust
- Views from other providers / users (Private and Voluntary and Community Sector organisations)

6.2 Mental Health - Working Together for Change Event – *Head of Safeguarding and Specialist Services*

6.3 Director of Public Health Annual Report 2017/18 – *Interim Director of Public Health*

Crime and Disorder Scrutiny

6.4 Regulation of Investigatory Powers Act 2000 (RIPA) Quarterly Update – *Chief Solicitor*

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

7.1 To receive the minutes of the meetings held on 14 September 2018.

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

8.1 To receive extracts from minutes for the meeting held on the 26 November 2018.

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

9.1 To receive the minutes of the meetings held on 13 September 2018.

9.2 Roseberry Park Working Group (6 December 2018) - Verbal Update *(Councillor Tennant)*

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

10.1 To receive the minutes of the meeting held on 12 October 2018.

PLEASE NOTE CHANGE OF TIME

11. **REGIONAL HEALTH SCRUTINY UPDATE**

11.1 To receive the minutes of the North East Joint Health Scrutiny Committee – 7 September 2018.

11.2 To receive the minutes of the Durham, Darlington and Teesside, Hambleton, Richmondshire and Whitby STP Joint Health Scrutiny Committee – 25 September 2018

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

For information: -

Date and time of forthcoming meetings –

Thursday 14 February 2019 at 10.00 am
Thursday 14 March 2019 at 10.00 am
Thursday 18 April 2019 at 10.00 am

AUDIT AND GOVERNANCE COMMITTEE

MINUTES AND DECISION RECORD

22 NOVEMBER 2018

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

Present:

Councillor: Brenda Loynes (In the Chair).

Councillors: Sandra Belcher, Rob Cook, Ged Hall, Lesley Hamilton and John Tennant.

Co-opted Members: Mr Stan Cronin and Parish Councillor Don Cameron

Also Present: Councillors Marjorie James and Ann Marshall.
Lynn Allison and Judith Gray, Hartlepool Healthwatch.

Officers: Peter Brambleby, Interim Director of Public Health
Sharon Robson, Health Improvement Practitioner
Tony Hanson, Assistant Director, Environment and Neighbourhoods
Neil Wilson, Assistant Chief Solicitor and Deputy Monitoring Officer
Joan Stevens, Statutory Scrutiny Officer
David Cosgrove, Democratic Services Team

55. Apologies for Absence

Apologies for absence were received from Co-opted Members Mr Norman Rollo, Ms Clare Wilson and Parish Councillor John Littlefair.

56. Declarations of Interest

Councillor Sandra Belcher declared a prejudicial interest in Minute No. 66.

57. Minutes of the meeting held on 18 October 2018

Confirmed.

58. Business Continuity (*Assistant Director, Environment and Neighbourhoods Services*)

The Assistant Director, Environment and Neighbourhood Services presented an update on the Councils Business Continuity arrangements, following a report presented to the Committee in July by the Head of Audit

and Governance which identified this area as having 'limited assurance'.

The Civil Contingencies Act (2004) places a statutory duty on Hartlepool Borough Council as a 'Category 1 Responder' "to maintain plans for the purpose of ensuring, so far as is reasonably practicable, that if an emergency occurs the person or body is able to continue to perform its functions". A review undertaken by the Council's Internal Audit identified a number of weaknesses within the existing arrangements whereby up to date information is not currently held, agreed or tested.

Consequently, a significant amount of work had been progressed to address the concerns highlighted by internal audit, with arrangements reviewed to reflect current best practice. These revised arrangements were currently being roll out across service areas to ensure that accurate up to date information is collected on services / business functions.

The Assistant Director indicated that it was proposed that work currently being undertaken continued in accordance with the following timeline, to ensure that the information collected was both accurate and consistent across all areas of the Council:

Compilation of service / function information	November 2018
Formation of Business Continuity plans	December 2018
Exercising of plans	March 2019

Recommended

That the proposed timetable for updating the Council's Business Continuity arrangements be noted and agreed.

59. Health Inequalities Annual Update - Public Health Outcomes Framework (*Interim Director of Public Health)*

The Interim Director of Public Health reported on the current level of performance of Hartlepool within Public Health England's (PHE) Public Health Outcomes Framework (PHOF). The Interim Director highlighted the following key points from his report for members information: -

- There were six "overarching" indicators, all relating to life expectancy, and in all of them Hartlepool sits in the worst performing quarter in England. Healthy life expectance at birth, for both male and female, are the two indicators in this section where Hartlepool ranks lowest. Within Hartlepool the gap in healthy life expectancy between the least deprived and the most deprived is 17.2 years for males and 14.9 years for females.
- Wider determinants of health is a significantly larger section, with 36 populated indicators, within which Hartlepool is in the worst performing quarter for 9 indicators and the best performing quarter for 6 indicators.

Days lost due to sickness absence and percentage of offenders who re-offend are outliers, as Hartlepool has the highest rate in England. Days lost to sickness absence, and its partner indicator, at least one day off in the previous week, have both seen a large rise in the last 6 years of reporting. Days lost had increased by 56% and those taking at least one day off by 67%, an increase of two thirds.

- Children in low income families, both under 16s and all dependent children under 20, were indicators where Hartlepool was ranked low. Both of these indicators had seen their rate fall over the 10 year data collection period, but at a lower rate than the England average, meaning that the current gap between England and Hartlepool is larger than it was in 2006.
- The percentage of people aged 16-64 in employment in Hartlepool was 63.1%, which not only placed Hartlepool firmly in the lowest quarter, it was the lowest rate in the north east. Again the rate for Hartlepool had improved over the reporting period, but at a slower rate than the England average.
- Hartlepool was performing well on the gap in employment rate between the overall employment rate and those with a learning disability, and those in contact with secondary mental health services. For both of these indicators Hartlepool had the highest (i.e. best) rate in England.
- Hartlepool has relatively high levels of social inclusion among adult social care users and adult carers. Both rates were well in the top quarter of local authorities in England, however, both rates were only slightly above 50%, at 55.1% and 55.0% respectively. Hartlepool also had low levels of 16-17 year olds not in education, employment or training, with a rate of 4.8%, compared with an England average of 6% and a national high of 44.8%.
- The Health improvement section had 48 populated indicators of which Hartlepool was in the lowest quarter for 23 indicators and in the highest performing quarter for 4 indicators.
- Breastfeeding initiation was one of two indicators where Hartlepool was the worst performing authority in England. Hartlepool had seen a decline of 11.7% in its breastfeeding initiation rate in the last two years, from 49.6% to 37.9%. In the same period both the England and north east averages had increased by 0.2%.
- Portions of fruit and vegetables consumed by adults accounts for the other indicator where Hartlepool had the lowest rate in the country. In Hartlepool 49.6% of adults eat 5 portions of fruit or vegetables a day. This means that fewer than one in two people were getting their recommended portions of fruit and vegetables daily. This was a decline of 4.4% on the previous year, and compared to an England average that had increased from its previous rate, from 56.8% to 57.4%. The average number of portions of fruit consumed daily in Hartlepool was 2.26, this was the lowest in England, and for vegetables is 2.43.
- Deaths from drug misuse was another area of poor performance for Hartlepool. There had been an increasing trend for three years in Hartlepool for death from drug misuse, moving away from a position of statistical similarity with the England average. During this period the gap between Hartlepool and England had increased nearly tenfold and

Hartlepool's rate has nearly trebled. The recent needs assessment conducted under the auspices of the Health and Wellbeing Board, and the completely re-worked service specification which followed it, should reverse this trend.

- Hartlepool's under 18 conceptions rate was the second highest in England. Hartlepool had experienced a declining (i.e. improving) trend in under 18 conceptions for 9 years from 2006 to 2014. Hartlepool's rate was statistically similar to the England average. However, in the following two years Hartlepool had seen a marked increase in its under 18 conception rate, increasing back up to 2012 levels, at the same time the England average continued to decline.
- Health protection had 24 populated indicators, of which Hartlepool was in the lowest quarter for 6 indicators and the highest quarter for 2 indicators. This section had 17 populated indicators for vaccination coverage. Of these Hartlepool was missing the acceptable target on 8 indicators and the World Health Organisation (WHO) target on 15 indicators, only MMR for one dose at five years old and Dtap/IPV/Hib at two years old met the WHO target. The HPV vaccination for females at 13-14 years old, shingles at 70 years old and flu at 2-3 years old all had particularly low uptake rates. The HPV vaccination rate fell by nearly half, and the shingles vaccination fell by just over a quarter from the previous year. The Chlamydia detection rate and incidence of TB were better than the national average. However, antibiotic prescribing for Hartlepool was above the national average, though this was reducing, and doing so at a faster rate than England.
- Healthcare and premature mortality had 28 indicators, of which Hartlepool was in the lowest quarter for 19 indicators and in the highest quarter for 1 indicator. Hartlepool was below the national average and in the lowest quartile for the mortality rate from causes considered preventable, and the under 75 mortality rate from all cardiovascular diseases, cancer, cancer considered preventable, liver disease, liver disease considered preventable, respiratory disease and respiratory disease considered preventable. Of these 8 indicators only 3, under 75 mortality from cancer, liver disease and liver disease considered preventable, were not on a negative trend. Excess winter deaths, for both all ages and for 85+, were low ranked indicators for Hartlepool and had seen increases in the latest figures, though both remained statistically similar to the England average. The indicator in the top quarter for Hartlepool in this section was dementia diagnosis rate, which had been better than the England average for both years of data collection.

Members queried why the numbers of children in poverty was not reducing at the same rate as the national figure. The Interim Director indicated that much of the rate was about low income in general for which the main solution was to bring good new jobs into the town. There was also the impact of Universal Credit which was reducing income in families on benefits.

Members discussed the issues around the needs for food banks, families

not using fresh produce for meals and fuel poverty. The Interim Director indicated that there were many reasons behind the low numbers using fresh produce, some related to habit and some around lack of cooking skills. The best venue for changing habits was school and teaching children and young people how to eat healthily. The Chair re-stated her view that much was simply down to the lack of cooking skills among young people, particularly young parents. Members supported this view and asked what could be done to address the issue in schools. It was suggested that perhaps the cookery knowledge and skills of older people could be used to help educate young people. The interim Director welcomed the suggestion and indicated that he would refer it on to the new Deputy Director of Public Health when they took up their appointment in the new year. The Interim Director also indicated that there were good opportunities for people to grow their own produce and that these opportunities should be promoted more widely. As well as allotments, representatives suggested that a garden sharing scheme could also be a way forward. It was suggested that Healthwatch could be used as a route of relaying information between those who have surplus garden space and those who might be interested in using the space to grow their own vegetables.

Members discussed the issues around substance misuse levels in Hartlepool and how this was to be addressed. The Interim Director indicated that discussions had taken place with the Police and agencies on reinvigorating the Drug and Alcohol Partnership and Hartlepool had joined with the rest of the Tees Valley authorities in investigating deaths related to drug and alcohol misuse to identify ways of preventing similar situations arising in the future. Part of this would be to look at the policies around the use of Naloxone, an antidote for opiate overdoses, to extend its use so that interventions could be made much more quickly. Members sought details of the numbers for Hartlepool for people misusing drugs and alcohol including misuse of prescription drugs; the Interim Director indicated that the figures would be circulated to Members.

Members questioned what work was being undertaken to improve the numbers of mothers breastfeeding. The Interim Director stated that he had had a meeting with health partners on that subject just prior to the meeting looking at how this could be improved. Some representatives were concerned that many young mothers still felt that it was too difficult, they couldn't do it anywhere public and there was some social stigma. The Interim Director did feel that it wasn't just about knowledge of the benefits but also about increasing young mums confidence and also the opportunities to breastfeed.

The Chair questioned why the rate of under 18 conceptions had risen again after a number of years of decline; was there insufficient sex education in schools or growing promiscuity. The Interim Director commented that the issue wasn't just young women but half the problem was young men. The general trend was downwards but these were also very small numbers, so an increase of a relatively small amount could statistically sway the numbers. The aim was that every pregnancy was planned so every child

was wanted. A lot of work on under 18 conceptions was under taken across the town and that would continue. A Member did feel that these statistics reflected the situation twenty years ago, so whatever was being done was having no effect. Perhaps it was morals, a failure of sex education or the availability of contraception but whatever it was, little difference had been made.

The Interim Director indicated that a lot of work was undertaken in improving self esteem, resilience and confidence with young people in schools as part of the programme of sex education. The availability of contraception, perhaps freely, was an issue. There was the more readily available morning after pill but no one wanted to see terminations as a solution. National trends did tend to show teenagers were becoming more responsible when it came to sex but it also had to be acknowledged that not all under 18 pregnancies were unplanned. Where young mums wanted to keep their baby then they should be as much support available to them as they needed.

A Member questioned that while much was being done on sex education to avoid pregnancies, was any advice given to those young people who identified themselves as LGBT. The Interim Director commented that this information wasn't regularly collected.

Recommended

1. That the report and the discussions be noted.

2. That, in addition to allotments, the potential of a 'garden sharing' scheme be explored, by the new Deputy Director of Public Health, as a means of providing an opportunity for residents to grow their own food.

3. That information detailing the breakdown of numbers involved in alcohol misuse and both prescription and illegal drug misuse in Hartlepool be circulated to Members and that thereafter, the Committee be provided with a regular update.

60. Needle Exchange (*Interim Director of Public Health*)

The Interim Director of Public Health submitted a report updating members on the current process in relation to the Needle Exchange and how we can make changes to reduce the number of used needles and drug paraphernalia found in community spaces.

There has been a needle exchange in Hartlepool for a number of years now in varying different settings. Over time there have been number changes to how this service has been delivered from a mobile service to static within the Treatment Service as part of the wider Harm Minimisation Service for clients.

The current needle exchange provision is delivered via contracts with the following Pharmacies in Hartlepool.

- Boots Pharmacy (Marina)
- Lloyds Pharmacy (Park Road)
- Headland Pharmacy
- Seaton Pharmacy

The idea was to give client's access to needle exchange in their local area; we also have other pharmacies that are willing to come on board, which would broaden access throughout the town. However, this is not without its issues of which we need to address. There has been a noticeable increase in discarded drug paraphernalia over the last two years, especially in the grounds of certain pharmacies that are now at the point of conducting daily patrols to remove such litter from their premises. However, we are also aware of other areas within the town with the same issues. There is also a telephone number in Hartlepool Borough Council that people can call to have litter removed within 2 hours. We are sure that if their call outs were monitored it would reflect this increase.

The Interim Director indicated that as part of a recent Needs Assessment for the whole Substance Misuse Service it has been identified that the needle exchange needs to be broadened into a Harm Minimisation Service to meet the needs of the clients. A Harm Minimisation Service would encourage Pharmacies to run alongside to give more options to clients. This would also take the pressure of the pharmacies who by default are currently acting as drug workers without the wider harm minimisation knowledge. This puts added pressure on the wider service the pharmacy delivers on the whole. A full Harm Minimisation Service would also enhance the service we can offer to our clients, and encourage more people into treatment.

Members expressed their concern at the increasing prevalence of discarded needles and drug paraphernalia around the town and indicated that the telephone number for reporting this kind of litter needed to be better publicised. The Statutory Scrutiny Manager stated that the telephone numbers for reporting drug litter would be circulated to Members and the opportunity for the Chair to issue a press release detailing the contact numbers would also be taken following the meeting.

A Member highlighted that one of the failures of the current system was that it was not an exchange programme at all with users not having to return used needles to get a fresh supply. The new contract needed to include some requirement for needles to be returned in order to get a fresh supply. The Member also asked if when needles were issued were users given a 'sharps bin' in order to store the used needles and to return them safely. The Health Improvement Practitioner stated that users were issued with a small kit that included needles and a small container to store needles after they were used but not given large sharps bins. There was currently no

requirement to return used needles though this was something that could be considered as part of the re-procurement process. The Health Improvement Practitioner did caution that 'we' did not want to see the situation where users were refused new needles because of the potential health impacts of using or sharing old needles. It may be possible to restrict the number issued if some were not returned.

The Interim Director stated that the new service would be aimed at providing a 'wrap around' service to provide more care interaction with users. In returning needles, it was possible to incentivise users to return used needles but these were people with often chaotic lifestyles that may not always comply. The potential of safe venues to inject was also being considered though this would need the support of all agencies.

It was highlighted by the Vice-Chair that the key issue was education and ensuring young people did not become the new users of the future. Getting the messages into schools and finding enough time within the curriculum to build in anti-drugs education was key and one the Chair considered that Councillors as School Governors should be pursuing.

Recommended

1. That the report and comments be noted.

2. That the telephone numbers for reporting drug litter would be circulated to Members and a press release issued from the Chair to raise awareness of the telephone number and process for discarded needle removal.

61. Minutes from Recent Meeting of Tees Valley Health Scrutiny Joint Committee - Stakeholder briefing – Update on learning disability respite services, October 2018

The Statutory Scrutiny Officer submitted a stakeholder briefing paper updating members on Learning Disability Respite Services. The Statutory Scrutiny Officer indicated that she would present future updates as and when they were available.

Recommended

That the briefing paper be noted.

62. Minutes from Recent Meeting of Safer Hartlepool Partnership

The minutes of the meeting held on 3 August 2018 were received.

63. Regional Health Scrutiny Update - Durham Darlington and Teesside, Hambleton, Richmondshire and Whitby STP Joint Health Scrutiny Committee

The minutes of the meeting held on 13 June 2018 were received.

64. Any Other Items which the Chairman Considers are Urgent

None.

The Committee noted that the next meeting would be held on Thursday 13 December 2018 commencing at 10.00 am in the Civic Centre.

In accordance with the declaration made at the commencement of the meeting, Councillor Belcher left the meeting at this point.

65. Local Government (Access to Information) (Variation Order) 2006

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

Minute 66 – (Consideration of Investigation Report - SC01/2018 (Chief Solicitor and Monitoring)) – This item contains exempt information under Schedule 12A Local Government Act 1972 as amended by the Local Government (Access to Information) (Variation) Order 2006 namely (para.1) information relating to an individual.

66. Consideration of Investigation Report - SC01/2018

(*Chief Solicitor and Monitoring) This item contains exempt information under Schedule 12A Local Government Act 1972 as amended by the Local Government (Access to Information) (Variation) Order 2006 namely (para 1 information relating to an individual)*

The Assistant Chief Solicitor and Deputy Monitoring Officer submitted a

report on an investigation into a complaint relating to a member's conduct in accordance with the Members' Code of Conduct and S28(6) of the Localism Act 2011.

Details of the discussion are set out in the Exempt section of the minutes.

Decision

The Committee's decisions are set out in the Exempt section of the minutes.

The meeting closed at 12.20 pm.

CHAIR

AUDIT AND GOVERNANCE COMMITTEE

17 January 2019

Report of: Statutory Scrutiny Manager

Subject: INVESTIGATION INTO THE PROVISION OF PREVENTATIVE MENTAL HEALTH SERVICES FOR HARTLEPOOL RESIDENTS: WORKING AGE SERVICES

---

1. PURPOSE OF REPORT

1.1 To inform Members that as part of the next stage of the Committees investigation into the provision of preventative mental health services for Hartlepool residents, evidence at today's meeting will focus on the provision of preventative mental health services for working age people.

2. BACKGROUND INFORMATION

2.1 Members will recall that at the meeting of this Committee on the 25th July 2018, the Scope and Terms of Reference for the investigation were agreed. This was followed by an initial 'setting the scene' presentation on the 18th October 2018.

2.2 The Committee will at today's meeting focus on the provision of preventative mental health services for working age people, with evidence from the following partners, providers and commissioners:

i) **Hartlepool Borough Council** (John Lovatt **-** Assistant Director (Adult Social Care)

ii) **Hartlepool and Stockton NHS Clinical Commissioning Group** (Karen Hawkins - Director of Commissioning and Transformation)

iii) **North Tees and Hartlepool NHS Foundation Trust** (Julie Parkes, Interim Director of Operations)

iv) **Tees Esk and Wear Valley NHS Foundation Trust** (Jane King (Head of Service) and Dr Ranjeet Shah (Associate Clinical Director))

2.3 In addition to the above, an invitation has also been extended to organisations and groups from the private and voluntary and community sector to participate in discussions.

2.4 In providing their evidence, each provider has been asked to assist the Committee in:

i) Gaining a clear understanding of the:

- Preventative mental health services currently provided for Hartlepool residents, their usage / demand and the effectiveness of pathways in facilitating access to them;
- Challenges facing the provision of these services (now and in the future) and proposals identified to respond to them; and
- Views of service providers and users on the services provided and consider any suggestions for improvements.

ii) Considering:

- The role for community bases assets in the provision of preventative mental health services (what is currently available and what examples of good practice may exist elsewhere);
- Progress against the proposed actions outlined in the Implementation Plan for the Hartlepool Joint Health and Wellbeing Strategy; and
- What is being done to challenge the stigma of mental health and what is the impact of these services.

2.5 The next stages of the investigation will focus on specific areas as follows:

- 14 March 2019 – Older People's Services

3. RECOMMENDATION

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

Contact Officer:- Joan Stevens – Statutory Scrutiny Officer
Chief Executive's Department
Hartlepool Borough Council
Tel: 01429 284142
Email: joan.stevens@hartlepool.gov.uk

BACKGROUND PAPERS

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

(i) Report of the Statutory Scrutiny Officer entitled 'Preventative Mental Health Services in Hartlepool' Presented to the Audit and Governance Committee on 25 July 2018

AUDIT AND GOVERNANCE COMMITTEE

17 January 2019

Report of: Head of Safeguarding and Specialist Services

Subject: MENTAL HEALTH - WORKING TOGETHER FOR CHANGE EVENT – FEEDBACK

---

1. PURPOSE OF REPORT

1.1 To update Members on the outcome of the Mental Health - Working Together for Change Event held on the 12 December 2018.

2. BACKGROUND INFORMATION

2.1 The focus of the event was to provide a summary of work to date on the outgoing Mental Health Implementation Plan 2015-2018 and look towards the development of a joint plan for Mental Health 2019 – 2021.

2.2 The morning session focussed on key achievements to date and highlighted the current work being undertaken by Audit and Governance, the reports presented to Adult Services Committee in March 2018 and examples of the work of the Mental Health Forum. Key speakers provided a picture of Mental Health in Hartlepool.

3. HARTLEPOOL PUBLIC HEALTH PROFILE

3.1 Mental wellbeing is the foundation for positive health and effective functioning for individuals and communities. One in four people will experience mental health problems at some point during their life.

3.2 Mental ill-health is common with a significant impact on individuals, their families and the whole population. 22.8% of burden of disease in UK is due to mental disorder.

3.3 The causes of mental illness are extremely complex – physical, social, environmental and psychological causes all play their part. The problems are unevenly distributed within the population and having mental ill-health further widens existing inequalities. The impact of mental health problems has wide-ranging and long-lasting effects, including trans-generational impacts which occur more often in groups at higher risk.

3.4 Mental health conditions are strongly associated with socioeconomic deprivation. The connection between rates of mental illness and other factors such as poverty, unemployment and social isolation is well established.

3.5 The cost of mental health problems to the economy in England is estimated to be £105 billion, and treatment costs are expected to double in the next 20 years (DH, 2011).

4. KEY FACTS

1 in 6 adults have had a common mental health problem in the last week
1 in 10 children experience a mental health problem
1 in 5 adults has considered taking their life at one point
9 in 10 people with mental health problems experience stigma and discrimination.

5. WORKING TOGETHER FOR CHANGE

5.1 Using the working together for change methodology Commissioners, Service Providers and people with lived experience were supported to look at three key areas, what is working, what is not working and what was important for the future. Prior to the event a number of people with lived experience were asked to fill in a pre-event questionnaire their responses where focused on the three key areas.

5.2 Some examples captured from people with lived experience as part of a pre event questionnaire.

6. WHAT IS WORKING?

- Mental health workers help and comfort me.
- Regular visits stop me from straying off track, I think more about my actions and on a daily basis I do more.
- What has been done for me is more than I could have hoped for and it is heart-warming.
- My mental health has improved over the last 2 years with the help I receive form workers; they are always at the end of the phone.
- I personally can say I get a great deal from going to the hearing voices group.
- I have a really good nurse who has helped me with a great deal.
- I was well informed about medication; regular medication has stopped me drinking.
- Nothing is too much trouble for staff, I feel I can breathe again, it’s the best I’ve been in 15 years. I no longer smoke cannabis.
- Psychiatric community care.

7. WHAT IS NOT WORKING?

- I appreciate the direct payment but the process is too long and complicated and takes too long to process.
- Trying to see a psychiatrist if needed.
- I am supported well at the hearing voices group but not in mental health I am not getting the support when I need it.
- Lack of communication when staff are ill or leave their jobs.
- Unfortunately I could do with a support worker but I would have to make a financial contribution.
- More should be done through a psychologist.

8. IMPORTANT FOR THE FUTURE?

- To be able to access support quickly if I am unwell
- Training for staff to deal with family of carers who are directly involved.
- I think there could be more psychiatric help from Doctors.
- Discussion with a psychiatric nurse.
- Group discussion and drop ins
- A system to alert staff if no contact has been made for more than 4 weeks, e.g. in person, phone call text of email.
- Offer counselling to family and friends who are directly involved with someone with mental health issues.
- One to one support for mental health issues.
- Discussions with a psychologist.

9. HARTLEPOOL PRIORITIES

9.1 Representatives from 16 organisations together with people with lived experience and family carers helped to develop a local action plan.

9.2 The top priorities from the day included:-

1. The development of a wellbeing Hub and Café.
2. Access to respite and Crisis Beds
3. Development of a Single point of access to mental health services.
4. A shift from Crisis to Prevention (described as the fire Service model)
5. Improving the timeliness of access into services.
6. GP time to talk, mental health (primary care services)
7. Tackling Social Isolation & Loneliness.
8. Transport / Conveyance / Travel concessions.
9. Children, Young People and educating the public on mental health
10. Stigma, understanding what is good mental health.

10. DEVELOPING A LOCAL PLAN

10.1 The Infographics (attached at **Appendix A**) depict the key areas explored and addressed at the Working Together for change event on 12 December 2018.

It is envisaged the Hartlepool Mental Health Forum will take forward the key priorities from the working together for change event and this will form the basis of the Mental Health Joint plan for 2019-2021.

11. RECOMMENDATION

11.1 It is recommended that the Members of the Audit and Governance Committee consider feedback from the event and seek clarification on any relevant issues where required.

Contact Officer:- Joan Stevens – Statutory Scrutiny Manager
Chief Executive's Department
Hartlepool Borough Council
Tel: 01429 284142
Email: joan.stevens@hartlepool.gov.uk

BACKGROUND PAPERS

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

Hartlepool Mental Health Joint Plan top 10 priorities

08.01.2019

1 in 10 children experience a mental health problem

1 in 6 adults have had a common mental health problem in the last week

Mental Health First Aid

Psychological Therapies

Intensive home based family support

Access to care in a crisis

1 in 5 adults have considered taking their own life in the past week

9 in 10 people with mental health problems experience stigma and discrimination.

Signs and symptoms

Too much sleep or trouble sleeping

Trouble focussing or having racing thoughts

Changes in appetite

Isolating yourself from others or losing interest in things you once enjoyed

Irritability or having a short temper

Hartlepool Mental Health joint Plan 2019-2021

Mental Health First Aid

- Tackling Social Isolation and Loneliness.
- The Development of a Wellbeing Hub and Café.
- Children & Young People, educating the public
- Transport and safe places.

Psychological Therapies

- Single Point of Access into Mental Health Services.
- GP Time to talk, raising awareness of primary care services.

Intensive home based family support

- Improving the timeliness of access to Mental Health services.
- Tackling stigma and understanding what is good Mental Health

Access to care in a crisis

- Access to local respite and crisis beds
- A shift from Crisis Care to Prevention and Early Intervention

Signs and symptoms

Too much sleep or trouble sleeping

Trouble focussing or having racing thoughts

Changes in appetite

Isolating yourself from others or losing interest in things you once enjoyed

Irritability or having a short temper

AUDIT AND GOVERNANCE COMMITTEE

17 January 2019

Report of: Interim Director of Public Health

Subject: DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2017/18

---

1. TYPE OF DECISION/APPLICABLE CATEGORY

For information.

2. PURPOSE OF REPORT

2.1 The purpose of this report is to present for information the Director of Public Health Annual Report for 2017/18. The report, including updated ward profiles for elected members, will be presented to full Council on the 20th December 2018.

2.2 It is a statutory duty of Directors of Public Health to produce an independent annual report on the health of the population and present it to Councilors for consideration.

3. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT - PROPOSALS

3.1 The 2017/18 Report focuses on 'starting well' in Hartlepool, highlighting the services, good practice and partnership working taking place across the Borough in order to provide all Hartlepool children with the best start in life, as well as some of the adverse trends and continuing challenges.

3.2 The theme of "starting well" is the beginning of a systematic approach covering each step in the Health and Wellbeing Strategy for Hartlepool in turn, so that every stage of life is covered in detail over a five year cycle.

3.3 In addition to a spotlight on young people, the report has chapters giving an overview of health and wellbeing, an assessment of need for drugs and alcohol, the importance of "prevention" and an account of stewardship of the public health grant. The concluding challenges relate to austerity, prevention and empowerment respectively.

3.4 As in previous years, the final report to full Council will be accompanied by a revised set of 'Ward Profiles' for Elected Members, which will highlight the key public health issues in each electoral ward.

3.5 A copy of the report is attached at **Appendix A** (an electronic version available via the below link).

www.hartlepool.gov.uk/downloads/download/309/director_of_public_health_annual_report).

4. RISK IMPLICATIONS

4.1 It is a mandated responsibility for Directors of Public Health in Local Authorities to publish an annual report on the health of their population.

5. FINANCIAL CONSIDERATIONS

5.1 There are no financial issues associated with the development and publication of the report.

6. LEGAL CONSIDERATIONS

6.1 There are no legal implications arising from this report. It is a statutory requirement.

7. CONSULTATION

7.1 No consultation is required, report is for information.

8. CHILD AND FAMILY POVERTY (IMPACT ASSESSMENT FORM TO BE COMPLETED AS APPROPRIATE.)

8.1 There are no child and family poverty issues arising from this report.

9. EQUALITY AND DIVERSITY CONSIDERATIONS (IMPACT ASSESSMENT FORM TO BE COMPLETED AS APPROPRIATE.)

9.1 There are no equality and diversity issues arising from this report.

10. STAFF CONSIDERATIONS

10.1 There are no staffing implications arising from this report.

11. ASSET MANAGEMENT CONSIDERATIONS

11.1 There is no impact on asset management.

12. RECOMMENDATIONS

12.1 The Audit and Governance Committee note the final report.

13. REASONS FOR RECOMMENDATIONS

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

14. BACKGROUND PAPERS

14.1 There are no background papers to this report.

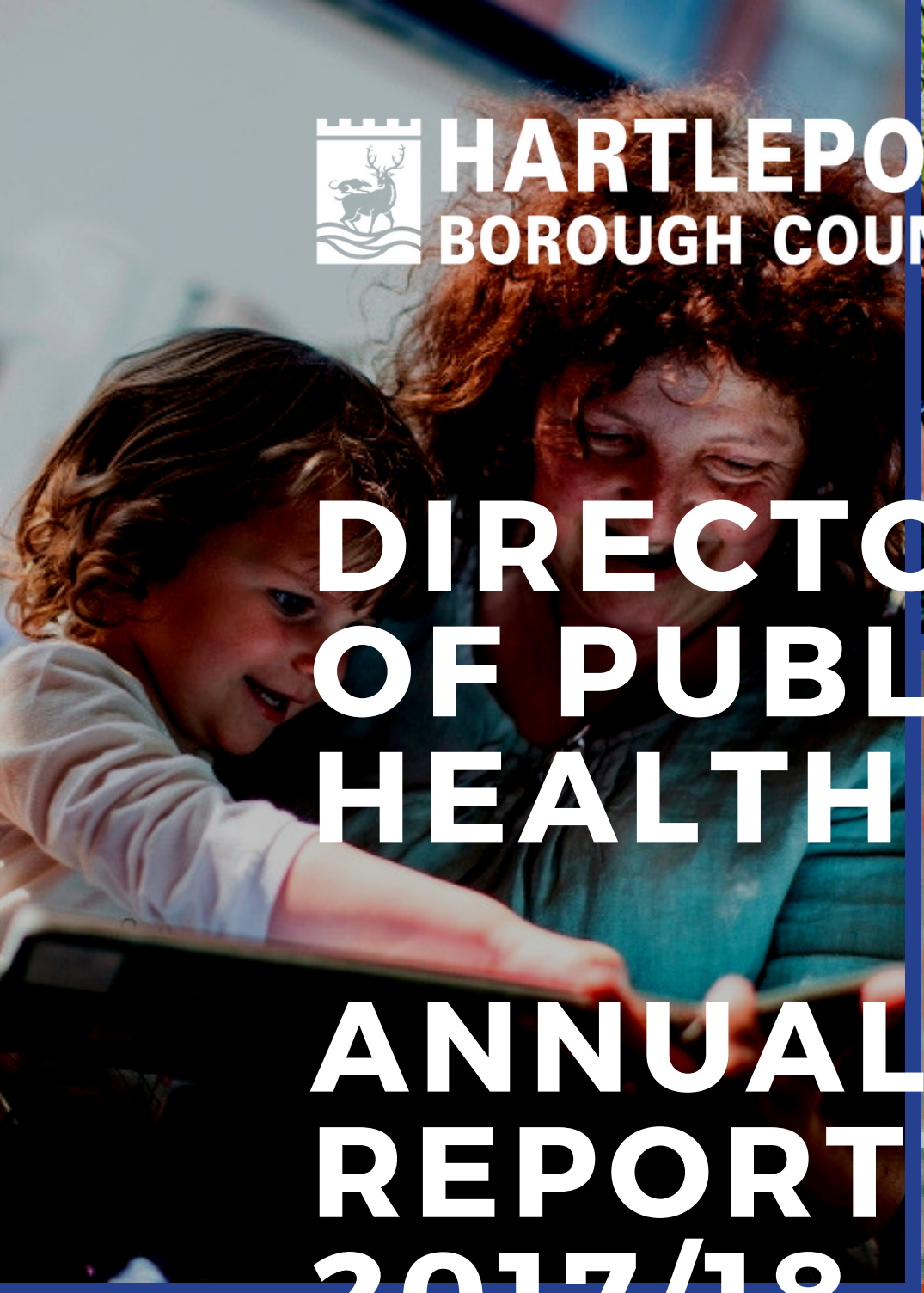
15. CONTACT OFFICER

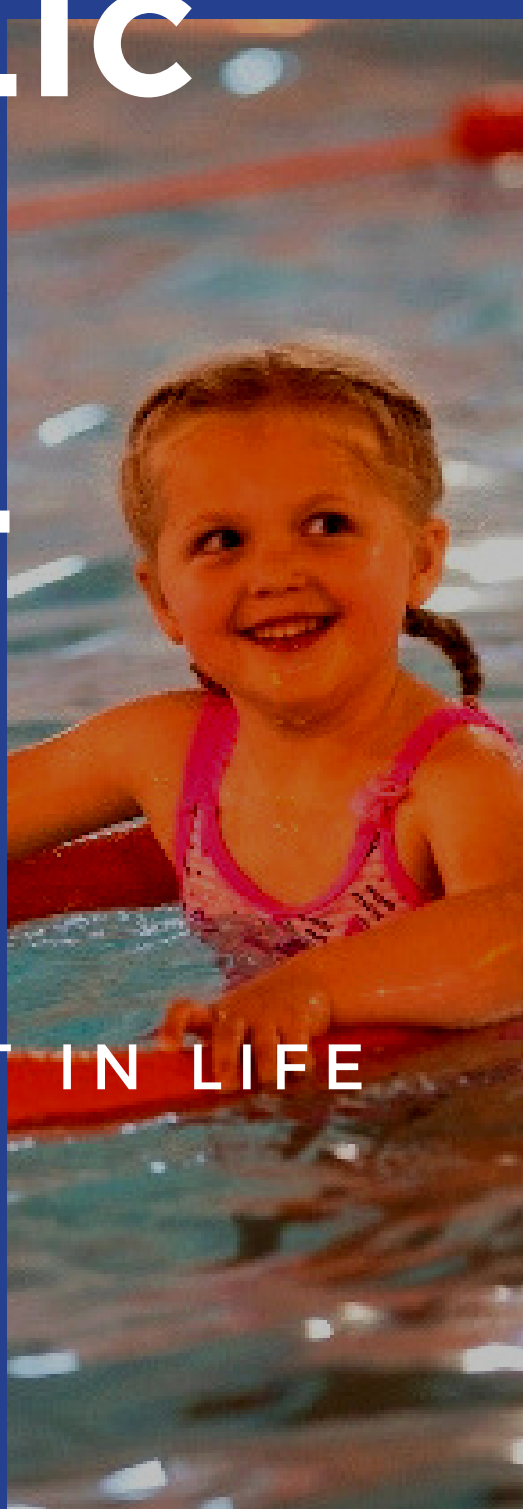
Dr Peter Brambleby DCH FRCP(Edin) FFPH
Interim Director of Public Health
Hartlepool Borough Council
Email: peter.brambleby@hartlepool.gov.uk

HARTLEPOOL BOROUGH COUNCIL

DIRECTOR OF PUBLIC HEALTH

ANNUAL REPORT 2017/18





BEST START IN LIFE

CONTENTS

FOREWORD.

It is a privilege, as Interim Director of Public Health since May 2018, to present this annual report. One of the statutory duties of a Director of Public Health, reiterated in the Health and Social Care Act 2012, is to produce "an independent annual report on the health of local communities."

In last year's report my predecessor, Dr Paul Edmondson-Jones, reminded us of another statutory duty, which is to maintain an up to date Joint Strategic Needs Assessment (JSNA). It is a pleasure to report that the JSNA is being restructured and rewritten in a way that makes it easier to track the life-course of our residents from "starting well" to "dying well" and relates more closely to the strategy for health and wellbeing. A few general points from the new JSNA are shown in chapter 1, and a further expansion of needs relating to "starting well" appear in chapter 2.

The JSNA is truly a joint assessment, drawing on the input of all partners in the Health and Wellbeing Board. Their contributions are gratefully acknowledged. The JSNA underpins our understanding of the nature and scale of the challenges, points to possible solutions, directs our commissioning and provision of services and helps us evaluate progress. One of its major features is to point to inequalities in health and wellbeing, and these remain a high priority for action.

Last year's report had a special focus on "ageing well." Two other features of that report were "social inclusion" and "regarding our residents as assets, not just needs." These two characteristics can be seen in much of our work this year and particularly in this year's needs assessment for drugs and alcohol services, where we have included people who used those services to shape our understanding of the needs and as a valued asset in addressing them. That assessment is described in chapter 3.

A recurring theme for councils and the NHS in England this year has been "prevention". It has been cited by the Secretary of State for Health and Social Care as one of his top three priorities. Chapter 4 is devoted to this topic.

In a period of prolonged austerity, attention naturally turns to value for money. Chapter 5 gives a brief account of stewardship of the public health grant this year – how it was embedded across all Council areas of activity and the anticipated return on that investment in terms of improved health and wellbeing. We are accountable for that grant not only to Public Health England (whose support we also gratefully acknowledge) but also to the people of Hartlepool and their elected representatives. It is worth noting that in this chapter, as in the rest of the report, the activities and outcomes are those of the whole Council and its partners in health and wellbeing; it is not simply an account of the work of the public health department. Health improvement is a collaborative effort. Public health is everyone's business.

The past year has been one of challenge, achievement and change. It is a pleasure to introduce Dr Patricia Riordan as the new and substantive Director of Public Health. She takes up the role in February 2019. I am confident that the readers of this report will give her every support, and will look forward to reading her report next year.

DR PETER BRAMBLEBY

INTERIM DIRECTOR OF PUBLIC HEALTH, HARTLEPOOL BOROUGH COUNCIL

CHAPTER 1

A snapshot of health and wellbeing in Hartlepool

The Public Health Outcomes Framework is a set of indicators collated by Public Health England (PHE) and published on their website. They highlight local authority performance across the full spectrum of public health. Since numbers can be small, and variations happen between years, the indicators often combine three years' data to smooth this out. Not all indicators are updated every year, and there is a slight time lag in getting all the national data collated and analysed. For details of each indicator please visit the **PHE website**.

Here is a snapshot of some important findings for Hartlepool:

Matters of life and death

Indicator	Period	Hartlepool	NE Region	England
Life expectancy at birth - males (years)	2014-16	76.4	77.8	79.5
Life expectancy at birth - females (years)	2014-16	81.3	81.5	83.1
Healthy life expectancy - males (years)	2014-16	57.7	59.7	63.3
Healthy life expectancy - females (years)	2014-16	57.4	60.6	63.9
Gap in life expectancy at birth - males (years) between most and least deprived areas)	2014-16	11.7	-	-
Gap in life expectancy at birth - females (years) between most and least deprived areas)	2014-16	10.2	-	-
Gap in healthy life expectancy - males (years) between most and least deprived areas)	2014-16	17.2	-	-
Gap in healthy life expectancy - females (years) between most and least deprived areas)	2014-16	14.9	-	-
Dying before 75 years - males and females (rate per 100,000)	2015-17	456	396	332
Dying from causes considered preventable - males and females (rate per 100,000)	2015-17	252	223	182

A new indicator this year is healthy life expectancy – the period of time in which people can expect to report good health. Although on average women in Hartlepool can expect to live five years longer than men, they do not enjoy more years in good health. Another stark finding is that the inequality gap between Hartlepool's most affluent 10% and least affluent 10% is very much wider, for men and women, when we look at quality at end of life and not just length of life. Behind these figures, the main causes of the gap in length are cancer, heart disease and respiratory disease, but the main threats to quality of life come from mental health problems (especially dementia and depression), musculoskeletal problems and problems with hearing and vision. As a consequence of these findings, we should not just seek to prevent "killer" diseases but also seek to prevent those that limit wellbeing. Another significant finding is that more people in Hartlepool die before their time (75 years in this indicator) that elsewhere, and much of this is driven by preventable diseases related to lifestyle choices.

Death from drug misuse is another area of low performance for Hartlepool. There has been an increasing trend for three years in Hartlepool for this cause, moving away from a position of statistical similarity with the England average. This year we have undertaken a comprehensive needs assessment for drugs and alcohol, and drafted a whole new specification which we will implement in 2019 (see chapter 4).

In sickness and in health

Indicator	Period	Hartlepool	NE Region	England
Self-reported "high happiness" score (%)	2015-16	70.7	-	74.7
Sickness absence (% working days lost)	2015-17	2.5	1.5	1.1
Dying in hospital (%)	2016	51	48	47
Dying in hospice	2016	9	4	5
Successful treatment of opiate addiction (%)	2017	6.3	4.9	6.5
Successful treatment of alcohol addiction (%)	2017	24	31	36

In surveys, most people say they would prefer to die at home but the figures show that at least half die in hospital. On the favourable side, twice as many Hartlepool people die in a hospice than the national average. Our successful treatment rates for opiate addiction, though low, are similar to the national average but are not so good for alcohol addiction.

Healthy lifestyles

Indicator	Period	Hartlepool	NE Region	England
Walking to work (%)	2016-17	18.7	20.4	22.9
Cycling to work (%)	2016-17	1.5	2.0	3.3
Fast food outlets per 100,000 population	2014	143.6	102.4	88.2
Regularly use outdoor space for health (%)	2015-16	11.3	17.3	17.9
Eat 5 portions of fruit or veg per day (%)	2016-17	49.6	56.5	57.4
Physically inactive adults (%)	2016-17	27.4	24.6	22.2
Smoking prevalence - adults (%)	2017	19.2	16.2	14.9

If we are to tackle people dying before their time, or living longer in poor health, then here are some obvious pointers. There is much that the Council already does to make healthy choices easy choices but in the final analysis it requires individuals to heed the information and use the opportunities for taking control over their own wellbeing.

When it comes to portions of fruit and vegetables consumed by adults, Hartlepool has the lowest rate in the country. This is a decline of 4.4% on the previous year, and compares with an England average that has increased slightly from its previous rate, so the gap is widening. The subject of prevention is discussed in chapter 5.

Other determinants of wellbeing

Indicator	Period	Hartlepool	NE Region	England
Households in fuel poverty (%)	2016	14.7	13.8	11.1
Adult unemployment (%)	2017	10.3	6.2	4.4
Violent crimes (per 1,000 population)	2017-18	26.2	30.2	23.7
First time offenders - all ages (per 100,000)	2017	176.6	161.6	166.4
Income-deprived people over 60 years (%)	2015	24.4	-	16.2
Average weekly earnings for employed (£)	2015	420	400	440

Public health is everyone's business and the causes and remedies lie deep. Here are some determinants of health and wellbeing that are worth watching and tackling.

Best start in life?

Indicator	Period	Hartlepool	NE Region	England
Birth weight at term below 2.5kg (%)	2016	3.4	3.0	2.8
Breastfeeding initiation (%)	2016-17	38	59	79
Children in low income families	2015	27	22	17
Children in care (per 100,000)	2016	129	92	62
Teenage mothers (% of all new mothers)	2017	2.0	1.4	0.8
Children in youth justice system (per 1,000)	2017	7.2	7.0	4.8
Ready for school aged 5 (%)	2016-17	69.6	70.7	70.7

"Getting the best start in life" is the focus of the next chapter but included here for completeness of the overview.

For breastfeeding initiation Hartlepool is the worst performing authority in England. Hartlepool has seen a decline of 11.7% in its breastfeeding initiation rate in the last two years, from 49.6% to 37.9%. In the same period both the England and North-East averages have increased by 0.2%. This statistic has been the focus of discussion between our own 0-19 nursing service, the hospital midwifery service and the Clinical Commissioning Group who commission the hospital service. Breastfeeding is just part of the preparation for parenthood and is the focus of much work (see the next chapter).

Children in low income families, both under 16s and all dependent children under 20, are indicators which have seen improvement over the 10 year data collection period, but at a slower rate than the England average, meaning that the current gap between England and Hartlepool is larger than it was in 2006.

Hartlepool's under-18 conceptions rate is the second highest in England. Hartlepool had experienced a declining trend in under-18 conceptions for 9 years from 2006 to 2014 but since then it has been rising while the England average continued to decline.

CHAPTER 2

Special focus: "Starting Well"

Adverse Childhood Events (ACEs). *With special thanks to Dr Joanne Buntin, Educational Psychologist, Hartlepool Psychology Team.*
joanne.buntin@hartlepool.gov.uk

In 1995, doctors Vincent Felitti and Robert Anda launched a large study in the United States that enquired about the child and adolescent experience of 17,000 people, comparing their childhood experiences with their later adult health records.

The findings were startling. Adverse Childhood Experiences (ACEs) - a term Felitti and Anda coined to encompass the chronic, unpredictable and stress-inducing events, were common. These included experiences that directly harmed, such as physical, verbal or sexual abuse, physical or emotional neglect; and those that affected the environments in which children grow up, such as parental separation, domestic violence, mental illness, alcohol abuse, drug use or imprisonment. Further ACE surveys have expanded this list to include abuse by brother or sister, witnessing violence in the community, being bullied, involvement with the foster care system, poverty, living in a war zone, or losing a family member to deportation.

Some distress is inevitable in the early years, but what elevated these factors to “toxic stress” was their frequency, severity and absence of relief or escape.

Another pioneer in the field, Dr Nadine Burke-Harris, uses the following analogy. Imagine you encounter a bear in the woods. Adrenaline kicks in and the body prepares for fight or flight. The primitive part of the brain remembers this and the next time a bear is encountered the response is even quicker – no need to think about it. Now imagine you lived with a bear in the room. The stress would be repeated and severe. This toxic stress is now known to permanently affect early brain development and health of body organs like heart and lungs. Then, to a child conditioned to stress, a simple reprimand at school or harsh word from a schoolmate can provoke rage to kick in without conscious thought, and the cycle continues. Such children are not wicked – they are wounded.

The researchers found that the higher the exposure to adversity and trauma, the more likely it was that an individual had long-lasting physical and mental health conditions. What surprised the researchers was that the harm was not simply restricted to emotional development and mental health, but was a risk factor for common diseases of adulthood such as cancer, heart disease, autoimmune conditions and diabetes. For example, someone with an ACE score of four was more than four times more likely to suffer from depression than someone with an ACE score of 0. From a score of zero to a score of six there is about a 50-fold increased likelihood of suicide attempts.

Effects of childhood trauma are often first evident in school. More than half of those with scores of four or more reported having learning or behavioural problems in school compared with those with a score of zero.

Does this mean that a child with a raised ACE score has irremediable damage? To some degree, yes, which is why prevention is so critical, but much can be done to mitigate the harm and restore reasonable behaviour, emotional resilience and healthier life expectancy. The three main thrusts of therapy are: to identify and remove the sources of stress as much as possible; to provide the child with a trusted adult (or adults) as a route of escape and to work on the child's own strategies for emotional maturity and appropriate responses to stressful situations.

Through a coordinated approach across the Children's Strategic Partnership, Hartlepool is embarking on becoming an ACE-aware town. In this it is following an evidence-based and experience-based trail from the USA and Britain. Scotland, and in particular Glasgow, is leading the way in the UK. The behavioural psychology team is at the forefront, and most schools and children's services are strongly committed.

A good example of Hartlepool's commitment is the Empowering Parents, Empowering Communities project described below.

Empowering Parents, Empowering Communities (EPEC): How we hope to help prevent the long-term effects of adverse childhood experiences (ACEs) in Hartlepool. *With special thanks to Jill Coser MSc, Parenting Lead, Hartlepool Borough Council.* ***jill.coser@hartlepool.gov.uk***

What is EPEC? In Hartlepool we are on a journey that has the potential to transform the way we support families facing the challenges of disadvantage. Hartlepool Borough Council has just become a member of the EPEC community. EPEC is a well-tested, highly effective method of prevention and early intervention that can transform the scale, reach and impact of local parenting support. EPEC combines local professional parenting expertise using evidenced-based methods with a parent-led approach that builds community resilience.

We have recently recruited 12 enthusiastic local parents from various communities, who are currently undertaking a 3 month training course to deliver the EPEC "Being a Parent" course. This course has been developed to promote child well-being and includes:

- Attachment and parent-child relationships.
- Understanding and managing children's feelings and parents' emotional regulation.
- Parenting roles, expectations and culture.
- Parent listening, communication, play and interaction skills.
- Positive behaviour management and discipline strategies.
- Managing parent and family stress.

The current EPEC group - trainer Jill Coser is at the front, left.

The growing evidence from this programme indicates that parents who attend an EPEC course can expect to see improvement in their children's social, emotional and behavioural development (Asmussen, K., Feinstein, L., Martin, J. & Chowdry H. (2016). Foundations for life: What works to support parent child interaction in the early years. London: Early Intervention Foundation). There is also compelling evidence to support working directly with parents to enable them to provide the nurturing and supportive environment needed for their children to thrive.

Why EPEC? We urgently need these improvements in Hartlepool as we have a significant number of children with social, emotional and behavioural difficulties that undermine developmental progress and educational achievement. Despite the high quality of our schools, 25% of local children do not reach expected levels at the end of primary school, with this negative trend continuing throughout secondary school. On leaving school, 47% of young people in our town do not achieve five GCSEs in A*-C. Many of these young people will have experienced adverse childhood experiences and will transition into adulthood with reduced opportunities and an increased likelihood of poor mental and physical health in later life.

"Despite difficulties in my own childhood, losing my mum as a young adolescent, becoming a teenage parent and having my own mental health difficulties, I am striving to be the best parent I can be. To overcome these obstacles in life I have been optimistic and shown strength. Despite my early difficulties I am a great parent and provide the love and support my children need. Through EPEC I am now learning so much about child development, how to manage difficult behaviour and how to encourage more positive behaviour. This is having a real impact in my home and my confidence is growing by the week. I am excited about the opportunities ahead of me and cannot wait to support other parents. I already know parents in my area that would really benefit from this course and I am looking forward to getting started."

Hartlepool EPEC Parent

We understand the reasons for poor child outcomes are complex, cumulative and life-limiting. We found many of the parents completing the ACE questionnaires on their own childhood experience had themselves been exposed to adverse childhood experiences. Some of these parents went on to poor educational attainment, being out of work and having mental and physical health difficulties. These experiences have in turn impacted on their resilience as parents and they have struggled to provide nurturing, calm and consistent environments for their own children. Yet, conversely some parents who have experienced a high number of ACEs have provided loving environments for their own children and are enjoying being a parent themselves. These parents are focussed on being the best parent they can be and are enthusiastic about learning new skills and broadening their horizons. They have invaluable experiences of building resilience and coping under difficult circumstances. We want to convert this knowledge and potential to empower not only themselves but also parents in our communities. The first 12 Parent Group Leaders are only the beginning of the EPEC journey and by July 2019 we hope this figure will double. Our plan is to widen our interventions to include courses for parents of children with Autism, ADHD, parents of teenagers and parents with significant mental health difficulties.

Delivering a better start in life

This, like the rest of public health, is a collaborative effort. Some of the indicators of child health were covered in chapter 1. Here are some illustrative factors in greater detail.

Healthy weight and healthy diets

According to an annual survey conducted across the country by Sport England, 81% of 15 year olds in Hartlepool spend at least seven hours a day, on average, sitting down. This is the highest (ie worst) level in the whole of England. But for those who are active, a different finding emerges: Hartlepool has the 5th highest (ie best) level in the North-East region (15.2%), and is above both the regional and England average.

The National Child Measurement Programme looks at the height and weight (body mass index, BMI) of children aged four to five, and again aged 10-11, in order to assess the levels of obesity within those populations.

When this is applied across England, the prevalence of excess weight in Reception is roughly one in five and at Year 6 is roughly one in three. When this is applied to Hartlepool, the prevalence of excess weight in Reception increases to roughly one in four, with the prevalence in Year 6 remaining at one in three.

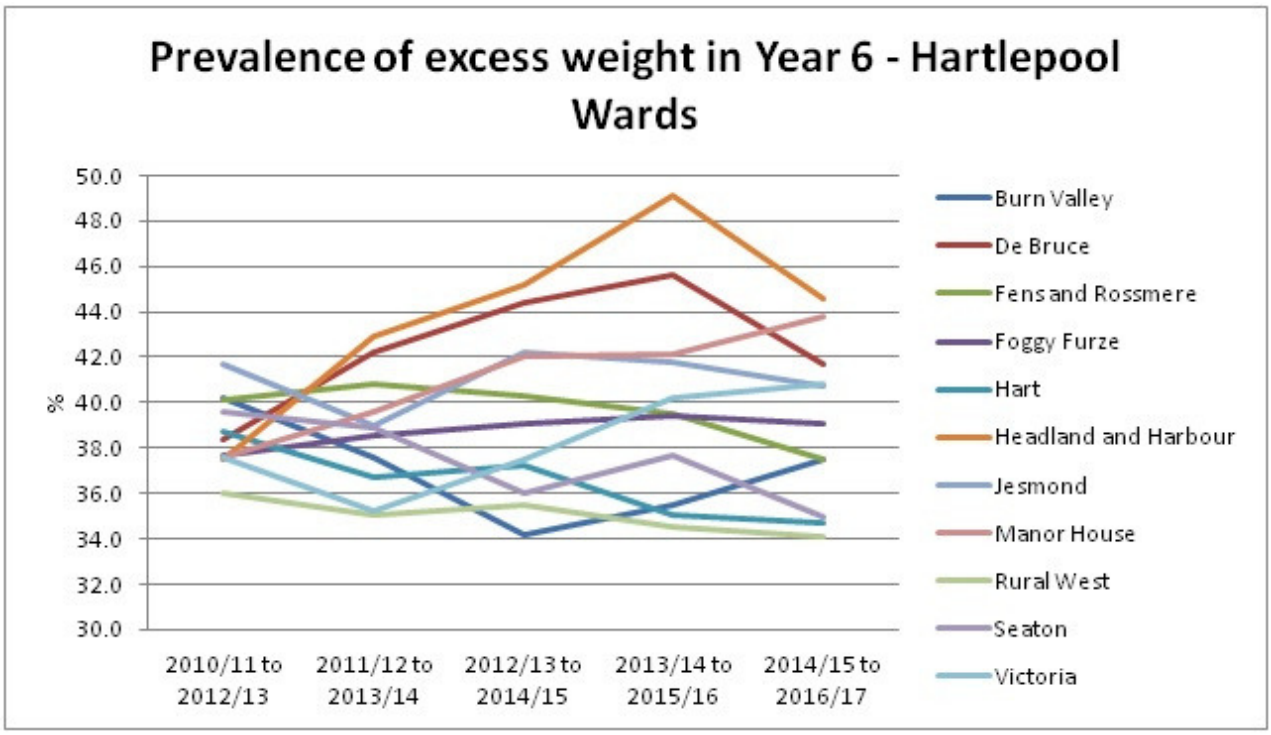
Trends are not looking good in the pre-school stage. Hartlepool's excess weight prevalence at school entry is at an eight year high both in terms of proportion of the Hartlepool population and the gap between Hartlepool's prevalence and the England average.

When prevalence of excess weight at age 10-11 is examined, the picture for Hartlepool becomes slightly better. At this stage Hartlepool's prevalence of 36.8% is below the North-East regional average of 37.3%, and the gap between Hartlepool and the England average has never been narrower. Hartlepool's prevalence figure for Year 6 is at a seven year low, which is good, and has decreased year on year for two years.

Taken together, it appears that adverse trend before primary school is being turned around a bit at school. This is to be applauded, but more could be done.

If we start to examine the differences within Hartlepool itself, we can see that, at ward level for 10-11 year olds, for excess weight, the difference between the best performing wards and the worst performing wards has increased.

In the last four years the difference between the highest prevalence ward and the lowest prevalence ward has nearly doubled. This shows that geographical factors are having a larger impact on a child's chances of excess weight in Year 6 than they were four years ago.



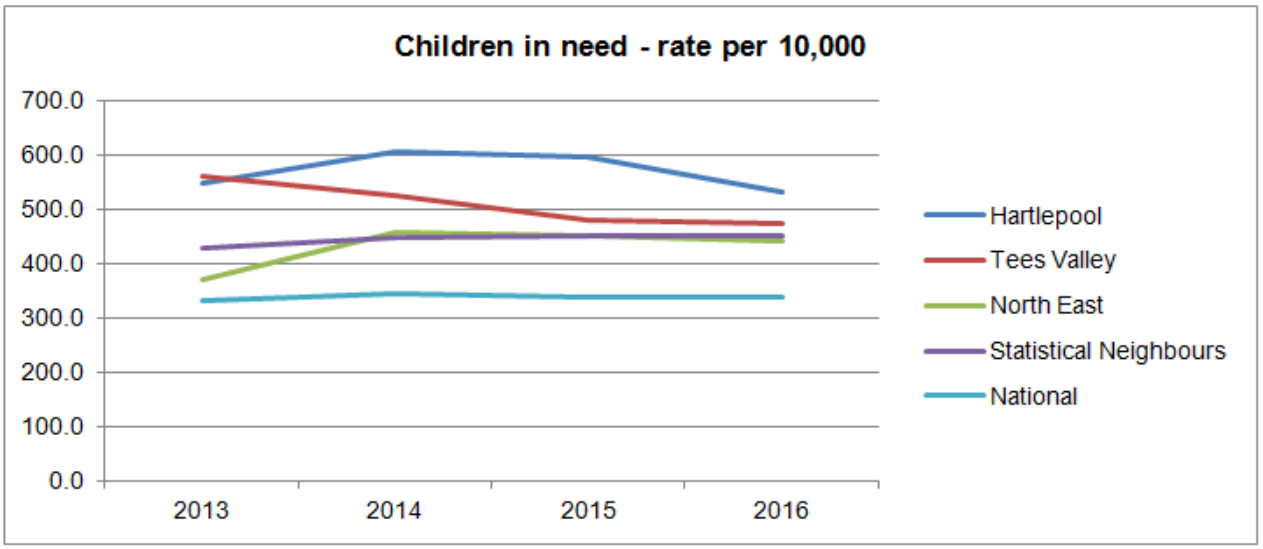
However at five years old (Reception) age this geographical factor is of less importance, as the difference between the highest and lowest prevalence wards has actually decreased by 0.7%.

If we look at other lifestyle indicators linked to obesity then a consistent picture emerges. Hartlepool has the largest proportion of 15 year olds with at least seven hours sedentary time per day in the whole of England, and also has only four out of ten 15 year olds eating five portions of fruit or vegetables a day, which is in the bottom quarter for performance in England. This highlights that the lifestyle trends captured at Reception and Year 6 are continuing into teenage years and beyond, with excess weight in Hartlepool's adult population at 70.1%, more than 10% above the England average.

In summary, we have a legacy of poor diets and inactive lifestyles, in childhood and adult life, which affect the less affluent areas of Hartlepool disproportionately and widen the health gap. At the moment the trend is not good in the pre-school years but there are signs that things improve during the primary school years. The challenge is to promote that trend through more children and their families eating more healthily and getting more activity.

Children in need

A child in need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled.



There has been a decrease in the number of children in need: the rate per 10,000 population decreased from 596.6 in 2015 to 531.0 in 2016. This is still significantly higher than the national figure of 337.7.

2016 attainment results

A child's educational attainment is closely correlated with his or her length and quality of life after school.

Foundation stage: of those children who were children in need, 30.2% achieved a 'good level of development' by the end of the Foundation stage compared with 68.4% of all pupils in Hartlepool and 69.3% of all pupils nationally. This highlights that by the end of the Foundation Stage the attainment gap between children in need and their peers is 38.2% and children in need are required to make greater than average progress in order to narrow the gap.

Phonics screening Year 1: of those children who were in need, 61% met the expected standard compared to 85% for all Hartlepool pupils.

Key Stage 1: of those children who were in need, 51.5% achieved the expected standard in Reading compared with 73% for all Hartlepool pupils; 42.4% in Writing compared with 65% for all Hartlepool pupils; and 36.4% in Maths compared with 71% for all Hartlepool pupils.

Key Stage 2: of those children who were in need, 36% achieved the expected standard in Writing compared with 76.1% for all pupils in Hartlepool schools; 43% in Maths compared with 71.6% for all pupils in Hartlepool schools; 43% in Spelling, and Punctuation and Grammar compared with 74% for all pupils in Hartlepool schools.

Key Stage 4: of those children who were in need, 17.2% achieved 5+ A*-C including English and Maths compared with 47.6% for all Hartlepool pupils.

The good news is that all stages, achievement for Hartlepool's children in need is close to or exceeded that of children in need in England as a whole.

Youth offending

New referrals to the Youth Justice System

The table shows the number of referrals made to the Youth Justice Service (YJS) from various sources over the period 2015-2018. Note that the number of referrals does not refer to the number of individuals as some received more than one referral.

	2015/16	2016/17	2017/18
Total referrals	320	271	222

Analysis of youth-related anti-social behaviour for the 2017 Safer Hartlepool Partnership Strategic Assessment revealed that more than 600 individuals were involved in more than 1,200 incidents during the reporting period.

48 individuals were recorded as being involved in five or more incidents in this year with the highest number perpetrated by any one individual being 38 incidents. The average age of repeat perpetrators in this year was 13 years and nine months.

During this assessment period, it is also evident that anti-social behaviour is a precursor to criminal behaviour. Many Prolific and Priority Offenders were known to the police and local authority as perpetrators of anti-social behaviour in their early teenage years.

A review of evidence by the Local Government Association (LGA) found robust evidence for a link between experiencing family violence and subsequent participation in youth offending. The more risk factors, for example adverse childhood experiences (ACEs) experienced by young people, the greater the likelihood of participation in youth offending.

Risk factors influencing the link between family violence and youth offending

Individual factors	Family factors	Community factors
Low social competency Experience of depression Failure at school Experiences of family violence that start in or persist into adolescence Substance abuse	Running away from home	Delinquent peers Verbal and physical abuse with peers

The LGA review also highlighted that there are a number of protective factors that reduce the risk that young people exposed to family violence will go on to offend; and, equally, a range of risk factors which increase this likelihood. These are shown in Tables 1 and 2 below:

Protective factors influencing the link between family violence and youth offending

Individual factors	Family factors	Community factors
High self-esteem	Good sibling relationships High quality relationships with supportive adults	Good peer relationships Safe school environment

Looked after children

There has been a significant increase in the number of looked after children since 2015. The majority of wards in Hartlepool have seen an increase in the number of children taken into care. Victoria Ward has seen the largest increase (52%).

Children who return home from care are the largest single group of children who cease to be looked after. Research shows that careful assessment of needs, evidence of improvements in parenting capacity, slow and well managed return home and the provision of services to support children and their families after the return home were associated with a positive experience of reunification which lasted.

Foundation Stage: of those children who were looked after for at least 12 months, 20% achieved a 'Good Level of Development' by the end of the Foundation Stage compared with 68.4% of pupils in Hartlepool. This highlights that by the end of the Foundation Stage the attainment gap between children looked after and their peers is 48.4% and children looked after are required to make greater than average progress in order to narrow the gap.

Key Stage 4: of those children who were looked after for at least 12 months, 16.7% achieved 5+ A*-C including English and Maths compared with 47.6% for all Hartlepool pupils and 13.6% for looked after pupils nationally. It is encouraging to see that looked-after children do better at school than the national average, but there is still a big gap from those who are not in this high level of need.

Childhood vaccinations

Hartlepool's vaccination coverage rate for the measles, mumps and rubella (MMR) vaccine is below the 95% coverage target for both the first dose and the second dose.

This will affect the overall "herd" immunity of Hartlepool, making the vaccinations less effective as a means of controlling outbreaks of these illnesses. The coverage rate for the first dose, in the 2016/17 data, is 89.6%. This is below both the England average of 91.6% and the North-East regional average of 94.9%. Hartlepool's coverage rate is at a four year low.

For the second dose Hartlepool has a population coverage of 88.7%. This is higher than the England average of 87.6% but lower than the regional average of 92.4%. Hartlepool's coverage rate is down on the 2015/16 rate of 91.3%. Both the first dose and the second dose coverage rates for Hartlepool are the lowest in the North-East.

If we look at the rates within Hartlepool, neither show a big difference between the least deprived and the most deprived, with a swing of 1.3% for the first dose and 1.5% for the second dose.

The coverage rate for the combined whooping cough, diphtheria, tetanus, polio and Haemophilus influenzae type b has been consistently above the 95% mark for five years, giving Hartlepool a robust protection across its young population for these diseases. The current coverage of 95.8% is higher than the national average of 95.1%.

Vaccination rates for the human papillomavirus (HPV) vaccine (to protect against cervical cancer) have fallen year on year across the three available reporting periods, 2014/15 to 2016/17. Hartlepool had a population coverage of 93.6% in 2014/15. This has fallen year on year, and is now 85.0% in 2016/17. This has seen Hartlepool fall from having population coverage higher than the England and regional averages, to having coverage 2.2% lower than the England average and 4.8% lower than the regional average. This is a challenging trend for Hartlepool and our public health nursing services.

Infant mortality

Hartlepool's infant mortality rate (deaths under 1 year of age), is at its highest level for seven years. After peaking with an infant mortality rate of 7.1 per 1000 in 2006-08, Hartlepool had seen five years of general decline in its infant mortality rate, down to 2.7 per 1000. However since this point there has been a gradual increase year on year, up to 4.4 per 1000 in 2014-16.

The difference between the most deprived areas and the least deprived is stark. The most deprived tenth of our population has an infant mortality rate of 5.9 per 1000, which is more than twice the size of the least deprived tenth, which has a rate of 2.8 per 1000. Actual numbers are very small.

Stillbirths have fallen for the past four years.

Injuries

The five most common unintentional injuries leading to a hospital admission are falls, injuries caused by humans or animals, injuries from being hit, crushed or cut, burns and scalds, and poisoning. Hartlepool's emergency admission rate for falls is above that of both the North-East and England averages. Figures are better for burns and scalds: Hartlepool is considerably below both the England and North-East rates, at around 21 cases per 100,000 population.

Hartlepool's rate of accidental poisoning from medicines for under 4s has fallen from 193.0 to 145.2 per 100,000 population. This is now similar to the North-East average of 145.8, but still some way higher than the England average of 101.5. However the gap between Hartlepool and England is narrowing.

The numbers of children killed or seriously injured on the roads in Hartlepool has recovered back to its 2008-10 level of 21 per 100,000, after peaking at 34 in 2011/13. Hartlepool has remained statistically similar to the North-East for the entirety of the 7 year reporting period and has only been statistically worse than England once in this period.

Young people and substance misuse

The national drug treatment monitoring system (NDTMS) looks at the performance and level of need regarding substance misuse in England. The 2017/18 NDTMS figures for young people in Hartlepool show that numbers in treatment are down by 24% from 107 in 2016/17 to 81 in 2017/18. Successful completions of substance misuse treatment have increased from 65% to 85% in the same period. Young people’s substance use in Hartlepool is predominantly cannabis and alcohol, with 80% of young people in treatment citing cannabis and 46% citing alcohol. The next largest substance of use is cocaine which was used by 7% of young people. This is similar to the national picture, where alcohol is cited by 88% and cannabis by 47%.

Five per cent of Hartlepool’s children in treatment for substance misuse are under the age of 13 years old, which compared with two percent nationally. Those Hartlepool service users under 13 cited alcohol, cannabis and benzodiazepines as their substance of misuse. In keeping with national trends, drug and alcohol misuse is falling slightly and starting later.

Low-income families

When comparing Hartlepool with the region, Hartlepool has the second highest rate of under 16s in low income families in the North-East. Only Middlesbrough, which has the highest rate in the whole of England, is above Hartlepool in the regional comparators.

The approach to best start in life can be summarised in the words of a familiar song:

The Greatest Love Of All (Lyrics by Michael Masse and Linda Creed, sung by Whitney Houston)

"I believe that children are our future;
Teach them well and let them lead the way.
Show them all the beauty they possess inside;
Give them a sense of pride.
Let the children's laughter remind us how we used to be."

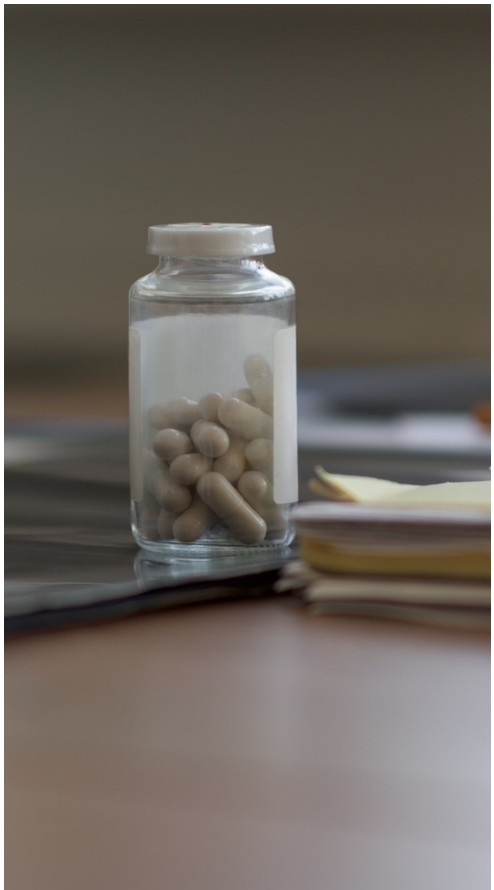
CHAPTER 3

A fresh look at Drugs and Alcohol Services

Background

Hartlepool has one of the highest death rates from drug misuse, and 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. The total cost to the local economy and caring services is around £6 million per year.

Nearly half of opiate users and high-level alcohol consumers drop out of treatment between assessment and the 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.



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. The contract with the latter is approaching time-expiration.

Hartlepool's Health and Wellbeing Board asked for a "needs assessment" to be conducted during 2018 and from that to produce this specification and engage in a dialogue with potential clinical providers to secure a new pattern of service. That assessment has been completed and a new service specification has been drawn up, for implementation during 2019.

Several needs were uncovered, of which some are summarised below.

A need to refresh the service outcomes:

- Reduce intoxication-related harm, and addiction-related harm such as: injuries, skin and vein infections, blood-borne viruses, smoking, sexual health, dental health, mental health, overdose and premature mortality.
- Reduce levels of use.
- Improve access to services.
- Reduce inequalities in use of services.
- Improve retention rates in therapy.
- Improve success rates.
- Reduce antisocial behaviours, crime and re-offending rates.
- Increase employment, volunteering and training rates ("something useful to do").
- Safeguarding of children and vulnerable adults in the household.
- Reduce incidence of domestic violence.

The need for a fresh approach to commissioning and contracting. Commissioning is a Council responsibility but will be conducted collaboratively with service users and providers. It was seen as helpful to regard this as "co-mission-ing" – an essentially collaborative endeavour based on common purpose. The lead commissioner will be supported by a governance board, chaired by the commissioner, with the main providers, partners and representatives of users as members.

The need for strong leadership. This will be a single service, under a single overall leader, trained and experienced in the role. It is envisaged that this leader will be a Council employee, accountable to the Director of Adults and Community Services. He or she will lead an in-house team focussing on key worker social support and psychological/behavioural support with the primary addictions. The service leader will oversee performance of the clinical services which will be brought in under a refreshed contract. The service leader will be a member of, and supported by, the Hartlepool Drug and Alcohol Harm Reduction Group, part of the Safer Hartlepool Partnership.

The need for flexibility, ambition and imagination. We want to promote a learning and evaluative culture, including willingness to adopt new models of care within the contract resource envelope – for example to explore the legal permissions and practicalities for prescribing and administering opiates in clinically supervised surroundings. It is recognised that as the evidence base, policy and practice evolve the Council, as commissioner, will need to have a sufficiently flexible agreement with its provider(s) to accommodate best practice within the resources available.

The need for much greater emphasis on prevention and early intervention – Hartlepool is embarking on becoming an "ACE-aware" town (Adverse Childhood Events) with attempts to prevent the "toxic trio" of drug and alcohol misuse, domestic violence, and mental ill-health through prevention of ACEs and to mitigate their adverse effects if they have arisen. This emphasis on prevention will include efforts to improve awareness and remove the stigma of addiction, and draw on the assets of recovered service users.

The need for whole-person care – we wish to see a "key worker" or small team providing continuity of care and building trust over the span of recovery from the first assessment through to discharge, starting with immediate needs of shelter, food and clothing, and moving on to medical, dental, sexual and mental health needs as well as addressing the addictive behaviours and prescribing. This includes "making every contact count" with respect to healthy lifestyle changes and finding service users "something useful to do." We wish to minimise the number of onward referrals to other services, preferring an in-reach of relevant services in a "one-stop-shop" model, with facilities to match.

The need for whole-household and family support – particular attention needs to given to safeguarding of children and vulnerable adults in the household, with closer ties to the Council's 0-19 public health nursing (currently provided in-house). For example, we would seek assurances that every service user's household in which there is a child under 16 receives a home visit by the public health nursing team, and that no-one is prescribed methadone to use at home if there is a child present. Greater connection with the Council's activity and creative offers, including outdoors, will be encouraged.

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. 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, with continuity of care throughout.
The need for clinical assessment and treatment with facilities and information technology fit for purpose.

Those individuals with coexisting mental health and addiction issues (dual diagnosis) have greater needs and this forms part of the assessment and response. Close working relationships with Mental Health Services are essential to address the needs of individuals presenting with a dual diagnosis. Our service model is for this to be provided on the same site (an in-reach mental health service) with joint sessions. We wish to discuss with potential providers how they would achieve this.

Harm minimisation will need to incorporate needle exchange, wound care, sexual health advice, blood-borne virus (BBV) and HIV management and dental health. 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 septicaemia (blood poisoning).

Aftercare packages should be embedded within the treatment plan which may include psychosocial support. Aftercare could be addressed by working alongside advocacy services in the community with strong links to a mutual aid group.

Residential detoxification and rehabilitation, as at present but preferably on a larger scale, would require a suitably home-like but clinically equipped rehabilitation facility.

Liaison with criminal justice - The service will seek to provide continuity of care if a client enters prison, leaves prison, and/or is under a court order or the probation service, and this is another role of the key worker. Such key workers will work with police and other partners with identified prolific and other priority offenders. At strategic level we are re-launching the Hartlepool Drugs and Alcohol Harm Reduction Partnership, with refreshed terms of reference and membership, under the auspices of the Safer Hartlepool Partnership. The Service Leader will participate in this group and the Drug Related Death (DRD) reviews, and actions which follow from them.

Assessing the need has been a major thrust of this year’s public health work.

CHAPTER 4

What do we mean by "prevention"?

Background

During my brief tenure as Interim Director of Public Health I have had the privilege of many conversations about “prevention.” Those conversations have included elected Council members, senior planners and commissioners in the Council and NHS, people who work in our services and people who use our services.

There has been considerable coverage of prevention issues in the local press, especially the Hartlepool Mail, and occasionally in the local broadcast media and national press. During the 2018 World Cup soccer competition we succeeded in persuading ASDA in all its stores nationally not to sell a T-shirt with the slogan “Win or lose, let's booze”, and this Christmas they have decided not to sell a novelty wine glass that holds a full bottle of wine. These are welcome trends.

So, what do we mean by “prevention”? To those with a health service responsibility, prevention usually means the avoidance of disease such as diabetes, cancer or stroke.

“Primary prevention” means stopping the disease in the first place and includes public health measures like healthy eating, physical activity, avoidance of smoking and drinking alcohol sensibly.

“Secondary prevention” means catching diseases early, often before symptoms appear, for example through breast, bowel and cervical cancer screening.

“Tertiary prevention” applies once a disease is established but helps prevent relapses or further damage, such as rehabilitation after a stroke.

That is the disease model of prevention. By analogy it can apply to conditions such as joblessness, domestic violence or poor educational attainment. Other aspects of prevention are “personal responsibility”, “independent living” and “resilience to adversity.” These have featured in conversations too. There is no “one size fit all”, but are we being assertive enough? An area I have found controversial in conversations with caring professionals is the degree to which should we encourage and support individuals to exert greater control and responsibility over their own wellbeing. (Parents recognise this with their children as “tough love”).

Is it better to offer a hand-out or a hand-up? How do we avoid the unintended consequence of promoting dependency, while at the same time not pushing too much responsibility too soon? The objectives are to obtain a sustained improvement in personal wellbeing, greater resilience and reduced demands on the caring agencies.

The reality is that both the Council and the NHS are swamped with demands which are rising and unaffordable, yet so much of that demand is driven by remediable causes which people themselves can address if they have the right help and incentives. The key to unlocking the dilemma is prevention. But how?

The New Economics Forum in Manchester has promulgated “Five ways to wellbeing” (see box). These are gaining momentum in local authorities and the NHS and now frequently appear in policy documents. By finding activities that cover all five “ways”, it is possible to produce sustained improvement in personal health and wellbeing and reduced calls on caring services. I would suggest adding a sixth way, which is “be creative” because there is a strong evidence base for the role of the arts in personal and community development. All these ways to wellbeing can address primary, secondary and tertiary prevention discussed above.

How can we afford to invest in "prevention" in a climate of austerity?

Money is not the only resource, and statutory agencies are not the only providers. If traditional sources of capital and revenue are running low, we should draw more explicitly on social capital and revenue – for example through volunteers, charities, and benefactors. And we should not just look at the “inputs” side of the equation – the money, staff, buildings, time, expertise, commitment and so on, but also the outcomes – improved health, wellbeing, independence and reduced inequalities. Rather than refer to “costs” and “cuts” we should refer to “investment” and “disinvestment” because that language prompts us to reflect on the returns we should expect.

The five ways to wellbeing

Be active: get out and about – even standing and walking are better than sitting
Take notice: be mindful of your surroundings, pause to take an interest in the wider world, take a break from your own troubles
Learn: keep your brain active by exploring new knowledge and taking up new interests
Connect: stay in touch with family and friends and make new friends – loneliness can seriously impair quality and length of life
Contribute: it is a boost to self-esteem and self-worth to know you are making a difference and doing something useful, perhaps for the environment or for another person
(And the sixth “way” for Hartlepool – be creative: find new ways to express yourself and fulfil your potential, for example through painting, writing, music, dance, photography or gardening**.)**

Allied to this idea of social capital is the concept of “social prescribing” – referring people who could benefit from a change in lifestyle in ways which are engaging and sustainable – instead of relying solely on a medical model of pills and clinical interventions. This notion has progressed well beyond a promising idea; it is now a well-studied and evaluated evidenced-based option.

Many of the social prescribing models involve volunteers or volunteering in some capacity and can be considerably cheaper (and more cost-effective) than clinical alternatives. The Council has a role, for example through neighbourhood regeneration, allotments, physical activity, arts, and outdoor green spaces, to greatly increase the social prescribing offer. A social prescription should be the first option, in suitable individuals, before referral to more expensive and more risky pills and hospital visits in many common presentations, such as mild depression, early type two diabetes, high blood pressure and raised cholesterol. If we go down this route we need to keep evaluation in place to track outcomes and value.

If we, across all partners in health and wellbeing, are to shift the focus of our attention from reactive care to proactive prevention we need a sea-change in incentives, investment and how we view success. We should not look at individuals and populations in terms of their needs alone but also in terms of their abilities. For years, reports like this have looked at inequalities in health and the strong association with material deprivation. But benefits and services which address material poverty alone will not reduce inequality: we need to address poverty of opportunity, poverty of aspiration, poverty of good role models and poverty of hope.

Myth-busting

Perhaps the reason that we are not further ahead with prevention is that we don’t really believe in it? Here are some common myths, and how to bust them.

“Prevention takes years to have effect, yet alone release savings.” Not true. Take quitting smoking for example. Within a day there is a measurable fall in exhaled carbon monoxide – which means the blood (and an unborn baby for a pregnant mother) is getting an immediate benefit.

Within a week the pulse is measurably slower – which means the heart is under less strain. Within a month there is a measurable fall in blood pressure and the risk of stroke and kidney disease is falling. And within a year there is a measurable decrease in visits to the doctor or hospital with exacerbations of chronic bronchitis and heart disease. There are long term benefits too, which are a bonus to the ex-smokers and the caring services as well.

“If one organisation invests, another reaps the rewards”. This is true to an extent. The argument goes: “Why should the Council invest in health promotion if the NHS reaps the financial reward?” But there are usually swings and roundabouts, where each organisation helps the other when it addresses prevention, and joined-up strategies for investment in prevention should promote collaboration and working at sufficiently large scale.

“Prevention of one condition such as heart disease just stores up problems from another like dementia later.” Not true. The thrust of prevention is to prolong healthy active life. Most lifestyle interventions reduce risks for a wide range of physical and mental conditions.

“Prevention is nannying and individuals should make their own life choices.” The part about individual choice is true, but proper prevention increases personal autonomy by providing information and healthier choices. And sometimes we do have to be nannied, for example the lives saved from seat belt legislation, food safety standards enforcement, and banning smoking in public places.

A good example of local prevention in action is the EPEC project covered in chapter 2: addressing the root causes of poor health, poor life chances and unjustifiable inequalities by helping individuals help themselves and their neighbours.

It is encouraging to see the emphasis that the NHS sustainable transformation plan (now evolving into integrated care systems and integrated care partnerships) is placing on the issue of prevention, and we look forward to the fully costed version of the local integrated partnership and the quantification of investment in prevention.

It is also encouraging to see reports such as that by the Royal College of Physicians into smoking cessation (“Hiding in plain sight: treating tobacco dependency in the NHS, June 2018, which alerts its own members to their responsibilities. It includes this recommendation on page 227: “It is therefore in the specific specialty interests of all clinicians, as well as the health interests of their patients, to ascertain and treat tobacco dependence. There is no justification for failing to do so. A rational approach for England would be to move responsibility for smoking interventions back into the NHS.”

CHAPTER 5

Stewardship of the Public Health Grant

In 2012 the Health and Social Care Act brought the public health function, team and budget out of the NHS and into local authorities. Implementation began in 2013. The grant for public health was “ring-fenced” and local authorities must account each year for how it is deployed.

There is considerable freedom, within the ring-fence, to define what is and is not public health, though certain areas are described in the legislation and must be covered to some degree.

“Public health is the science and art of prolonging life, promoting health and preventing disease, through organised efforts of society” (Sir Donald Acheson, former Chief Medical Officer for England)

“Science reassures: art disturbs” (Georges Braque, artist)

Over time in Hartlepool the public health staff and their budget have been increasingly embedded in other directorates. It can be argued that everything a Council does is related in some way to health and wellbeing so there is justification for this approach so long as governance of standards and outcomes is maintained.

In order to keep track of the public health grant, the staff employed from it, the activities generated by it, and its outcomes achieved, a set of “service level agreements” has been agreed between the director of public health and each of the other directors or assistant directors who manage the budget. For information, these are summarised in the table on the next page.

The balance of the public health grant = £347,278. It was spent on the core public health offer: the Director and Deputy Director of Public Health, two senior public health practitioners and a data analyst, plus their associated costs for their direct public health activities.

Where did the public health grant go in 2017/18?

DIRECTORATE/ DIVISION	PROGRAMME/PURPOSE	BUDGET (£)
Children and families (52 funded staff over all programmes)	Health visiting & school nursing	1,566,000
	Early intervention	950,000
	Children's centres	650,000
	Family poverty initiatives	250,000
	Intensive response team	150,000
	Other staff costs (eg training)	22,000
	Non-recurring reserves	516,000
	TOTAL	4,104,331
Joint commissioning (3 funded staff over all programmes)	Substance misuse contracts - clinical & prescribing	1,279,782
	Sexual health contract	622,282
	Health checks	58,000
	Healthy start vitamins	10,000
	TOTAL	1,970,064
Adults and community (37 funded staff over all programmes)	In-house drugs & alcohol services	981,980
	Sports and recreation	277,785
	Community Hubs	144,355
	Mental health	150,000
	Older people	94,000
	Falls service	90,000
	Health promotion resource library	27,762
	Non-recurring reserves	171,286
	TOTAL	2,066,168
Neighbourhoods & Regeneration (All funds from reserves - N.R)	Public protection & admin support	77,259
	Allotments	50,000
	Consumer services	16,900
	TOTAL	144,159
Finance & Policy	Finance & audit	40,500
	Human resources	29,000
	Strategy	23,000
	Communications & marketing	20,000
	Information technology	12,000
	Legal services	7,000
	Non-recurring from reserves	22,000
	TOTAL	132,000
TOTAL CONTRIBUTION OF PUBLIC HEALTH GRANT TO OTHER DIRCTORATES		**8,416,722**

Given the dispersed nature of the public health workforce and new lines of managerial accountability, the directorate of public health has introduced monthly lunchtime seminars on topics of public health interest to allow staff from any background to become familiar and stay up to date with public health practice. The first three topics were health promotion, health economics and screening for diseases, respectively.

Public health outcomes (including inequalities) are scrutinised by the Audit and Governance Committee with respect to the Council's objectives, and by the Health and Wellbeing Board with respect to partnership objectives. Chapter 1 of this report covered some of these outcomes. Both meetings are held in public and attracted constructive coverage in the local press.

Through that medium some important messages and discussion points reached a wider local audience. Topics covered by the Hartlepool Mail this year, for example, following meetings of these two bodies, include: teenage pregnancy; "five a day" fruit and vegetables; breast feeding; gaps in life expectancy; sensible drinking; drugs and childhood obesity. That coverage illustrates the breadth of the challenge but also the degree of public interest and engagement.

Coping with cuts

In 2018/19 we are expecting a cut in our grant from Public Health England of £228,000. In discussion with the Corporate Management Team, and then following approval from the Finance and Policy Committee, the approach to disinvestment was as follows.

We looked at the five main areas of public health activity: public health nursing (0-19 years old); drugs and alcohol services; healthy weight and healthy lives activities; sexual health services and smoking cessation services. Rather than take a proportionate reduction from all of them, irrespective of value to our corporate objectives and return on investment, we decided to identify the programme with least value and take the cut from that.

In order to assess the contribution of these public health programmes to our corporate objectives, we came up with 11 criteria by which to assess the programmes. Since not every criterion carried equal weight, we allocated a weighting score (adding up to 100) for each. Those criteria, and the weightings we gave them, are listed as follows.

Weighted criteria for prioritising disinvestment (or new investment) in public health programmes

CRITERIA	WEIGHTING (ADDS UP TO 100)
Benefit is felt by many people rather than a few	15
Benefit is large and lasts a long time	15
It helps reduce inequalities in health or wellbeing	15
It empowers people/communities to sustain health & wellbeing, for example education, skills, job opportunities	10
It improves efficient use of resources, including "invest to save"	10
It reduces demand on other Council services	10
It reduces demand on other partners (eg NHS)	5
There is an alternative if the Council no longer provides	5
It has public support and protects the Council's reputation	5
It does not damage the environment or sustainability	5
The evidence for the criteria above is strong	5

Having applied these criteria to the public health programmes, one service emerged with a clearly lower score and discussions are in hand with that contracted provider to achieve the necessary level of savings.

Tough choices on funding priorities are an inevitable part of budget management, and particularly stark during periods of austerity. On the positive side, we believe we are deploying the resources we do have as efficiently and transparently as possible, and we are looking just as hard at outcomes as we are at inputs.

Summary: the pursuit of efficiency

The pursuit of efficiency is an ethical imperative for all who work in publicly funded services because at the end of the day it is the public who pay for any efficiency and the currency in which they pay is not just their taxes but in missed life chances, avoidable inequalities, needless distress and even dying before their time.

CHAPTER 6

Concluding challenges: austerity, inequality and empowerment.

Austerity

Austerity is both a challenge and an opportunity.

Are the public sector cuts leading to hardship and detriment to health and wellbeing? Yes.
If we had more resources could we use them to improve health and wellbeing? Undoubtedly.
Are we using every bit of resource currently to its best advantage? Probably not. Therein lies a challenge that we can do something about.

As regards the public health function, austerity drives us to look more closely at value for money and creative thinking about new ways of working – often in partnerships – to deliver the desired outcomes within the resources entrusted to us. In some service areas we know the costs but not the value. We are becoming expert in doing things right ("technical efficiency") but are we doing the right things ("allocative efficiency".)

When we have to take money out of programmes (or in rare instances increase investment in programmes) we need to be explicit with ourselves and others about how those choices are made.

To make our decisions more open, inclusive and robust, we need to draw on disciplines such as epidemiology (the nature and scale of the problems), effectiveness (scrutinising the evidence base), economics (relating inputs to outcomes), evaluation (checking that stated objectives are being met) and ethics (being clear about value judgements).

Hartlepool Borough Council might want to take stock of this skill set and maybe fill any gaps by partnership with the education sector and universities. Other partners in health and wellbeing might want to share the cost since they face the same needs.

At the very least it would be constructive if Hartlepool Borough Council had an agreed list of criteria, perhaps similar to those listed in chapter 5, by which officers could prepare decisions for public scrutiny.

Inequality

This report draws attention to many areas of inequality – some getting wider – where evidence from other boroughs with similar population profiles and affluence appear to be getting better results. Reducing these avoidable gaps is, and must continue to be, a priority objective for all Hartlepool Council programmes, with even greater scrutiny of the "inequalities" section in papers that come to committees.
We will never eliminate inequalities because every individual has a unique genetic endowment and life experience (for example we never have every baby born at the same weight, everybody experiencing the same diseases and accidents, everybody choosing the same occupation and earning exactly the same wage, and everybody dying at exactly the same age, and so on). But we can reduce unfair and avoidable inequalities.
Some of the current inequalities mapped out in this report are in relation to material deprivation, and the correlations are very strong. This does not mean that money alone is the cause or the solution. Just as important as inequality in material wealth are inequalities in opportunity, inequalities in aspiration, inequalities in positive role models, inequalities in hope, and so on. These are areas that we certainly can address, without waiting for new money to materialise.

Empowerment

Hartlepool's greatest resource is its people. Without waiting for the economic upturn we can get on with recognising and developing individuals and community assets. For the local NHS in general, especially but not exclusively general practitioners and pharmacists, there could be a greater emphasis on empowering patients to take greater control over lifestyle choices, to making a "social prescription" the first offer more often, and thereby freeing the hospitals to do what only they can do and do best. Part of the Council's task, including all those programmes funded by the public health grant, should support a wider social prescription offer and make healthier choices easier choices.

Helping all Hartlepool's children away from adverse childhood events, and its older citizens to adopt the five "ways to wellbeing" suggested in chapter 4, (or six, if we include creativity) would be very significant steps towards a healthier Hartlepool, with fewer inequalities, and release resources for those who need it most and cannot help themselves.

"It is better to light a candle than curse the darkness"

(Anonymous proverb)

HARTLEPOOL BOROUGH COUNCIL

If you wish to comment on this report, or ask questions arising from it, please contact:

Dr Patricia Riordan
Director of Public Health (from 1 February 2019)
pat.riordan@hartlepool.gov.uk

AUDIT AND GOVERNANCE COMMITTEE

17 JANUARY 2019

Report of: Chief Solicitor

Subject: REGULATION OF INVESTIGATORY POWERS ACT 2000 (RIPA) QUARTERLY UPDATE

---

1. PURPOSE OF REPORT

1.1 To provide members with a quarterly update on activities relating to surveillance by the Council and policies under the Regulation of Investigatory Powers Act 2011.

2. BACKGROUND

2.1 Hartlepool Borough Council has powers under the Regulation of Investigatory Powers Act 2000 (RIPA) to conduct authorised covert surveillance.

2.2 This report is submitted to members as a result of the requirement to report to members under paragraph 4.47 of the Covert Surveillance and Property Interference Revised Code of Practice (August 2018) which states that:

Elected members of a local authority should review the authority's use of the 1997 Act and the 2000 Act and set the policy at least once a year. They should also consider internal reports on use of the 1997 Act and the 2000 Act on a regular basis to ensure that it is being used consistently with the local authority's policy and that the policy remains fit for purpose.

Members were previously updated via performance and risks reports submitted quarterly to Finance and Policy Committee. However following a review of the Council's arrangements it was considered more appropriate for use of RIPA provisions to be reported to this Committee.

3. RIPA AUTHORISATIONS

3.1 In the quarter to 31 December 2018:

Communications Data	Nil
CHIS	Nil
Directed Surveillance	Nil

4. RECOMMENDATION

4.1 That the quarterly report be noted.

5. REASONS FOR RECOMMENDATIONS

5.1 To enable the Council to monitor the RIPA system effectively and as required by law and guidance.

6. CONTACT OFFICER

6.1 Hayley Martin
Chief Solicitor and Senior Responsible Officer for RIPA
Hayley.martin@hartlepool.gov.uk
01429 523003

HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

14 SEPTEMBER 2018

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

Present:

Karen Hawkins – Representative of Hartlepool and Stockton-on-Tees Clinical Commissioning Group (In the Chair);

Prescribed Members:
Elected Members, Hartlepool Borough Council (HBC) – Councillors Buchan.
Interim Director of Public Health, HBC – Dr Peter Brambleby
Director of Children's and Joint Commissioning Services, HBC – Sally Robinson
Director of Adult and Community Based Services, HBC, Jill Harrison
Representatives of Healthwatch – Margaret Wrenn and Ruby Marshall

Other Members:

Representative of Cleveland Police - Jason Harwin
Representative of Tees, Esk and Wear Valley NHS Trust – Dominic Gardner
Representatives of North Tees and Hartlepool NHS Trust – Julie Parkes
Representative of Hartlepool Voluntary and Community Sector – Tracy Woodhall

Also in attendance:-

Councillor McLaughlin as substitute for Councillor Thomas.
Hilton Heslop, North Tees and Hartlepool NHS Trust
Stephen Thomas and Judy Gray, Hartlepool Healthwatch
Wendy Harrison, Hartlepool Deaf Centre
Christine Fewster and Simon Piercey, Hartlepool Carers
Bill Keen, Fifty+ Forum

Officers: David Cosgrove, Democratic Services Team

10. Apologies for Absence

Councillor C Akers-Belcher, Leader of Council;
Councillors Brenda Harrison and Stephen Thomas;
Councillor Brenda Loynes, Audit and Governance Committee observer;
Dr Nick Timlin and Ali Wilson, Hartlepool and Stockton-on-Tees Clinical Commissioning Group;
Gill Alexander, HBC Chief Executive;
Denise Ogden, HBC Director of Regeneration and Neighbourhoods;

Fiona Adamson, GP Federation;
Julie Gillon and Deepak Dwarakanath, North Tees and Hartlepool NHS Trust.

11. Declarations of interest by Members

None.

12. Minutes

With reference to Minute 3, Minutes of the meeting held on 5 March 2018, the representative of the Tees, Esk and Wear Valley NHS Trust corrected the record in that the referral rates were higher across the whole Hartlepool and Stockton on Tees CCG area, with rates in Stockton slightly higher that Hartlepool.

(i) Subject to the comments above, the minutes of the meeting held on 25 June 2018 were confirmed.
(ii) The minutes of the meeting of the Children's Strategic Partnership held on 21 March 2018 were received.

13. 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*)

Representative from Hartlepool Healthwatch and the Hartlepool Deaf Centre gave a presentation to the Board updating members on the progress made in the implementation of recommendations from the May 2017 report on Deaf Patient Experience of Local GP and Hospital Services.

The presentation outlined the training that had taken place at North Tees Hospital, Hartlepool and Stockton on Tees CCG and GP surgeries. Sensory loss resource boxes had been given following training to Sensory Loss Champions on NT hospital wards. The use of SMS text services for communication between GP surgeries and deaf patients was being examined and GP surgeries were being encouraged to include visual indicators in waiting rooms.

Deaf Awareness training was being extended into Job Centre Plus and GP surgeries. A deaf patient experience report for primary care was to be undertaken with revisits to GP surgeries, pharmacies, opticians and dental practices. Use of the TrakCare Symbol and confirmation of the availability of interpreters in appointment letters was also being explored with the North Tees and Hartlepool NHS Trust.

It was highlighted that Junior Doctors had specific training time protected within their working hours and it may be useful to look to extend the deaf awareness training to them.

The use of mobile phone apps was questioned as a means of helping deaf patients and GPs, in particular, communicate clearly. The Hartlepool Deaf Centre representative indicated that there were a number of such apps available, though some did often have quite high recurring fees associated with them and doctors were reluctant to use them. Communication on medical issues could be difficult even with trained deaf interpreters.

The representative from the North Tees and Hartlepool Trust commented that the Trust would look to providing additional support for deaf patients and key workers through the use of a text service for the integrated support service and also the potential use of System 1 to link into primary care staff.

Decision

1. That the progress update be noted.
2. That a further progress report be submitted to the Board in twelve months time.

14. HealthWatch Hartlepool and Hartlepool Carers Joint Health Care Experience Consultation (*Healthwatch Hartlepool*)

The Healthwatch representative updated Board Members on the outcomes of the recent Health focused consultation events undertaken by Healthwatch Hartlepool and Hartlepool Carers with carers in Hartlepool. A copy of the Healthwatch report was submitted for Members information.

The Healthwatch representative indicated that initial discussions gave rise to themes centred on Personal Health Budgets and Continuing Health Care. It was considered that carers were experiencing increasing difficulties, and often, inconsistent application by health professionals when applying for funding from both sources. It was agreed that a series of focus groups would be held, to which carers would be invited with the initial area of discussion at the meetings focussing on experiences of applying for Personal Budgets and Continuing Health Care.

One of the main issues highlighted through the focus groups was the speed of the processes with many finding difficulties in navigating their way through the application process to the extent that they gave up citing the reason that they simply did not see it was worth their while to complete because it took so long. It was also clear that many professionals didn't fully understand the process as well which simply compounded the disappointment most carers felt with the process as a whole. Those that had completed the application process and were in receipt of a personal health budget were also critical that once within the system they became aware very quickly that the whole process was financially driven; budgets only seemed to go down in years two and three.

One area of significant concern which was raised by quite a number of carers

in different forums was the continence service. The service simply appeared to be failing many patients, particularly the young. The products available were often not suitable and didn't provide any dignity particularly for the elderly living with dementia. It was understood that patients in the Stockton area were also reporting similar issues through Stockton Healthwatch.

Other areas highlighted through the focus groups were the removal of the link post between Hartlepool Carers and the GP surgeries which was already creating issues. Most surgeries required patients needing appointments that day to call first thing on a morning exactly at the time of day most carers were extremely busy. The wheelchair service was also criticised for its one size fits all approach, when clearly it didn't. The mental health of carers was highlighted as an issue across all sectors with many feeling they did not get the support they needed from health professionals. The Hartlepool Carers Group, however, was praised for its support. The well known issues around accessing CAMHS were also discussed.

The recommendations from the focus groups were set out in the submitted report and briefly outlined in the meeting.

The Vice-Chair of the Hartlepool Carers group was present at the meeting and outlined his personal experiences of the continence service in caring for his elderly father. The inadequate supplies and the poor quality of many products were leading his family to spend around £500 in six months on additional and better products. The dignity of patients should outweigh costs and better products would result in fewer complaints. Service users were also critical of the poor support given with many reporting no contact after the initial assessment to see how people were coping.

The North Tees and Hartlepool NHS Trust representative commented that feedback on the wheelchair service was usually very positive, so the comments outlined in the report did need to be examined further. It was clarified further that the referral and assessment processes with the wheelchair service were not the issue but the equipment provided was.

In terms of the incontinence service, the Trust representative conceded that the landscape of patient need had changed so it may be necessary to recognise that the service also had to change. Engagement with carers and service users would be needed.

The representative of Tees, Esk and Wear Valley NHS Trust indicated that some of the comments in the report were challenging and it was acknowledged that there were issues in the children's and families services due to the high referral rates. The Trust would welcome future working with Hartlepool Carers as while internal feedback was somewhat better, the service did need to improve.

The Chair thanked the presenters for their input into the meeting and acknowledged that some important points had been raised through the report which would need a multi-disciplinary approach to resolve. Ongoing

developments in e-consultation could potentially help with access to GPs and it was to be hoped the same conversations were not being had in twelve months time.

Decision

1. That the report from Healthwatch Hartlepool and Hartlepool Carers be noted and the recommendations within agreed.
2. That a progress report be submitted to the Board in twelve months time.

15. Drug and Alcohol Service Needs Assessment and Next Steps for Service Delivery (*Interim Director of Public Health*)

The Interim Director of Public Health submitted the Drug and Alcohol needs assessment and an outline of the next steps for the delivery of the service which was due for re-procurement. The needs assessment showed that a much greater focus needed to be placed on the users of the service; these were people who were essentially the experts in drug and alcohol services and many had a strong desire to give something back after they had been helped on the road to recovery.

The Interim Director saw the aim of the service shifting towards recovery rather than simply harm reduction. With such an approach there would be a need for services to 'wrap around' the individual. At present many workers in the system found themselves restricted by the contract rather than being free to support people through recovery.

In terms of the re-commissioning of the service, there was the potential to extend the current contract for a year should the work on a new service be incomplete. The service could potentially be brought in-house if that was seen as the way forward or re-commissioned in a way that fit the purposes needed in providing refocused support to recovery programmes. The Interim Director indicated that one change that had to happen was that the new contract must not be so inflexible as to bow people into only one way of doing things.

The Interim Director sought feedback from all the partners represented on the Board over the following two weeks before a finalised proposal was included on the JSNA website.

The Police representative stated that 'they' would like a bigger conversation on drug and alcohol problems as the Police did feel many of the drug and alcohol issues they were faced with were public health problems and not criminality that required Police action. Heroin and Cocaine use here was the highest in the country and that had to be addressed. The Home Office were already looking into this. There still needed to be a realistic review of the drugs problem in particular as the political view was still centred on enforcement.

It was also highlighted to the meeting that the Harm Reduction Group under the Safer Hartlepool Partnership was to be re-launched.

Decision

1. That the Health and Wellbeing Board notes the first draft of the needs assessment for the drug and alcohol service and that any feedback / comments on the content and next steps be submitted to the Interim Director of Public Health within two weeks of this meeting.
2. That the re-procurement of the Drug and Alcohol Service be referred to the Finance and Policy Committee.

16. Sustainability and Transformation Partnership / Integrated Care Systems Update (*Hartlepool and Stockton-on-Tees CCG*)

The Chair indicated that a communications pack providing information on the emerging health picture across the North East and North Cumbria was submitted for Board Members information.

Decision

That the Communications Pack be noted.

17. Update on Healthy Weight Strategy (*Interim Director of Public Health*)

The Interim Director of Public Health provided the Board with an update report on the progress of the Healthy Weight Strategy. The report outlined key local progress together with the key future strategic direction being set by national government. The Interim Director highlighted that in April 2018 Hartlepool Borough Council had been awarded a £280,620 grant by Sport England to deliver a four-year project working on bringing families closer together through sport and physical activity.

Decision

1. That the Board note the progress to date in implementing the strategy and approves the future strategic direction in line with the national approaches.
2. That an annual performance and monitoring framework for the strategy be developed with key priorities and indicators to ensure engagement and accountability among partners.

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

The Interim Director of Public Health provided the Board with an update report on the progress of the implementation of the Joint Health and Wellbeing Board with specific reference to the two deep dive areas of the JSNA, Reducing Drug and Alcohol Harm and Improving Mental Health and Wellbeing. Reducing drug and alcohol harm had been discussed earlier on the agenda. In terms of mental health and wellbeing, the Interim Director commented that most work centred around improving the mental health and resilience of young people and reducing the levels of loneliness in older people. There were also a number of key officer positions that still needed to be filled.

Decision

1. Reducing Drug and Alcohol Harm:-
   (i) That the proposals for future service delivery, considered earlier in the agenda be noted.
   (ii) That nominations be sought for the two remaining lead officer positions to progress the outcome and output measures though the agreed lead committees.
2. Mental Health and Wellbeing:-
   (i) The actions identified (in Table 2 of the report) be approved.
   (ii) That nominations be requested for lead officer(s) for the appropriate lead committees and bodies, and that partner representatives to progress the actions reported.

19. Audit and Governance Committee Work Programme 2018/19 – Investigation in to the Provision of Preventative Mental Health Services in Hartlepool

(*Statutory Scrutiny Officer*)

The Interim Director of Public Health informed the Board that the Audit and Governance Committee had selected the topic of the Provision of Preventative Mental Health Services in Hartlepool for investigation during 2018/19.

Decision

That the report be noted.

20. Departmental Restructure (*Director of Children's and Joint Commissioning Services*)

The Director of Children's and Joint Commissioning Services informed the Board of a departmental restructure of the Council's Children's and Joint Commissioning Services. The Director also requested that the Assistant Director of Joint Commissioning, Danielle Swainston, be invited to join the Board as a non-prescribed member and also act as the nominated substitute for both the Director of Children's and Joint Commissioning Services and the Director of Adults and Community Based Services.

Decision

1. That the restructure of Children's and Joint Commissioning Services be noted.
2. That the Assistant Director of Joint Commissioning be invited to join the Board as a non-prescribed member.

21. Better Care Fund 2018/19: Q1 Performance Update (*Director of Adults and Community Based Services*)

The Director of Adults and Community Based Services updated the Board on the quarter 1 performance against the indicators in the Hartlepool Better Care Fund Plan.

Decision

That the Board approve, retrospectively, the Better Care Fund Quarter 1 return and notes the current position in relation to performance.

22. Presentation - CCG Annual Report (*Hartlepool and Stockton-on-Tees CCG*)

The Chair (representative from Hartlepool and Stockton Clinical Commissioning Group) gave an overview of a presentation made to the CCGs Annual General Meeting. The presentation outlined the CCGs vision and principles, key aims and challenges and its four key ambitions. The presentation went on to outline the CCGs performance, governance and utilisation of resources and finally set out the key priorities for 2018/19.

The Chair highlighted that there were some key achievements that warranted recognition, such as the 'Outstanding' rating given to the CCG following its inspection, the Urgent Care Centre at the Hospital which was being recognised across the country as a successful model, the implementation of the national diabetes prevention programme and access to GP appointments seven days a week.

Decision

That the CCG Annual Report be noted.

23. 38 Degrees – Petition to the Secretary of State for the Reopening of University Hospital of Hartlepool A&E

(*Statutory Scrutiny Officer*)

The Board was informed that a copy of a petition sent to the Secretary of State for Health and Social Care, calling for the re-opening of Hartlepool A&E Unit, had been received by the Leader of the Council on 1 August 2018. The petition had been signed by 7,145 people and stated: -

"There are 34 A&Es around the country currently threatened with closure or downgrading, or have already been closed. As shown in Newark, this will put people's lives at risk. We are calling on you to order a moratorium on 34 pending A&E closures and downgrades until a nationwide study has been completed. Furthermore, our chief wish in relation to Hartlepool A&E is to see it re-opened, given that its closure in 2011 occurred despite protests."

As the petition was addressed to the Secretary of State, the Health and Wellbeing Board was asked to note its content.

Decision

That the petition sent to the Secretary of State, as reported, be noted.

24. Any Other Items which the Chairman Considers are Urgent

The Healthwatch representatives referred to the recent changes to the Podiatry Service which had raised a number of concerns among patients who were being removed from the patient list. The Chair commented that a number of patients had been reviewed as not needing medical intervention and those patients had been discharged. A communication had been issued which the Chair undertook to re-send to Healthwatch.

A member of the public referred to the consistency and audit trail of information sharing between NHS services, GPs and their patients. The Chair commented that the operational strategy was monitored through this Board with work with clinicians and providers to ensure services were fit for purpose.

The Board noted that the next meeting would be held on Friday 10 December 2018 at 10.00 a.m. in the Civic Centre, Hartlepool.

Meeting concluded at 11.40 am.

CHAIR

FINANCE AND POLICY COMMITTEE

MINUTES AND DECISION RECORD

26 November 2018

EXTRACT

63. Savings Programme 2019/20 (*Director of Children's and Joint Commissioning Services and Interim Director of Public Health*)

Type of decision

Budget and Policy Framework.

Purpose of report

The purpose of the report was to enable Members to consider proposals to achieve further savings in 2019/20.

Issue(s) for consideration

The Interim Director of Public Health reported that the financial strategy for 2019/20 will be underpinned by identifying new savings which could be implemented in 2019/20 and detailed proposals for the Public Health Grant budget were set out in the report. The Interim Director stated that in order to achieve the required savings a detailed assessment of all service areas funded by the grant had been undertaken. The five main service areas were:

- early years nursing;
- drugs and alcohol;
- healthy weight and healthy lives;
- sexual health
- smoking cessation.

A standard options appraisal approach was used to evaluate each service against weighted criteria. Rather than curtail all areas slightly and render them less efficient and effective, it was proposed that all the cuts fall on the lowest priority service (as set out in Confidential Appendix A to the report) thereby protecting those at higher priority. The appendix contained exempt information under Schedule 12A of the Local Government Act 1972 (as amended by the Local Government), (Access to Information), (Variations Order 2006) namely, information relating to any individual (Para 3)). Attention had been paid to trends in health need and uptake of services, focussing on areas of falling demand and least value for money.

The Interim Director also reported that Hartlepool, along with all other Tees Valley local authorities made annual contributions to Fresh North East (the regional dedicated tobacco control programme) and Balance North East (the regional dedicated alcohol information and support group) totalling £55,000. A decision had been made in 2017 by all Tees Valley Authorities to cease these contributions from 1 April 2019 on the basis that the lobbying and press relations that Fresh and Balance offered were poorer value for money than other priorities, and also not closely aligned to local authorities core business.

The savings generated an additional £187,000 more than the grant reduction of £228,000. The savings would also protect the other four main service areas provided through the Public Health Grant. However, in recognition of the wider financial pressures faced by the Council and the significant budget deficit it was proposed that this additional funding was used by the MTFS to support the changes in children's health and early help services, which would help deliver better public health outcomes. As detailed in the Confidential Appendix, only £130,000 of additional funding would be available in 2019/20 to support the MTFS, with the balance being made available in 2020/21.

Decision

That the recommendations set out within the confidential appendix to the report be approved and that this is reflected in the budget proposals to be referred to full Council.

Tees Valley Joint Health Scrutiny Committee

A meeting of Tees Valley Joint Health Scrutiny Committee was held on Thursday, 13th September, 2018.

Present: Cllr Grainge, Hall, Weston (Sub for Cllr Cunningham), Cllr Newall, Cllr Taylor, Cllr Jeffrey, Cllr Tennant

Officers: Peter Mennear, Michael Henderson (SBC), Caroline Breheny (MBC), Laura Stones (HBC)
Also in attendance: Karen Hawkins, Jo Heaney, Graeme Niven (HaST CCG), Alex Sinclair, Julie Bailey (South Tees CCG).

Apologies:

1 Evacuation Procedure, Audio Recording and Housekeeping

Members noted the Evacuation Procedures for the meeting room.

2 Declarations of Interest

Cllr Lisa Grainge declared a personal non prejudicial interest in the minutes of the previous meeting of the Joint Committee as they referenced, Roseberry Park and she was a Regional Union Official, representing staff from TEWV.

3 Minutes of the meeting held on 18th June 2018

The minutes of the meeting held on 18 June 2018 were confirmed as a correct record.

Members were provided with a brief update on the work of the Joint Committee's Task and Finish Group which was undertaking a review of the impact of building defects, at Roseberry Park Mental Health Hospital, on patients, carers and staff. Further updates would be provided as the Task and Finish Group's work progressed.

4 Appointment of Vice Chair for 2018 - 2019

Nomination to come from Hartlepool Borough

Council

RESOLVED that Councillor John Tennant be appointed vice chair for 2018 - 2019.

5 Recommissioning of Improving Access to Psychological Therapies (IAPT) Services

The Joint Committee was provided with an update in relation to the re- commissioning of Improving Access to Psychological Therapies (IAPT) Services.

A review of services had been undertaken and a proposed expanded IAPT model had been developed. Further engagement, with service users and stakeholders, had been undertaken, and the feedback from that engagement was provided to the Joint Committee. Overall, feedback about the proposal was positive, but there were some areas identified that the feedback suggested could be improved and this had been included in the service specification.

It was explained that the procurement process would commence, in September, with a new contract being put in place in April 2019.

It was anticipated that the new provider would be appointed by the end of November 2018, and Members would be advised of this, with further details being provided at the Joint Committee's December meeting.

Discussion:

- The value of the contract was around £13 million across Durham and Tees Valley.

- Members requested that they receive details of all the bidders for the contract and CCG representatives indicated that they would take advise on what information could be provided and pass it to the Joint Committee.

- It was noted that transitional arrangements would be in place, if the provider changed, and there would be continuity of therapy and patients would conclude their therapy with the therapist they were familiar with.

RESOLVED that:

1. the programme of current IAPT provision be noted.

2. the engagement feedback report be noted.

3. the pending procurement process be noted and a update report be provided following the award of the new contract.

4. the CCG considers what information it is able to provide to the Committee, relating to bidders in the procurement process and, subject to the outcome of its consideration, appropriate information be provided.

6 CCG Updates on GP Numbers, Delivery of Urgent Care Services, and Financial Outlook

Following a request, at the Joint Committee's last meeting, members received updates on GP Numbers, Delivery of Urgent Care Services and Financial Outlook.

Discussion:

- It was explained that options for the One Life Centre, in Hartlepool, would continue to be considered in consultation with the local authority and other partners.

- Difficulties associated with GP recruitment was a national issue. CCGs were working with partners to raise the profile of health professions, as career choices.

- Members asked for a post redesign chart for Integrated Urgent Care North of Tees.

- It was noted that GPs developed their own appointment models and there were variations in these models across the area. The CCG was attempting to cut down on the variations and to work with practices to identify a range of access opportunities for patients, including online booking of appointments and e-consultation.

- Reference was made to Integrated Care Partnerships and it was suggested that those members, who wished to receive more information in this regard, should attend the dedicated Sustainability and Transformation Plan (STP) Joint Health Scrutiny Committee, where updates were provided and there were opportunities to ask questions of the STP lead.

- there was national recruitment programme, for GPs, and also a regional team had been established that was trying to attract doctors to work in the North East.

- International GP recruitment was a key aspect of the recruitment programme and further details of the whole programme, together with GP development could be provided to the committee, at a future meeting.

- It was explained that, nationally, a decision had been taken not to recruit from countries that had a shortage of doctors.

- In addition to recruitment efforts, work was ongoing to retain GPs, develop local locum pools, and redesign the whole primary care workforce in line with the Five Year Forward View.

- Members asked for details of the number of GPs in the South Tees area.

- Work experience was available at GP surgeries and this could provide a useful insight for young people considering a career in primary care.

- Members discussed the announcement that an additional £20 billion, in real terms, would be made available to the NHS up to 2023/2024. There had been no indication of how this would be distributed.

- South Tees had a £10.8 million deficit for the last financial year and had a target of a £5 million deficit for this year, which relied on the delivery of a £19 million efficiency programme.

RESOLVED that;

1. the information provided and ensuing discussion be noted/actioned as appropriate.

2. that an update on some of the issues discussed, including developments relating to additional funding and GP Sustainability Initiatives be reported to a future meeting.

7 Regional and Local Health Scrutiny Committee Work Programmes

The Committee received an update on the work of other local and regional health scrutiny committee work programmes in order to enhance joint working and reduce duplication.

In addition to the report it was noted that Darlington Council's Children and Young People Committee was undertaking joint work with its Health Committee on a range of issues.

RESOLVED that the update be noted.

8 Committee Work Programme

Members considered the Committee's work programme and noted some amendments that had come out of this meetings discussions.

The Committee noted some updates from other Tees Valley Authority Health Scrutiny work programmes and it was agreed that a number of recent final reports would be shared.

SAFER HARTLEPOOL PARTNERSHIP
MINUTES AND DECISION RECORD
12 October 2018

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

Present:

Councillor: Councillor Jim Lindridge
Denise Ogden, Director of Regeneration and Neighbourhoods
Barry Coppinger, Office of Police and Crime Commissioner for Cleveland
Chief Inspector Nigel Burnell, Chair of Youth Offending Board
John Bentley, Safe in Tees Valley
Sally Robinson, Director of Children's and Joint Commissioning Services
Jill Harrison, Director of Adult and Community Based Services

Alison Peevor was in attendance as substitute for Jean Golightly and Ian Armstrong was in attendance as substitute for John Graham

Also Present:
Rachelle Kipling, Office of Police and Crime Commissioner for Cleveland
Jo Duffy, Cleveland Police

Officers: Danielle Swainston, Assistant Director, Children's and Families' Services
Rachel Parker, Community Safety Team Leader
Kate Ainger, Research Officer, Hartlepool Community Safety Team
Denise Wimpenny, Principal Democratic Services Officer

19. Appointment of Chair

In the absence of the Chair and Vice-Chair nominations were sought for the appointment of Chair. Agreed that Chief Inspector Nigel Burnell be appointed as Chair for this meeting.

Chief Inspector Nigel Burnell took the Chair

20. Apologies for Absence

Apologies for absence were submitted on behalf of Councillor Christopher Akers-Belcher, Hartlepool Borough Council, Superintendent Bev Gill, Cleveland Police, Ann Powell, Head of Cleveland Area, National Probation Service, John Graham, Director of Operations, Durham Tees Valley Community Rehabilitation Company, Chris Joynes, Thirteen Group and Jean Golightly, Director of Nursing and Quality, NHS Hartlepool and Stockton on Tees CCG.

21. Declarations of Interest

None.

22. Minutes of the meeting held on 3 August 2018

Confirmed.

23. Think Family Evaluation of the Troubled Families Programme in Hartlepool (*Director of Children's and Joint Commissioning Services)*

Purpose of report

The report provided an overview of the Troubled Families Programme in Hartlepool. It sets out how delivery of the programme had developed since its inception in 2012, what evidence existed in terms of improved outcomes for families and how it had acted as a catalyst for wider service transformation across all partners in Hartlepool.

Issue(s) for consideration

The Assistant Director presented the report which provided background information to the launch of the Troubled Families Programme in 2012 together with an overview and history of the programme. In relation to the first phase of the programme, Hartlepool had been mandated to identify and turn around 290 families by March 2015. The Government estimated the average unit cost of intensive intervention with a family was £10,000 and made available £4,000 for each family attached to the programme, details of which were included in the report.

A second phase of the National Troubled Families Programme was announced in 2014 with the aim of supporting a further £400,000 families nationally until 31 March 2020, equating to 1,000 families in Hartlepool. This second phase of the programme differed from phase 1 in a number of ways, details of which were provided and included a different payment by

results model which was based on a £1,000 attachment plus a £800 results payment based on achieving significant and sustained progress for families or moving them into sustained employment.

The Assistant Director was pleased to report that as at end June 2018, 900 families had been identified (90% of target) and 414 claims made (41% of target compared to 26% nationally). It had been confirmed that Hartlepool had achieved the highest results in the North East to date. In January 2018, Hartlepool had been subject to a "spot check" by MHCLG who assessed the reliability of the Council's evidence of successful outcomes and the efficacy of practices, of which outstanding feedback had been received.

The Partnership was referred to the Think Family Evaluation of the Programme, attached at Appendix A to the report. The evaluation showed that the approaches that Hartlepool had taken to implement the national Troubled Families Programme had made a positive impact on families and individuals. Based on this evidence, a number of recommendations, were made, details of which were included in the report. The evidence from the six years of the Programme showed that a clear focus on outcomes helped to evidence impact of interventions, building trusting relationships with families was critical to success and that data could be used more effectively to identify local priorities and drive important strategic decisions.

In the lengthy discussion that followed, Partnership Members were pleased to note the success of the programme and the approaches taken in Hartlepool to implement the programme which had resulted in positive outcomes for families in Hartlepool. Reference was made to the underlying issues facing troubled families and Members were keen to better understand the root causes of such problems. The need to continue to explore the potential links and impact of such issues were acknowledged. It was noted that the lack of information around the mental and physical health conditions affecting families had significantly affected the ability to analyse their impact and better partnership working to ensure information of this type was shared was key to the success of the programme.

The Assistant Director went on to respond to issues raised arising from the presentation. In response to a query raised regarding the potential savings as a result of investing in initiatives of this type, Members were advised that whilst the Government had reported savings arising from reductions in domestic violence, hospital admissions and social worker interventions, information of which could be shared with the Partnership, the reliability of the data was uncertain.

A Member commented on the importance of the family worker in terms of building trust and positive relationships with families which was key to the success of the programme.

Partnership Members discussed the recommendations and recognised the importance of prevention and the need to further develop partnership

working between organisations in Hartlepool.

Decision

That the contents of the report, be noted.

24. Hate Crime Update (*Director of Regeneration and Neighbourhoods*)

Purpose of report

To provide the Partnership on the level of reported hate incidents and crimes across Hartlepool.

Issue(s) for consideration

The report provided an overview of hate crime and incidents in Hartlepool during the period 1 August 2017 to 31 July 2018. Hate crime by type was provided, including information as a comparator with the previous year. As in previous years, racial hate offences were by far the most commonly reported in Hartlepool representing over 80% of all reported hate offences. The Partnership was advised that the Community Safety Team continued to take a proactive approach to tackling hate and during the last 12 months the team had undertaken a variety of activities around tackling hate crime, details of which were provided. In presenting the report, the Reserach Officer highlighted salient positive and negative data and responded to queries in relation to hate crime figures by type.

Partnership Members discussed issues arising from the report. The Police and Crime Commissioner reported on the recent work and successes of two hate crime investigators which had resulted in over 200 successful charges. Reference was also made to the benefits of the work of the early intervention team in terms of engaging with children at risk of being drawn into anti-social behaviour.

Decision

That the trends in relation to hate crime and incidents in Hartlepool and the comments of Partnership Members be noted.

25. Acquisitive Crime Task Group Update (*Director of Regeneration and Neighbourhoods)*

Purpose of report

To update the Partnership on the findings of initial research into a potential link between Universal Credit and acquisitive crime rates in Hartlepool.

Issue(s) for consideration

The Community Safety Team Leader reported that following the establishment of the Task Group in March 2018 the Group had investigated the potential impact of the Government's welfare reforms and the implementation of Universal Credit on acquisitive crime. A detailed update report in relation to the work of the group was presented.

In order to establish trends in acquisitive crime, recorded crime data for the period 1 April 2015 and 31 March 2018 had been analysed to produce the Initial Scanning Document.

With regard to research findings, as detailed in the report, the data revealed that acquisitive crime in Hartlepool was increasing before the introduction of Universal Credit and had continued to increase since. Interviews with offenders carried out by Durham Tees Valley Community Rehabilitation Company had highlighted that, contrary to the theory of stealing due to hunger, much of the offending in Hartlepool was drug related. The majority of interviewees stated that funding their drug habit was their primary motivation and prioritised their drug needs ahead of their food needs.

In conclusion, from the initial research it had not been possible to establish a clear link between acquisitive crime trends and Universal Credit in Hartlepool. However, what had been apparent was that the factors leading to the high rate of acquisitive crime were complex and further research was required to investigate this further.

Clarification was provided in response to queries raised regarding the research undertaken. A Member placed emphasis upon the importance of supporting repeat victims of crimes. The Partnership was advised that there was a victim care and advice service available for victims of crime and anyone who met the vulnerability criteria were contacted following a crime and both practical and emotional support was available.

The Chair of the Youth Offending Board added that national studies suggested that half of acquisitive crime was as a result of drug or substance misuse. Evidence had revealed that crime prevention was one of the most effective methods of reducing crime of this type, examples of which were shared with the Partnership. The need to continue to drive forward crime prevention measures was highlighted.

A representative from the Durham Tees Valley Community Rehabilitation Company referred to the benefits of an integrated offender management system and took the opportunity, on behalf of the Community Rehabilitation Company, to thank Rachel Parker for the research work that had been undertaken in this regard and a comprehensive report.

The Police and Crime Commissioner for Cleveland commented on the value of the work of the Probation Service staff in terms of their contributions to partnership working. Concerns were expressed regarding the Government's ongoing consultation around a new structure for the Probation Service which would present significant challenges for the region. These concerns had been reported to the Ministry of Justice.

Decision

That the findings of the initial scanning document in relation to acquisitive crime and the comments of Members be noted and actioned as appropriate.

26. Local Government (Access to Information) (Variation Order) 2006

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

Minute 27 – Repeat Victimisation Presentation – This item contained exempt information under Schedule 12A Local Government Act 1972 as amended by the Local Government (Access to Information) (Variation) Order 2006 namely information which is likely to reveal the identity of an individual (para 2).

27. Repeat Victimisation Presentation *(Representative from Cleveland Police)* This item contained exempt information under Schedule 12A Local Government Act 1972 as amended by the Local Government (Access to Information) (Variation) Order 2006 namely information which is likely to reveal the identity of an individual (para 2).

Issue(s) for consideration

The Partnership received a comprehensive presentation by a representative from Cleveland Police in relation to understanding repeat victimisation at a strategic level in Cleveland.

Further details were set out in the exempt section of the minutes.

Decision

That the contents of the presentation and comments of Members be noted and actioned as appropriate.

28. Date and Time of Next Meeting

The Chair reported that the next meeting would be held on Friday 23 November 2018 at 10.00 am.

The meeting concluded at 11.20 am.

CHAIR

North East Joint Health Scrutiny Committee

North East Joint Health Scrutiny Committee
10am Tuesday 27 November 2018
Committee Suite, Town Hall and Civic Offices, Westoe Road
South Shields, NE33 2RL

Agenda

1. **Chairman's Welcome and Introductions**

2. **Apologies for absence**

3. **Minutes of the meeting held on 7 September 2018**

4. **Translation and Interpretation Service**

   To discuss the commissioning and provision of Translation and Interpretation Services in the region.

5. **Joint Scrutiny Committee Updates**

   To receive updates from the Joint Scrutiny Committees operating in the region.

   Durham, Darlington and Teesside, Hambleton, Richmondshire and Whitby STP Joint Health Scrutiny Committee

   Northumberland, Tyne and Wear and North Durham STP Joint Health Scrutiny Committee

   South Tyneside and Sunderland Joint Health Scrutiny Committee

   Tees Valley Joint Health Scrutiny Committee

6. Work Programme

To consider topics for inclusion in the Committee's Work Programme.

7. Any other business

8. Date and time of next meeting

North East Joint Health Scrutiny Commitee

North East Joint Health Scrutiny Committee

Minutes of meeting held on 7 September 2018 at South Shields Town Hall

Present:
Councillors: McCabe (Chair) (South Tyneside), Grainge (Stockton), Green (Gateshead), Loynes (Hartlepool), Mendelson (Newcastle), Snowdon (Sunderland), Spillard (North Tyneside), Watson (Northumberland) and Watts (Redcar)

Also in attendance:
Paul Baldasera (South Tyneside), Mike Bird (Northumberland), Caroline Breheny (Middlesbrough), Karen Christon (Newcastle), Nigel Cummings (Sunderland), Angela Frisby (Gateshead),Peter Mennear (Stockton), Alison Pearson (Redcar), Joan Stevens (Hartlepool) and Brian Springthorpe (South Tyneside),

Mark Cotton (NEAS), Philip Kerr (North East Independent Complaints Advocacy Service), Dawn Marshall (Becoming Visible)

1 member of the Press and public

---

1. **Apologies**
   Cllr Dryden (Middlesbrough), Stephen Gwillym (Durham)

2. **Minutes of the last meeting**

   The Committee approved the minutes of the last meeting held on 21 June 2018 as a true record.

3. **North East Ambulance Service**

   Mark Cotton, Assistant Director of Communications and Engagement, North East Ambulance Service, gave the Committee a presentation on ambulance performance standards.

   The presentation covered:
   - Current performance standards for each category of call;

- Average response times achieved and reducing the tail of 'hidden waits';
- New response performance standards;
- Specialist heart centre targets and performance;
- Stroke centre targets and performance;
- Unscheduled care response times and benchmarking data;
- Number of calls received by the Operation Centre;
- See and Treat/convey and handover data;
- Workforce issues including sickness, turnover and vacancies;
- Introduction of new staff rota;
- Recent service improvements, See and Treat performance, Clinical Assessment Service and other developments.

Councillor Watson noted that the tail of 'hidden waits' was longer in Northumberland due to its geography and questioned how need was assessed. The Committee was advised that the clinical pathways determined the category of call and the required response.

Councillor Watts raised the issue of A&E closure due to winter issues and the difficulties faced by some residents. The Committee was advised that the bad weather experienced in February/March had led hospitals to cancel elective surgery. Demand for ambulances had dropped during the period and the service coped during the severe weather, although response times had not been met.

Councillor Grainge raised the issue of how response times were measured and available staff and ambulance resources. It was confirmed that the clock was reset on each occasion a call was re-categorised. There were a few examples where there had been a mismatch of staff and vehicles due to a variety of reasons which included shift changes, breakdowns and sickness absence.

Councillor Loynes highlighted the Air Ambulance service. The Air Ambulance service received the same 999 information and had the option to offer assistance or dispatch themselves in response to an incident. NEAS could also request Air Ambulance support if required.

Councillor Spillard raised the issue of the speed of response required in stroke cases. The Committee was advised that specialist centres were the preferred method of treatment to provide the best patient outcomes for stroke as well as for heart attacks and trauma incidents. In such call-outs patients would be taken directly to a specialist centre.

Councillor Snowdon asked for information on how call handlers advised patients regarding the time it would take an ambulance to arrive. It was noted that a script had been developed with NHS England to assist call handlers manage expectations of patients.

Councillor Grainge highlighted issues of staff turnover and recruitment. The Committee was advised that previously no career progression was available to staff. This had been now been put in place. Work continued with Sunderland and Teesside universities. Recruitment also took place from overseas including the European Union. NEAS had been voted in the top 100 employers for LGBT awareness by Stonewall.

Councillor Green asked about the work done with the Armed Forces community. The Committee was advised that NEAS was looking at the Armed Forces Covenant. A number of NEAS staff were reservists and had previously been deployed on active service. Their skills were recognised by NEAS.

Councillor McCabe recognised the service improvements and performance of NEAS and asked if it had enough financial resources to operate in the years ahead. The Committee was advised that resources were a key challenge to be faced by NEAS.

Agreed: (a) That the presentation be noted, (b) that a visit to a Control Room would be arranged for a later date and (c) that the Committee would be kept informed of NEAS performance and how it intended to meet the challenges ahead.

4. North East NHS Independent Complaints Advisory Service

Philip Kerr, Contracts Manager North East NHS Independent Complaints Advocacy, gave a presentation which covered:

- History of the organisation;
- Consortia of 10 North East local authority areas;
- Provision of free, confidential and independent advocacy support for residents to complain about NHS care or treatment;
- Available resources and staffing;
- Range of support available;
- Limits of available support;
- Partnership working;
- Sources of complaints and numbers of clients;
- Type of complaints.

Councillor Green highlighted that he had been unaware that Gateshead Council acted as lead local authority. Phillip Kerr confirmed that Gateshead Council had acted as lead authority since 2013 and that monthly statistics were provided to it for circulation to all local authorities. Meetings such as this provided a good opportunity to raise awareness and promote the service with elected Members.

Councillor Mendelson asked how the service was promoted. It was confirmed that the service was well known to all agencies and organisations within the wider health care system and referrals were received directly from members of the public, from the NHS itself and from organisations such as Healthwatch. Numbers of referrals had increased by approximately 25% year-on-year and there were 1,000 active client cases.

Councillor Spillard highlighted that local authorities picked up the costs for providing social care resulting from residents being discharged from hospital to avoid bed blocking.

It was noted that Northumberland was not part of the consortium; however, the service supported clients from Newcastle and North Tyneside who had used the Accident and Emergency hospital at Cramlington.

Agreed: That the presentation be noted.

5. Translation and Interpretation Service

Dawn Marshall, from Becoming Visible, explained the role of the organisation and highlighted issues affecting the deaf community. Becoming Visible was based at Mea House in Newcastle and had six members of staff. The staff provided a British Sign Language interpreting service to residents and groups. It took years of training to become an effective interpreter and was a skilled job.

There were approximately 40 BSL interpreters for the North East to support a community of 5,000 deaf people. Deaf people often felt very isolated in the community and often relied on interpreting services to communicate with organisations and service providers. Deaf residents often felt forgotten about by organisations.

The Committee was advised that locally, the procurement of translation and interpretation services changed in March 2018 without consultation with the deaf community, with a Lancashire based company being awarded the contract. It was felt that the new service was detrimental to the needs of residents with no choice of interpreter being available. It was stressed that a deaf client needed to have confidence in their interpreter.

NHS complaints processes were slow and cumbersome and not suited to dealing with deaf residents and deaf residents relied heavily on the support of the Independent Complaints Advisory Service.

Concerns were expressed over the lack of consultation over the service, the change in provider, the impact this had on deaf residents and the value for money and effectiveness of the contract.

During discussion, Councillor Spillard advised that the North Tyneside deaf community had mixed feelings over the issue. It was clear that choice was very important to deaf residents and there was a concern that residents may drop out of the system putting their health at risk as a result.

Councillor Watts highlighted concerns over confidentiality. Dawn Marshall advised that the new service provided a qualified interpreter; however, not one necessarily experienced with the issue at hand.

Paul Baldasera confirmed that the service was commissioned regionally by the NHS and suggested that the commissioners be invited to a future meeting to discuss the issue in greater depth to establish how the quality of the service was maintained.

Agreed: (a) That the report be noted and (b) to invite the commissioners to a future meeting to discuss the issue.

6. Work Programme

Paul Baldasera advised that the Newcastle Council work programme would be added to the list. Councillor Watt highlighted Breast Screening services as a future item which would have a wide ranging impact.

Discussion took place on a range of issues affecting the Tees Valley area and it was recognised that those issues should initially be considered locally.

Councillor Green raised the issues of support for members of the Armed Services and the impact of improvements made to pharmacy services in the Gateshead area. The Chairman advised that some pharmacists were allowed to prescribe although this service had not been commissioned in South Tyneside.

7. Any Other Business

There was no any other business.

8. Date and time next meeting.

It was agreed that the next meeting would be arranged at a mutually convenient date.

item 4

PRESENTATION

Translation and Interpretation Service

item 5

VERBAL

Joint Scrutiny Committee Updates

North East Joint Health Scrunity Commitee

Meeting on 27 November 2018 at 10am, South Shields Town Hall

item 6

Work Programme 2018/19

Report of the Strategy and Democracy Officer, South Tyneside Council.

Purpose of the report

1. To seek approval for the North East Joint Health Scrutiny Work Programme for 2018/19.

Work Programme 2018/19

items	Meeting date
Performance report NEAS Independent Complaints and Advocacy Service NE Council Work Programme summary	7 September 2018
Translation and Interpretation Services Updates on North East Region Joint Health Scrutiny Committees	27 November 2018
NEAS Quality Accounts Breast Screening and Cancer Mortality Expan*sion of the Pharmacy First Service* Resettlement Programme for Overseas Doctors and Health Care Professionals (REPOD)	February 2019 (date TBA)

Contact Officer, Paul Baldasera, Strategy & Democracy Officer, 0191 4246022

Recommendations

2. That the Work Programme for 2018/19 be noted and approved.

item 7

VERBAL

Any Other Business

Durham Darlington Teesside Hambleton Richmondshire and Whitby STP Joint Health Scrutiny Committee

At a meeting of the **Durham Darlington Teesside Hambleton Richmondshire and Whitby STP Joint Health Scrutiny Committee** was held in the Council Chamber, Redcar & Cleveland Community Heart, Redcar on **Tuesday 25 September 2018 at 2.00p.m**.

Present:

Councillor L Tostevin (Darlington Borough Council)
Councillor E Dryden (Middlesbrough Council)
Councillors J Robinson, J Chaplow and R Bell (Durham County Council)
Councillors J Blackie and H Moorhouse (North Yorkshire County Council)
Councillors N Cooney, M Ovens and R Goddard (Redcar and Cleveland Borough Council)
Councillors S Bailey and L Hall (Stockton-on-Tees Borough Council)
Councillor Brenda Loynes (Hartlepool Council)

Officers

Peter Mennear (Stockton-on-Tees Borough Council)
Alison Pearson (Redcar and Cleveland Council)
Lucy Donaghue (Redcar and Cleveland Council)
Stephen Gwillym (Durham County Council)
Caroline Breheny (Middlesbrough Borough Council)
Laura Stones (Hartlepool Council)

Trust and CCG Representatives

Mary Bewley, Head of Communications and Engagement, North of England Commissioning Support

Apologies

Councillors W Newall and J Taylor (Darlington Borough Council)
Councillors J Chaplow and J Clark (Durham County Council)
Councillors B Brady and A Hellaoul (Middlesbrough Council)
Councillor L Grainge (Stockton-on-Tees Borough Council)

9. Substitute Members

None.

10. To receive any Declarations of Interest by Members

None recorded.

11. Minutes

Agreed that the minutes of the meeting held on 13 June 2018 be confirmed and signed by the Chair as a correct record.

The Principal Overview and Scrutiny Officer from Durham County Council provided an update on the 3 acute hospital site model.

Members requested that a copy of the letter sent to the Chief Executives of County Durham and Darlington Foundation Trust (FT); North Tees and Hartlepool NHS FT and South Tees Hospitals FT, and any responses received be circulated to the DDTHRW STP Joint Health Scrutiny Committee**: - NOTED.**

12. Empowering Communities – Communications and Engagement for Integrated Health and Care

The Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby STP Communications Lead presented a report and gave a presentation on the communications and engagement work stream for NHS organisations in North Cumbria and the North East Region.

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

Spending less time in hospital is better for patients' recovery and 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.

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.

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.

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.

As part of the ensuing discussions, the following comments were made:

- The time it had taken to get this point was not acceptable. There had been a number of mistakes made in the past and the performance to date had been disappointing. Members were advised that there was the opportunity to share good practice across regions.
- Concern was raised that the work had taken 3 years and there appeared to be no discernible progress.
- A Member commented that the consultations had produced a number of concerns from communities around access, travel, the distance patients would have to travel and patient transport. These areas of concern had still not been explored.
- Not enough detail had been provided. These were major changes and needed to be formally consulted upon.
- Concern was raised that in some previous consultations, the public were only choosing from the limited options put forward. Care should be taken in the way options were developed.
- The presentation had been updated each time it had been presented to include feedback that had been provided.

- A website was being developed that would provide all the necessary information in a single space
- A Member asked why a project plan wasn't in place? It would be helpful to know what action had been taken in respect of each milestone.
- Some examples of other ICPs and ICSs across the country could have been shared.
- It was important that the 3 acute hospital site model was retained.
- The clinicians could be invited to attend the DDTHRW STP Joint Health Scrutiny Committee.
- Every meeting this was discussed was not only costing the NHS money but it was also a cost to Local Government.
- The NHS had been a wonderful service to the public over the years and people wanted this service to remain.

At the conclusion of the discussions the following action was agreed:

1. The report be noted; and
2. The Chief Executives of each of the three NHS Foundation Trusts be invited to a meeting of this committee to discuss in more detail the service changes in the North East ICP area.

13. Durham Darlington and Teesside, Hambleton, Richmondshire and Whitby STP – Workstream Update

The Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby STP Communications Lead provided an update on the work that had been undertaken within the area.

The Principal Overview and Scrutiny Officer from Durham County Council advised that an update on "Our Journey So Far" had been circulated to the committee via email. It was a lengthy document that included a lot of individual links so it was best to view it electronically. If Members had any questions or feedback they could contact the Principal Overview and Scrutiny Officer.

The Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby STP Communications Lead advised that a bulletin had been circulated and another would be released within two months**: - NOTED.**

14. Chairman's Urgent Items

None.

15. Any other business

None.

16. Date and Time of next meeting

The next meeting date was to be confirmed but would be before December 2018. A Member suggested that the next meeting be held at Darlington Civic Centre as it was a central location for all attendees**: - NOTED.**

The meeting ended at 3.45 pm.