Version 1.0

Hartlepool
Joint Strategic Needs Assessment
2012-15

Unmet needs and commissioning intentions arising from JSNA

4th September 2013

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Learning disabilities

Learning disabilities – unmet needs

Mental health of people with learning disabilities
People with learning disabilities and their families tell us that they do not get support to think or talk about mental health problems in the same way that they get increasingly with physical health. If a mental health problem occurs, for whatever reason, it is more likely to be attributed to their learning disability (diagnostic overshadowing) or classed as challenging behaviour.

Autism

- Many people with autism also have a learning disability. There may be a lack of identification of adults with autism.
- Confusion for direct payment services, where a child may not get support but their carer may.
- People with autism spectrum condition (ASC) falling between learning disability and mental health services.
- Problems in transition planning for young people with autism.
- A lack of community acceptance for people with ASC.
- Better training from DEAs and in turn better employment support from them and Job Centre Plus.

Service uptake within specific ethnic groups
The 2005 Equality Impact Assessment identified lower levels of service uptake within certain Black and Minority Ethnic communities. This needs to be investigated further to clarify whether adequate care is being provided from alternative sources and/or whether the development of additional council services is justified.

Enablement
Research carried out by the Care Services Efficiency Delivery team (CSED) highlighted a gap in the current provision of ‘enablement services' for people aged under 65. The specific client groups affected include learning disabilities, physical impairment, and social inclusion care management. Further investigation will be undertaken to see how this can be solved.

Transport
An issue raised frequently by people attending local consultation groups is transport. It was noted that “many service users find regular transport to be a problem due their disabilities or deteriorating conditions”. Taxis were seen as very expensive and often unable to provide wheelchair access.

Learning disabilities – commissioning intentions

2012/01
Provide good quality healthcare that meets the needs of people with learning disabilities by:

- Ensuring people with learning disabilities have a health action plan.
- Providing annual health checks.
- Training healthcare staff to understand the needs of people with learning disabilities.
- Improving access to mainstream health services and mental health services.
- Providing health improvement courses for people with learning disabilities.

2012/02
Create employment opportunities for people with learning disabilities by:

- Increasing employment options for people with a learning disability, including education, training and apprenticeships.
- Working in partnership with key organisations.
- Exploring new ways of creating employment opportunities for people with a learning disability.

2012/03
Ensure the housing requirements of people with learning disabilities are identified and catered for by:

- Increasing the range and types of housing available for people with learning disabilities.
- Planning for the future needs of people with a learning disability – ensuring information on future need is captured.
- Increasing the number of people with a learning disability in settled accommodation.

2012/04
Provide carers with the integrated and personalised services they need to support them in their caring role.

2012/05
Ensure advocacy is available to all people with learning disabilities.

2012/06
Support people to maximise their independence and travel independently by increasing awareness of the “Safe on the move in Hartlepool” scheme.

Autism

Autism – unmet needs

Hartlepool Borough Council has engaged with people with autism with a view to identifying what is working, what is not working and what needs to change. This process, also known as Working Together for Change (WTFC), is a tried and tested approach to co-producing change with local people and harnessing the energy and intelligence from that process to drive commissioning and service development activity.

WTFC can help to make better use of scarce resources, improve productivity and lead to better outcomes for people by ensuring services provide the things people want and need in the way that makes most sense to them.

It goes significantly beyond consultation, towards empowering people to play a leading role in determining the changes and improvements they want to see. It has been recognised as national best practice and is being used across the country in a wide variety of settings as a tool for delivering inclusive change. WTFC uses person-centred information, most commonly from individual reviews, to illuminate what is working well for people, what is not working and what might need to change for the future.

During consultation in Teesside in 2011/12, the WTFC process highlighted a number of areas which required further consideration. It is estimated that approximately 1 in 100 people has autism – so for Hartlepool this could be as many as 900 people based on local estimates.

About 140 people are currently in receipt of services, so it may be that as many as 760 people could be living in Hartlepool with an autism spectrum condition.

Autism – commissioning intentions

2012/01
The Autism Act statutory guidance puts duties on local authorities, NHS bodies and NHS Foundation Trusts in order to meet the needs of people with autism living in their area. Amongst other actions, the guidance clearly states that local authorities and the NHS should:

- Provide autism awareness training for all staff;
- Provide specialist autism training for key staff (eg. GPs and community care assessors);
- Not refuse a community care assessment based solely on IQ;
- Appoint an autism lead;
- Develop a clear pathway to diagnosis and assessment; and
- Commission services based on adequate population data.

2012/02

In April 2011 the Government published a list of the ten outcomes that should be achieved. These are:

1. Adults with autism are included and economically active;
2. Adults with autism achieve better health outcomes;
3. Adults with autism are living in accommodation that meets their needs;
4. Adults with autism are benefiting from the personalisation agenda in health and social care, and can access personal budgets;
5. Adults with autism are no longer managed inappropriately in the criminal justice system;
6. Adults with autism, their families and carers are satisfied with local services;
7. Adults with autism are involved in service planning;
8. Local authorities and partners know how many adults with autism live in the area;
9. A clear and trusted diagnostic pathway is available locally; and
10. Health and social care staff make reasonable adjustments to services to meet the needs of adults with autism.

Physical disabilities

Physical disabilities – unmet needs

Service uptake within specific ethnic groups
The 2005 Equality Impact Assessment identified lowered levels of service uptake within certain black and ethnic minority communities. This needs to be investigated further to clarify whether adequate care is being provided from alternative sources and/or whether the development of additional council services is justified.

Enablement
Research carried out by the Care Services Efficiency Delivery team (CSED) has highlighted a gap in the current provision of ‘enablement services' to under 65s. The specific client groups affected include learning disabilities, physical impairment, and social inclusion care management. Further investigation will be undertaken to see how this can be developed.

Transport
An issue that is raised regularly by people attending local consultation groups is transport. It was noted that “many service users find regular transport to be a problem due to their disabilities or deteriorating conditions”. The taxis were seen as very expensive and often unable to provide wheelchair access.

Physical disabilities – commissioning intentions

2012/01
Develop services and responses that will prevent people from developing a long-term condition – promote health and wellbeing and identify and support people at risk of developing a long-term condition.

2012/02
Make self-care the norm – encourage people to maintain their own health and lead independent lives.

2012/03
Deliver more services close to home – provide personalised community-based integrated care.

2012/04
Reduce the number of admissions and the length of hospital stay for those with long-term conditions – people should not be admitted to hospital unnecessarily because services have failed to provide appropriate care at home.

2012/05
Develop a workforce which has the skills to deliver care in the right place at the right time – invest in professional education and skills development.

2012/06
Harness technology to support those who care for and those who live with long-term conditions – take advantage of the possibilities opened up by new technologies.

2012/07
Reduce inequalities in local health and experience and access for those managing long-term conditions – deliver convenient, quality services.

2012/08
Commission services and measure outcomes that matter to those living with a long-term condition – find out what people want from services working with a range of providers to commission effective, holistic responsive packages of care.

2012/09
Commission services and measure outcomes that matter to those supporting and caring for people with a long-term condition – create an environment that allows carers to take greater control over their own health and the health of others in their care.

2012/10
Provide a systematic, person-centred approach to the management of long-term conditions.

Sensory disabilities

Sensory disabilities – unmet needs

Lip-reading skills
There is evidence of a demand for lip-reading classes in Hartlepool (classes currently being carried out by Durham Deafened Support).

Hearing tests
It is estimated that only 55% of people with a hearing loss are referred by their GP for a hearing test. Therefore, it is possible that several thousand people in Hartlepool are trying to cope unaided with their hearing loss.

Service uptake within specific ethnic groups
The 2005 Equality Impact Assessment identified lowered levels of service uptake within certain black and ethnic minority communities. This needs to be investigated further to clarify whether adequate care is being provided from alternative sources and/or whether the development of additional council services is justified.

Enablement
Research carried out by the Care Services Efficiency Delivery (CSED) team has highlighted a gap in the current provision of 'enablement services' for under 65s. The specific client groups affected include learning disabilities, physical impairment, and social inclusion care management.

Local intelligence and statistical information
Due to inconsistencies between children and adults information systems, data available for people with sensory impairment may not be robust.

Transport
Many service users find regular transport to be a problem due their disabilities or deteriorating conditions. Taxis were seen as very expensive and often unable to provide wheelchair access.

Sensory disabilities – commissioning intentions

2012/01
Review the 'Self-Directed Assessment Questionnaire' (V5.5) to establish its effectiveness for those people with sensory impairment.

2012/02
Review the process for the transfer of information between Care-first and Innovative Communication Services (ICS) to ensure children are included on the deaf and hard of hearing register.

2012/03
Review the scope of the North Regional Association for Sensory Support (NRASS) contract in consultation with the deaf community and consider using the community group meetings to improve engagement.

2012/04
Develop a central focal point in Hartlepool for people with sensory loss to meet, obtain information and gain support.

2012/05
Review the commissioning of communication and translation services (in consultation with other partners in Teesside and members of the deaf community).

2012/06
Consider the benefits of a 'virtual' assessment team for adults to improve cover and reduce backlogs.

2012/07
Update and improve access to information, advice and guidance for people with sensory impairments (both hard copy and web-based).

2012/08
Explore the value of offering patients greater choice with 'In the Ear' hearing aids in their commissioning plans for hearing aid provision.

2012/09
Develop a strategic approach to engaging people with sensory impairments, enabling them to be fully involved in decisions and changes in services affecting them.

2012/10
Seek the views of local community groups to explore possible solutions to improve access to sensory support services.

2012/11
Work with 'Durham Deafened Support' to determine how best to address the needs of Hartlepool's hard of hearing and deafened people.

2012/12
Survey the hard of hearing community on their needs for social and communication support, including lip-reading provision and the availability of a support group.

2012/13
Review the health needs of the deaf community to inform the 'Focus on Health' project aimed at improving the physical and emotional wellbeing of Hartlepool's deaf community.

2012/14
Review the peripatetic and paediatric support pathways for children with sensory disabilities in order to provide appropriate support and information to them and their families.

2012/15
Review the current provision of mental health services available to children and young people, working with partners to achieve economies of scale and considering the development of links between local CAMHS services and the National Deaf Service for Children.

2012/16
Work with partners to ensure that British Sign Language (BSL) interpreting services are commissioned to a consistently high standard across organisations to improve continuity of service where possible across the pathway, and where appropriate checks and feedback is sought on the provision of that service.

2012/17
Continue to promote and provide deaf awareness training across all sectors, making it a mandatory part of induction for staff.

Sexual violence victims

Sexual violence victims – unmet needs

Tackling sexual violence, particularly against women and girls, requires an integrated approach at a local level through effective partnership.

The Tees Sexual Violence Needs Assessment highlighted that there is good provision of specialist sexual violence services with a skilled and committed workforce in Teesside. However, it identifies the following areas where further work is needed:

- Develop and implement an information-sharing protocol (to include anonymous intelligence and third party reporting) between sexual violence service providers.

- Commissioners and service providers develop clear plans for engaging individuals or groups representing BME communities in sexual violence work.

- Sexual violence and learning disability service providers work closely to ensure that services are both available and effective for people with learning disabilities who have experienced sexual violence.

- Improve the identification, recording, flagging and monitoring of sexual violence in non-sexual violence specific services, such as sexual health, general practice, emergency services/A&E, mental health, drug and alcohol and lesbian and gay agencies to improve co-ordination of support.

- Develop mechanisms for obtaining feedback from individuals that reflect their experiences for the entire victim experience.

Sexual violence victims – commissioning intentions

2012/01
Monitor the implementation of pre-trial protocols to ensure that support provided to victims prevents the failure of a criminal case.

2012/02
Continue to review the commissioning and provision of sexual violence services to ensure they meet the needs of victims, are sustainable and provide value for money.

2012/03
Develop standardised pathways and referral protocols which include:

- when referrals should be made and to which agencies;
- standard referral forms;
- level of information required to make the referral;
- mechanism for feedback to the referring agency; and
- mechanism to obtain feedback from victims or users

2012/04
Develop sexual violence service specifications which specify required quality standards, key performance indicators and reporting requirements to ensure a consistent approach to service monitoring.

2012/05
Develop a minimum data set for sexual violence services to enable routine monitoring of outcomes and benchmarking to drive up standards.

2012/06
Improve public and professional awareness of sexual violence and services.

2012/07
Develop a better understanding of services and support for acute child sexual abuse cases (within 7 days of abuse occurring) and non-acute or historical cases of child sexual abuse, where sexual abuse occurred more than 7 days previously.

2012/08
Develop and implement an information sharing protocol (to include anonymous intelligence and third-party reporting) across sexual violence service providers.

2012/09
Develop clear plans for engaging individuals or groups representing BME communities in sexual violence work.

2012/10
Work closely to ensure that services are both available and effective for people with learning disabilities who have experienced sexual violence.

2012/11
Improve the identification, recording, flagging and monitoring of sexual violence in non-sexual violence specific services, such as sexual health, general practice, emergency services/A&E, mental health, drug and alcohol and lesbian and gay agencies to improve co-ordination of support.

2012/12
Develop mechanisms for obtaining feedback from individuals that reflect their experiences for the entire victim experience.

Domestic violence victims

Domestic violence victims – unmet needs

Data sharing
Improved data sharing across statutory agencies, voluntary sector and between departments within the Local Authority is needed.

Referral protocols
All agencies including voluntary sector, Police, Health, Local Authority Departments, Housing and the Crown Prosecution Service need to be involved in developing and/or agreeing to referral protocols for clients.

Workforce development & training
Raising the awareness domestic violence with frontline practitioners and professionals, including education and health professionals through training and effective practice.

Strengthen protection
The need for the early identification and clear referral process for vulnerable children and pregnant mothers who are at risk of domestic violence.

Young perpetrators and victims
Identification and support for young perpetrators and victims of domestic violence, challenging their behaviour and attitudes.

Provision of specialist services
Limited availability of specialist services in Hartlepool for the BME community, LGBT community and male victims of domestic violence.

Domestic violence victims – commissioning intentions

2012/01
Develop, implement and monitor the Safer Hartlepool Domestic Violence Strategy 2012–2015 to break the cycle of domestic violence in Hartlepool, focusing on:

- Prevention & Early Intervention: Increase awareness and knowledge of the impact of domestic violence, services and options available and intervene early to reduce violence and the escalation of violence.

- Provision of Services: Provide support to victims/survivors, and children whose lives are blighted by domestic violence and to perpetrators and ensure that they face minimal barriers in accessing the support they need.

- Partnership Working: Work closely with partners to obtain the best outcome for victims and their families.

- Justice Outcomes and Risk Reduction for Victims: Take prompt action to reduce the risk to victims and their family. Empower victims to support the criminal justice process to ensure perpetrators are brought to justice.

Carers

Carers – unmet needs

Identification of carers
The local authority carried out 1,538 carer assessment during 2010/11. Hartlepool Carers is in contact with approximately 700 other carers. However the 2001 census shows 9,853 people who identified themselves as carers (11% of Hartlepool's population). It means that potentially there are over 7,600 carers not in contact with either formal or voluntary support. This figure is likely to increase when the results of the 2011 census are known.

Even if the number of carers in the 2001 census who said they carried out more than 50 hours a week of caring is used (2,680), this still exceeds the number known to the local authority and key carers support agency by more than 400.

The Hartlepool Carers Strategy identifies the need for appropriate information, tailored to differing caring situations such as:

- new carers;
- those carers who are coping but need to be kept up to date with what support and particularly finances may be available ;
- carers who are now finding it hard to cope or where circumstances are deteriorating.

This information needs to include benefits and financial advice including working tax credits.

More needs to be done to identify younger carers particularly, but not exclusively, those whose parents are involved with substance misuse or have mental health issues. Schools in particular should be aware of the needs of child carers.

Adequate support with assessment
Anecdotally, many carers report that they are not aware that they have had a carer's assessment even though a carer's assessment has been recorded (source: comments collected during the consultation on the Carer Strategy in 2010/11). A robust assessment is the gateway to carer support. The new Carers Self-Directed Assessment Questionnaire (CSDAQ) will support this following implementation in the summer of 2012.

Access to health services and awareness of carers within general practices
Awareness of carers within primary health care has markedly improved following a local initiative rising from 100 to 700 cares registered with their GP (source: - Hartlepool Carers GP registration programme). However, this is well short to the number known to the local authority and Hartlepool Carers.

Health services need to be aware of the importance of carers' health and well-being and their role as an expert regarding the person they care for, but also the risk of neglecting their own health. Identification of carers in general practices is now a requirement of the Quality and Outcomes Framework (QOF).

The emotional support and mental health of carers
The mental health of carers has been highlighted as an issue where further support is needed. The Carers Strategy action plan identifies that further work is needed to:

- improve support regarding well-being and self-help;
- identify options for mutual support;
- identify more options to have a 'life of one's own';
- improve the range of opportunities for short breaks, respite, and activities that the cared for and carer can enjoy together;
- get appropriate medical and psychological support.

Deaf carers and carers from BME communities
Recent consultation indicates that carers in the deaf community find it harder to access information and support.

Hartlepool has a relatively small population from black and other ethnic minority communities, but carers in these communities have been recognised as hard to reach.

Removal of discrimination of carers
Clear pathways are needed to ensure that young carers are are identified and supported at an early stage.

Adult carers areas of concern include the lack of recognition of their key caring role when accessing services for themselves (such as health services) which can severely restrict their ability to access rigid systems, such as appointment systems.

Training and support
Work is needed to ensure that when carers are identified they can then easily access appropriate training both to assist them in their caring role but also to allow them to remain in employment, train or retrain for employment.

Carers and employment
Work is needed to help carers remain in or return to employment. Awareness of carers' issues remains very mixed with employers. Some larger statutory organisations have already initiated family-friendly policies but anecdotally carers are still reporting that they have had to give up working because of the dual demands.

A scheme to support carers into employment lost its funding when the Working Neighbourhoods Fund was withdrawn in 2011 and has only partially been able to continue functioning due to voluntary sector support.

The Carers Strategy identifies the need for:

- family / carer friendly employment, training and education;
- better and timely access to information on employment issue;
- better and timely access to support to stay in work.

Carers – commissioning intentions

2012/01
Identify carers so that effective support and information can be made available at the time when it is needed. This includes identification of carers in primary care.

2012/02
Enable carers to access the right information in the right place at the right time.

2012/03
Promote representation from “hard to reach groups” and should include people whose first or only language is not English, people from BME communities and deaf people.

2012/04
Build on the work already done to identify carers in primary health care to ensure all carers are known to their GPs.

2012/05
Improve emotional support and mental health of carers by improving support regarding well-being, self-help and mutual support, identify more options to have a ‘life of one’s own’ and improve the range of opportunities for short breaks, respite, and activities where the cared for and carer can enjoy together and enable appropriate medical and psychological support.

2012/06
Improve access to work, education and leisure for carers by working with employers and educational institutions.

2012/07
Improve data collection locally to better identify carers and the amount of support they offer so that a more accurate figure is obtained.

End of life care

End of life care – unmet needs

People receiving end of life care require services from a range of providers from the health, social care, community and voluntary sectors. Sometimes these services might not be fully co-ordinated.

The majority of people are dying in hospitals, but expressed preferences of the majority show that they would prefer to die in a different setting.

End of life care – commissioning intentions

2012/01
Reduce inequalities and improve identification through de-stigmatising death and dying and encouraging healthcare professionals and people with end of life care needs, their families and carers to engage in open conversations.

2012/02
Improve the quality of care including care after death, through holistic assessments and timely interventions in the right place by a knowledgeable, caring and competent workforce.

2012/03
Increase choice and personalisation through care planning and advance care planning, including advance statements and advance decisions to refuse treatment and provision of resources that enable these choices to be achieved.

2012/04
Ensure care is co-ordinated and integrated across all sectors involved in providing end of life care.

2012/05
Improve the psychological, physical and spiritual well-being of people with end of life care needs and their carers through access to an appropriately trained and resourced workforce

2012/06
Focus on outcomes, for example: end of life pathways; use of 'Deciding Right' documentation; ‘family voice’ feedback; care and co-ordination measures i.e. use of general practice palliative care registers; response times for practical help; and complaints related to end of life care.

Ex-forces personnel

Ex-forces personnel – unmet needs

The level of resettlement support is determined by the length of military service and is not dependent on the rank of the service leaver.

Service leavers who are discharged compulsorily have no entitlement to formal support.

All early service leavers are often discharged at very short notice making it difficult to provide appropriate support packages to prepare them for the transition to civilian life.

There is a lack of awareness and understanding of the unique experiences and challenges of service personnel by civilian professionals and institutions. This has an impact when considering the awareness of veterans’ health issues and in particular the special needs of older and disabled veterans.

Ex-forces personnel – commissioning intentions

2012/01
Raise awareness of the entitlement of veterans to priority access to NHS care by NHS staff.

2012/02
Work in partnership with other agencies and the voluntary and community sectors to prevent homelessness, tackle unemployment and other social exclusion issues amongst veterans, where the problems have arisen from their service.

2012/03
Ensure the effective and timely direct transfer of medical records from Defence Medical Services to GPs when individuals leave the armed forces.

2012/04
Implement the report of the Joint Health Overview and Scrutiny Committee of North East Local Authorities on the regional review of the health needs of the ex-service community that was formally launched in March 2011. The report identified 47 areas for improvement, including 12 areas specifically related to mental health. These include:

A strong role for the new local Health and Well-being Boards in assessing needs and co-ordinating service provision;

Enhanced awareness among primary care providers and GPs of the particular mental health needs of the ex-service personnel and particularly of the need for priority treatment for health care needs arising from their service;

Appropriate training is required by commissioners of NHS services. This should guide them on how to:

- Produce guidance specifically for primary care providers and GPs to explain the priority healthcare entitlement;
- Identify ex-servicemen and women;
- Adapt their systems to accommodate priority treatment for the ex-service community;
- Accept referrals from ex-service charities, including the Royal British Legion and Combat Stress, but also smaller local organisations providing for some of the most marginalised/excluded ex-service personnel;

Local authorities and GP consortia should be actively engaged in joint planning and commissioning of services with the NHS;

Local authorities should be actively engaged in the North East NHS Armed Forces Network and consider how they can take on a leadership role in relation to veterans mental health issues;

Primary care and acute trusts should take steps to improve awareness of veterans' mental health issues among health workers generally, including appropriate training and supervision.

2012/05
Consider some groups within the ex-service community may need special attention, including prisoners and early service leavers (those who leave the service after less than four years).

Migrants

Migrants – unmet needs

None identified.

Migrants – commissioning intentions

2012/01
Leaflets available in different languages should be produced.

2012/02
Consider the need for appropriate interpretation facilities to be available in the housing office.

Travellers

Travellers – unmet needs

None identified.

Travellers – commissioning intentions

None identified.

Offenders

Offenders – unmet needs

None identified.

Offenders – commissioning intentions

2012/01
Develop, implement and monitor the Safer Hartlepool Partnership (SHP) strategy 2011-2014 to tackle crime, disorder, substance misuse and reduce offending in Hartlepool by focusing on the following strategic objectives and priorities:

Reduce crime and repeat victimisation for:

- Acquisitive crime (domestic burglary and theft);
- Violent crime (including domestic violence & abuse);
- Support victims and reduce the risk of repeat victimisation.

Reduce the harm caused by drug and alcohol misuse by:

- Reducing substance misuse through a combination of prevention, control and treatment services.

Create confident, cohesive and safe communities by:

- Tackling anti-social behaviour through a combination of prevention, diversion and enforcement activity.
- Protecting and supporting vulnerable victims and communities.
- Improving public reassurance and the fear of crime by actively communicating, engaging and involving local people.

Reduce offending and re-offending by:

- Preventing and reducing offending, re-offending and the risk of offending.

Crime

Crime – unmet needs

While there is a commitment to maintain high levels of service and support during times of austerity, it is clear that the pressures on budgets and the impact this will have on capacity will affect the level of service delivered. This in turn could potentially lead to a lack of community reassurance linked with the wider feeling that public services are stretched at a time when unemployment is high.

Crime – commissioning intentions

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Reduce offending and re-offending by:

- Preventing and reducing offending, re-offending and the risk of offending.

Education

Education – unmet needs

Secondary schools currently receive limited school improvement support from the Local Authority. Few members of the LA School Improvement Service have a secondary teaching background. The Local Authority has acted to remedy this but a more comprehensive support service for secondary schools will not be available until 2013.

School-to-school improvement work is still in is infancy and will require careful strategic managing by a range of partners, including the LA, headteachers and the Hartlepool Teaching School Alliance, to ensure that it is able to address issues appropriately.

Education – commissioning intentions

2012/01
Offer schools a more coherent package of school improvement measures through a targeted, flexible and, where necessary, bespoke School Improvement Service Level Agreement designed to meet the specific needs of individual schools.

2012/02
Apply rigorously the Hartlepool LA Schools Causing Concern Protocol to ensure that concerns are identified earlier and that an escalating series of support and challenge measures are implemented to bring about improvement.

2012/03
Commission high quality external School Leadership Partners (SLPs) to supplement LA SLPs to ensure that every Hartlepool school is subjected to scrutiny each term with consistent reporting back to the Local Authority.

2012/04
Commission the Hartlepool Teaching School Alliance to provide expertise and personnel to supplement the School Improvement work of the Local Authority and to promote a self-supporting school improvement strategy.

Employment

Employment – unmet needs

A comprehensive assessment of the relationship between service provision and demand is required.

Further research is needed to evaluate if the services offered to both unemployed and employed adults meet their needs. Increases in the unemployment rate could mean that demand outstrips supply.

- The potential of a new group, recently unemployed who may have an increased need for health services. Unemployment could have a detrimental effect not only to an individual's health, but to other members of their family. Adults who are at risk of redundancy or are made redundant may not seek help because of the stigma attached to mental health problems or by the reluctance to admit that there is a problem.
- To ensure that there are regular reviews of unmet needs, it is important that statutory agencies, health services, post-16 providers and employers' network together to debate where there are service gaps and how these can be plugged through existing services.
- Employers would value access to independent expert advice on the functional capabilities of sick employees, especially in longer-term and more difficult instances of sickness absence, where there is great risk of people never working again.

If an Independent Assessment Service (IAS) is not introduced nationally, then consideration should be given to how existing local health and employment services, particularly those who currently offer in-work mentoring, HR and employer advice can work together to sustain adults in work.

Employment – commissioning intentions

2012/01
Complete a comprehensive needs assessment to understand the health service requirements of unemployed and employed adults. Particular qualitative and quantitative research should be undertaken on how both cohorts have potentially differing needs for health service provision.

2012/02
Improve links to existing services for employed adults to ensure that they are adequately connected to early intervention health programmes such as Improving Access to Psychological Therapies (IAPT) service. This will require increased engagement with employers which can be facilitated by the Economic Regeneration Forum.

2012/03
Provide Intermediate Labour Market (ILM) placements to provide work experience with supportive employers who understand the challenges faced by long-term unemployed adults re-entering employment.

2012/04
Commission pre-employability programmes that incorporate healthy lifestyle and fitness to work sessions. These should be focused at pre-Work Programme customers.

2012/05
Provide experienced Information, Advice and Guidance (IAG) officers based within the community and as an integral part of multidisciplinary teams, including health professionals to provide appropriate careers advice and signpost to suitable provision.

2012/06
Promote a healthy and supportive working environment that includes implementing health initiatives and raise awareness of how to tackle in-work stress, anxiety and depression.

2012/07
Provide early access to health provision for employed adults, specifically targeted at preventing those adults reaching the stage of being classified as ‘long-term sick’.

Environment

Environment – unmet needs

An average of 50 additional people die each winter in Hartlepool. Their needs for more appropriate housing and care may contribute to this.

Environment – commissioning intentions

2012/01
Create sustainable neighbourhoods by bringing derelict land and buildings back into use; making streets safer, cleaner and greener; and developing, maintaining and improving green spaces, parks and recreational areas.

2012/02
Ensure that a proactive response to climate change is adopted in Hartlepool by ensuring that buildings do not suffer from water ingress; raising awareness of the risks of skin cancer; planning and testing emergency responses to flooding.

2012/03
Tackle nuisance noise by developing noise action plans in identified areas; tackling highways where noise is a problem; and ensure that noise investigation and enforcement services are maintained.

2012/04
Maintain air quality and reduce pollution so that no Air Quality Management Areas are designated in Hartlepool.

2012/05
Ensure a decent standard of housing by reinvigorating priority neighbourhoods with high quality design and construction of new homes, giving access to vulnerable groups; driving up standards in existing homes where a priority will be improving energy efficiency and providing affordable warmth products; and investing in property to enhance fuel efficiency.

2012/06
Provide an effective pest control service to mitigate pests which harbour diseases, bacteria and parasites.

2012/07
Ensure water quality by sampling both drinking and bathing water (for example, in swimming pools, hydrotherapy/spa pools and Jacuzzis).

2012/08
Reduce work-related death, injury and ill-health, ensuring that resources are focused on the areas which present the highest risk. Management of asbestos, gas safety and cellar safety are identified as priority areas.

Housing

Housing – unmet needs

There are considerable pressures on the resources that are available to deliver the aims of the Housing Strategy and resources are likely to be further reduced as the Council has to achieve considerable savings. There is also increased demand on budgets such as Disabled Facilities Grants.

Priorities have been outlined for investment in housing, associated infrastructure and the economy to the Homes and Communities Agency (HCA) through the Tees Valley Economic Regeneration Investment Plan (TVERIP).

Innovative solutions to attracting funding will be sought and this will involve close partnership working to look for opportunities to combine resources and bid for funding.

The key sources of funding that have been identified to deliver the priorities with the Housing Strategy have been identified as:

- Developer contributions delivered through a Section 106 Legal Agreement
- HCA funding for affordable homes through National Affordable Housing Programme
- HCA funding for empty homes through National Affordable Housing Programme
- DCLG Disabled Facilities Grant for adaptations
- DCLG funding for housing advice and homelessness activity
- DCLG funding for mortgage rescue
- DCLG funding for housing-related support
- Registered provider (RP) investment to continue improvements in social housing stock
- Regional Growth Fund
- The sale and efficient use of Council assets and potential borrowing subject to income streams to cover repayments for re-investment in housing-related programmes.

This funding will be required to meet the following needs:

- Disrepair in the private sector stock and Category 1 hazards.
- The provision of disabled adaptations to meet waiting list demand.
- Housing related support services.
- Handyperson service.
- Emergency Accommodation for homeless households.
- Emergency accommodation and resettlement/move on accommodation for persons with chaotic lifestyles.
- Appropriate housing for vulnerable and older people which would allow them to stay independent for longer.
- Affordable housing to address the identified shortfall for both general needs and specialist accommodation.

It has been identified that there is a lack of suitable accommodation for people under the age of 55 with a disability and this gap needs to be addressed through the Strategy.

Around 80% of newly forming households are finding it very difficult to access open market accommodation.

Housing Benefit (HB) reforms, implemented in January 2012, place restrictions for people under the age of 35. This has seen landlords expressing concern and refusing this age group. This has resulted in increasing numbers of people presenting to the Housing Advice Team who are not classed as priority but genuinely homeless with nowhere to go.

The affordable housing requirement calculated by the Hartlepool Strategic Housing Market Assessment (SHMA) was 244 net additional units. This was revised to 193 by the Tees Valley SHMA.

Housing – commissioning intentions

2012/01
Reinvigorate priority neighbourhoods with high quality new homes, to give access to vulnerable groups.

2012/02
Drive up standards for existing homes where a priority will be improving energy efficiency and providing affordable warmth products. Invest in property to enhance fuel efficiency to generate further funding for investment.

2012/03
Reduce the number of long-term empty properties by bringing them back into use and making their standards higher than ‘fit for purpose’ (that is investment is higher than the value of the property).

2012/04
Fund adaptations thereby enabling people in need to stay in their homes longer and reduce stays in hospitals and care facilities.

2012/05
Invest in appropriate ‘housing-related’ support services (for care leavers, those with learning disabilities, those with complex needs, families with a history of tenancy failure etc.) to ensure individuals/households can live independently.

Poverty

Poverty – unmet needs

Maximising income
Not all benefits are claimed by those who are entitled to them. The following table shows key benefit take-up nationally and the number of people who may be entitled and do not claim. There is lower take-up of pension credit, council tax benefit and jobseekers' allowance compared with other benefits. Assuming benefit uptake in Hartlepool is similar, and that Hartlepool has 0.152% of the population of Great Britain, the number of people not claiming benefits can be estimated.

Estimated take up of income-related benefits, Hartlepool, 2009/10		
Benefit	Estimated take-up (Great Britain)	Estimated number of people with unclaimed benefits in Hartlepool
Income Support and Employment and Support Allowance (Income Related)	77-89%	400 to 900
Pension Credit	62-68%	1,800 to 2,400
Housing Benefit (including Local Housing Allowance)	78-84%	1,100 to 1,700
Council Tax Benefit	62-69%	3,600 to 4,900
Jobseeker's Allowance (Income-based)	60-67%	700 to 900
		Source: DWP, 2012a

Planned changes in the benefit system may affect the number of unclaimed benefits. However, there may still be many people, counted in thousands, not claiming their full benefit entitlement that could lift them out of poverty.

Food needs
There is an unmet need for food. A food bank in Hartlepool provides for households which cannot afford sufficient food (The Trussell Trust, 2012).

Employment needs
In Hartlepool, there are 11 people seeking work for every job centre vacancy (Nomis, 2012).

Poverty – commissioning intentions

2012/01
Ensure residents have access to finance and benefits advice.

2012/02
Ensure that all unemployed and economically inactive adults have greater access to employment and training initiatives. This will require employment and training providers to work closer together to develop bespoke programmes that will help adults overcome barriers to employment.

2013/03
Close the gap in educational attainment between disadvantaged children and other children.

2012/04
Raise awareness of existing employability programmes, such as FamilyWise.

2012/05
Create Intermediate Labour Market (ILM) programmes for the long-term unemployed by all partners pooling resources.

Transport

Transport – unmet needs

None submitted.

Transport – commissioning intentions

None submitted.

Alcohol misuse

Alcohol misuse – unmet needs

None submitted.

Alcohol misuse – commissioning intentions

None submitted.

Illicit drug use

Illicit drug use – unmet needs

None submitted.

Illicit drug use – commissioning intentions

None submitted.

Smoking

Smoking – unmet needs

Education and support of young people
Young people continue to take up smoking. There is a continuing need to educate young people on the harms of cigarettes and the benefits of not smoking. Training needs to be given to youth/community workers in smoking awareness and brief interventions and also to identify positive role models to emphasise the 'no smoking being the social norm' message.

As very few young people access current Stop Smoking Service provision there is also a need to set up a dedicated Stop Smoking Service for those young people who are addicted to smoking and wish to quit. There are four pharmacies in Hartlepool operating under the Community Pharmacy Stop Smoking Enhanced Service scheme but currently they are only able to offer stop smoking support to young people aged 16 and over. However, the intention stated in the Service Level Agreement is that suitably experienced and trained pharmacy staff will be able to offer a service to young people aged 12 and over, adhering to Fraser Guidelines for young people aged between 12 and 16.

It is recommended that suitable training to support this young age group is developed and delivered as soon as possible to meet the Government target ambition 'To reduce rates of regular smoking among 15 year olds in England to 12% or less by the end of 2015'.

Young people under the age of 18 still have illegal access to cigarettes.

Smoking rates are highest in the most disadvantaged electoral wards. Data from the MOSAIC programme indicates that stop smoking provision in Hartlepool is set up in the areas of highest smoking prevalence and SSS data shows the highest number of quit dates set each quarter come from the most disadvantaged wards, but successful quit rates are lowest.

Smoking during pregnancy
Many pregnant women continue to smoke, thus failing to give their child the best start in life.

Second hand smoke
Many non-smokers continue to suffer the effects of second-hand smoke, particularly at home and in private cars.

Mental health patients
The physical health needs of mental health patients are not being fully met by difficulties in engaging staff in undertaking the relevant brief/intermediate intervention training. A top down approach is required.

Use of information
More information on general lifestyle issues (such as weight gain) should be available in community clinics.

More social marketing is needed to identify barriers to accessing Stop Smoking Services and quitting and also use of MOSAIC to target messages appropriately.

Stop Smoking Services
The development of a model of working in the SSS that offers more flexible support to reach more smokers as it is evident from the numbers accessing services that not all smokers feel they can, or want to, stop smoking in the way currently available.

The SSS needs to develop new ways of working such as the New Routes to Quit options currently being piloted in the Region.

Pharmacies and prescribing
Currently only 4 pharmacies are funded to provide a stop smoking service through a tariff system. This was commissioned primarily to improve access in terms of extended opening hours and increased convenience and choice of stop smoking services. Community pharmacies must apply to join the Scheme by completing a self-assessment document to demonstrate that they can comply with the Scheme requirements. Selected pharmacies must agree to adhere to a service level agreement involving appropriate governance procedures; providing an appropriate level of trained staff; and collecting the full gold standard dataset in a timely manner, reimbursed under a tariff payment system.

Other pharmacies in Hartlepool have expressed an interest in providing this service. There is currently not sufficient resource to extend this work to enable pharmacies to provide an enhanced service particularly for clients who are routine and manual workers, pregnant women and young people, thereby contributing to a reduction in health inequalities.

From Statistics on NHS Stop Smoking Services; England 2009/10 experimental statistics from SSS indicate that varenicline was the most successful smoking cessation aid between April 2009 and March 2010. Of those who used varenicline 60% successfully quit, compared with 50% who received bupropion only and 47% who received NRT. Clinical Governance requirements for the Stockton & Hartlepool SSS stipulate that if clients wish to be prescribed Varenicline, medical records must first be verified by their own GP to ensure there are no underlying medical conditions that would prevent its use. When medical records are confirmed clients are then asked to attend for a specific appointment at a designated community clinic with an appropriately trained nurse prescriber. Delays for clients are often experienced through waiting for confirmations from GPs, leading to frustrations for clients and SSS staff. There is continued pressure on the SSS to reduce prescribing costs.

Smoking – commissioning intentions

Smoking Cessation
2012/01
Issue a service tender for the North Tees and Hartlepool Stop Smoking Service which will need, in the next 3-5 years, to:

- Identify and commission key hub functions from the SSS including quality assurance for all providers; training, mentoring and competency assessment for health and health-related professionals who are working in partnership with the Service; central data co-ordination and monitoring; authorisation and payment of tariff systems for providers.
- Commission delivery services appropriate for Hartlepool. This would mean a mix of nurse-led provision, pharmacy provision and provision within the secondary care setting. Currently for Hartlepool there are only 4 pharmacies delivering stop smoking support on a tariff basis through the Community Pharmacy Stop Smoking Enhanced Service. Other pharmacies in Hartlepool have expressed an interest in service provision, but there is currently not the additional resource to fund this.
- Ensure a whole health system approach to tackling smoking by developing service level agreements which:
    - require all health professionals including primary and secondary care staff, midwifery and mental health staff to raise the issue of smoking through a brief intervention and refer to Stop Smoking Services for support;
    - stipulate that referral to Stop Smoking Services is included in relevant care pathways and rehabilitation services for smoking-related disease;
    - include an active case-finding approach for chronic obstructive pulmonary disease.

2012/02
In the longer term there will be a need to consider payment by results using a tariff payment system for Stop Smoking Services as some areas are currently implementing and evaluating this approach.

Tobacco control
2012/03
Continue investment in comprehensive, multi-component tobacco control.

2012/04
Ensure Trading Standards and Environmental Health Departments within the Council have the capacity to contribute to the tobacco control agenda.

2012/05
Engage a variety of other local authority departments in tobacco control work such as adult and children's services, housing and planning.

Diet and nutrition

Diet and nutrition – unmet needs

There is increased demand for the Health Trainer service, which is currently the only provider of diet and nutrition advice in the community at the tier 1–2 level of intervention. Therefore there is a need to review referrals and pathways to meet current and future demand.

For breastfeeding, there are unmet needs for:

- A universal model of antenatal information giving/contact with pregnant women delivered by health visiting teams to identify and act upon barriers to healthy feeding choices for babies.
- An increase in the capacity of health professionals to be able to support women with breastfeeding in the first two weeks after delivery when Hartlepool has its greatest ‘drop off’ in the numbers breastfeeding.
- A comprehensive paid peer support programme (NICE 2008a, 2008b, 2006)
- Multiple ‘Breastfeeding Welcome’ venues, both statutory and private retail, in Hartlepool.
- More ‘local’ breastfeeding support groups.

As the Healthy Start scheme is significantly under utilised for vitamin supplements there is a need to raise the awareness of the scheme, in relation to the vitamin element particularly, both with professionals and families. There is a lack of organisation of the scheme as there is no lead person allocated for the overall co-ordination locally.

There is a need for intensive engagement with people with learning disabilities to develop a greater understanding of healthy eating and weight management. There is a particular need for increased support and education for adults who move from a care setting to independent living and those already in supported living as often they lack the resources and knowledge to purchase and eat a balanced diet.

It is essential that staff working with people with learning disabilities, in particular the care providers’ workforce, receive basic nutrition awareness and identify champions in areas to enable them to support people with learning disabilities to make healthy meals. Currently, this is not available. There is also a lack of specialist help available to support people with learning disabilities who are diagnosed with diabetes.

There is a lack of awareness about the correct use of identification tools for malnutrition and processes followed in community care and social care settings.

Diet and nutrition – commissioning intentions

2012/01
Implement evidence-based best practice to maximise breastfeeding initiation and continuation. Ensure appropriate support services are in place and that health professionals are appropriately trained to provide support and consistent advice throughout antenatal and postnatal periods.

2012/02
Promote healthy eating, making use of national campaigns and brands, and develop joint working with key sectors, such as planning and transport departments, to ensure the potential for physical activity and healthy eating is maximised, including the use of health impact assessments to address the causes of obesity.

2012/03
Increase promotion and uptake of the national Healthy Start initiative, in particular vitamin supplements, to both professionals and the target audience.

2012/04
Ensure targeted support and increase Health Check uptake for those identified as most at risk of malnutrition. This includes tackling wider determinants by providing debt advice, improving housing conditions and ensuring access to affordable food.

2012/05
Develop consistent and integrated strategies among all health and social care providers to detect, prevent and treat malnutrition. Make appropriate training available to staff in all settings so that they have a common basic knowledge of nutrition and the skills to promote a nutritionally adequate diet.

2012/06
Ensure that good quality and healthy food is provided by working with local public sector service providers, such as schools, hospitals, and prisons.

Physical inactivity

Physical inactivity – unmet needs

A significant proportion of facilities are education owned and this has implications in terms of accessibility.

There is only one public access swimming pool which accounts for 50% of the total water area in Hartlepool. All other pools are on school sites.

The Sport England Active Places model indicates that 908m2 of swimming pool area is required for Hartlepool. The actual area is 1477m2 prior to the closure of one pool.

Only one secondary school has been granted Building Schools for the Future (BSF) funding. This loss of BSF for all other secondary schools limits their community sporting provision.

There is a demand for sports halls for physical activity but there is limited access on some sites during the day as they are school sites.

There are high numbers of facilities within Hartlepool but they are not all in the best locations. Some have poor levels of maintenance and are in need of refurbishment.

There is a range of activities offered by the council which are reasonably accessible by vulnerable and older people, but some members of the community are not aware of the opportunities.

Physical inactivity – commissioning intentions

2012/01
Implement joint commissioning to support a move from a mainly project-based approach to one which embeds healthy weight in all commissioning decisions.

2012/02
Provide early interventions from preconception up to age 2 years to address the rising levels of child obesity.

2013/03
Develop and agree healthy weight protocols for adults, children and families which explain the role of all professional groups from early prevention to specialist treatment. This should include input from key partners including extended services, sport and recreation and play.

2012/04
Implement family-based interventions as these are the most successful approach to tackling obesity in children. Advice from the former National Support Team (NST) recommends that extended services are pivotal to engage with parents to tackle obesity.

2012/05
Develop strategies for both walking and cycling which include a multi-agency approach.

2012/06
Increase community access to existing school facilities.

2012/07
Support the Community Activities Network to provide a base for commissioning opportunities in Hartlepool and as a central point for discussion and planning.

2012/08
Commission a single website that brings together the physical activity opportunities available in Hartlepool instead of having multiple sources of information, although steps must be taken to avoid increasing health inequalities via the 'digital divide'. Any such site should incorporate the current and emerging opportunities offered by social networking.

Obesity

Obesity – unmet needs

Hartlepool continues to provide some weight management services but due to financial constraints, there are several significant gaps in services.

All the services within Hartlepool have been mapped using the life course perspective. This was discussed in Fair Society, Healthy Lives: The Marmot Review by Professor Michael Marmot. It states that disadvantage starts before birth and accumulates throughout life, and action must be taken before birth and continue throughout the life of a child/person.

By mapping services according to each life course stage, it allows an understanding of whether there are any service gaps affecting different age groups in the population. The life course perspective approach below shows that there is a lack of services for children (under 18 years) and their families.

Service Area	Life Course Stage
Health trainer-type service for children. Service to include working with people with learning disabilities	Primary school 4-11 years Secondary school 11-16 years
Family health trainer-type service	Across all life course stages
Early years healthy weight service	Maternity-9 months Post Natal & Weaning 0-2 years Pre-school 3-5 years
Tier 3 weight management intervention with clear pathway	Primary School 4-11 years Secondary School 11-16 years Adulthood 16-60 years Ageing 60+ years
Tier 4 weight management intervention with clear pathway	Adulthood 16-60 years Ageing 60+ years
Standard and consistent psychological support provided alongside weight management services	Across all life course stages

Obesity – commissioning intentions

2012/01
Address and prevent early years and childhood obesity.

2012/02
Prevent people becoming overweight and obese by focusing on population-wide interventions and weight management services in community settings (tier 1 and tier 2 services).

2012/03
Focus on a healthy weight – the aim of Hartlepool's Healthy Weight Strategy is to "improve the health of people by ensuring a healthy weight culture which supports and encourages people to achieve and maintain a healthy weight and lifestyle".

2012/04
Commission specialist weight management services for Hartlepool.

- Tier 3 specialist weight management service with an effective pathway for children within Hartlepool
- Tier 3 weight management service with an effective pathway for adults
- Tier 4 weight management service with an effective pathway for adults
- Health trainer type provision for families, children and people with learning disabilities or mental health problems.

Sexual health

Sexual health – unmet needs

Although TPA provide rapid testing for HIV they do not appear to have the capacity to provide this service in Hartlepool, therefore access to rapid HIV testing is required.

There is limited access to sexual health services for people with learning disabilities.

Sexual health services for young people. Following "You're Welcome" feedback recommendations and the continuous rise in teenage pregnancies, this dedicated service is a requirement to meet the needs of young people in Hartlepool.

School-based sexual health services are not available in all schools and colleges.

Some schools are not delivering recommended sex and relationship programmes which are age appropriate and evidence-based.

Sexual health – commissioning intentions

2012/01
Reduce under 18 conceptions by maintaining efforts to reduce teenage pregnancy in the context of work to reduce child poverty and health inequalities and focusing targeted interventions in specific areas where there are high levels of teenage pregnancy.

2012/02
Reduce sexually transmitted infections by increasing testing in high risk groups and maximising service contacts. Increase chlamydia testing coverage and diagnosis by focusing on the National Chlamydia Screening Programme key messages and use of the commissioning toolkit.

2012/03
Increase uptake of HIV testing and reduce late HIV diagnosis by exploring the merits, acceptability and cost-effectiveness of setting up specific community-based HIV testing sites targeted at the Black African population and men who have sex with men.

2012/04
Ensure young people have access to sexual health services by making certain that services are delivered in accordance with service standards and are appropriate and accessible to all, including provision and access for young people. Improve the quality and opportunities for sex and relationship and risk-taking behaviour education in schools and other settings.

2012/05
Increase long-acting reversible contraception (LARC) provision and ensure the workforce is trained to offer and provide LARC.

2012/06
Make sure that service provision is in line with need by combating discrimination and stigmatisation and reducing barriers to access sexual health information.

Cancer

Cancer – unmet needs

Low screening uptake
Participation in cancer screening programmes could be improved by:

- Better meeting the needs of those with physical and learning disabilities
- Ensuring people who are not registered with a GP have access to screening
- Working with local communities to raise awareness, address screening myths and improving participation in screening.

Stage of diagnosis
Early diagnosis and treatment of cancer is an important factor in improving outcomes for cancer. In addition to programmes targeted at the population such as awareness campaigns and population-based screening for cancer, providing fast access to efficiently managed services remains key to ensuring a patient moves along the pathway towards diagnosis and treatment in the most timely and appropriate manner.

GP support
Although GPs typically only see around eight or nine new cancer patients each year, they see many more patients presenting with symptoms that could be cancer. A range of support is available to help GPs assess when it is appropriate to refer patients for investigation for suspected cancer, such as NICE referral guidelines, but more could be done to support them.

Media campaigns to increase signs and symptoms awareness
Recommendations from the Tees NAEDI evaluation, carried out by Durham University revealed that most participants in the project felt that a media campaign to support this awareness and early diagnosis initiative would have been beneficial. There was initial consensus that more media campaigns delivered regionally would be useful.

The most popular means of communication selected was TV (45%), closely followed by leaflets/flyers (40%) newsletters (27%) and doctors' waiting rooms (23%). Male respondents were significantly more likely to be interested in communication via the TV (50%) and radio (18%), while women were significantly more likely to be interested in leaflets and flyers (46%) and newsletters (30%).

The launch of the regional bowel and lung cancer symptom awareness campaigns offers an opportunity to develop future work in response to the Cancer Awareness Measure results which reflect the needs of the population.

Cancer – commissioning intentions

2012/01
Reduce premature deaths from cancer through improved cancer prevention, early detection and prompt, effective treatment and care. This will help to reduce the death rate from cancer, improve prospects for survival and improve quality of life for those affected by cancer. Reducing the delay before first going to see a GP among patients from disadvantaged groups can reduce inequalities in cancer outcomes. Ensuring patients are referred quickly to specialist services by GPs and improving access to diagnostic services can reduce cancer mortality.

2012/02
Tackle lifestyle risk factors by using interventions that reduce smoking and alcohol consumption, increase fruit and vegetable consumption, reduce obesity and encourage physical activity. Primary prevention (preventing people getting cancer in the first place) is seven times more effective than secondary prevention (detecting cancer before it is symptomatic leading to prompt treatment).

2012/03
Improve screening uptake. Achieving adequate levels of uptake in cancer screening requires a variety of approaches that need to be shaped by the characteristics of both the screening programme and the target population. Addressing inequalities in uptake is a priority for screening programmes. Cancer screening has the potential to make a major contribution to early diagnosis initiatives and will best be achieved through uptake strategies that emphasise wide coverage, informed choice and equitable distribution of cancer screening services.

2012/04
Improve awareness of cancer signs and symptoms. The public's awareness of early cancer symptoms is poor and may be contributing to late presentation and poorer survival. Early diagnosis and treatment of cancer is an important factor in improving outcomes for cancer services. Early diagnosis requires that individuals are aware of the symptoms of early cancer, that they have access to primary care professionals and seek advice from them if symptoms occur, that these symptoms are then identified as potential symptoms of cancer, and finally that appropriate investigations and referrals are initiated.

Circulatory diseases

Circulatory diseases – unmet needs

Increasing risks
With trends in obesity levels rising it is anticipated that there will be a significant increase in the number of diabetes cases and pre-diabetes which is likely to have an impact on the incidence of CVD. In addition, there is a need to improve diagnosis and management of patients with impaired glucose regulation.

Undiagnosed disease
There are gaps between actual and estimated prevalence with some CVD-related conditions. By definition, these undiagnosed individuals have unmet needs, and are the 'missing thousands' referred to by the Health Inequalities National Support Team.

Screening for disease
The NHS Health Check programme aims to identify and appropriately manage individuals at risk, though there are problems with uptake by some groups and individuals, most notably men and deprived groups.

Emergency admissions
Emergency admissions indicate unmet need. While decreasing in some cases, they still remain significantly above the England average, and also highlight intra-district inequalities. In 2009/10, the emergency admission rate for CHD, all persons, in Hartlepool was 369.0 per 100,000 (428 admissions). This is significantly higher than England (205.3 per 100,000) and the North East (259.5 per 100,000). Male CHD emergency admission rates are significantly higher than female CHD emergency admission rates.

Circulatory diseases – commissioning intentions

2012/01
Include NICE guidance CG95 (Chest Pain of Recent Onset recommends use of CT calcium scoring as the first-line diagnostic investigation for CAD, and the removal of exercise ECG to diagnose or exclude stable angina for people without known CAD) in locality pathways.

2012/02
Monitor anticoagulant therapy in primary care.

2012/03
Ensure systematic patient involvement in CVD possibly through Local Health Watch.

2012/04
Use the Health Inequalities National Support Team (HINST) approach to active disease register management and QOF support for GP practices as recommended in 'Closing the gap - finding the missing thousands' to ensure that this target group are engaged to consider reasons why they have not previously engage/taken up offers of support;

2012/05
Ensure that the learning from evaluation of the NHS Health Checks programme is adopted to improve this programme further.

Diabetes

Diabetes – unmet needs

Self-management is recognised as the cornerstone of diabetes care but currently there is no routine, ongoing assessment of educational need. Structured education programmes are limited to those newly diagnosed.

People at risk of developing diabetes are not being systematically identified. When they are identified, many people still continue to progress to develop diabetes.

Despite the introduction of systematic review for patients, diabetes complications rates remain high.

Diabetes – commissioning intentions

2012/01
Develop, implement and monitor strategies to reduce the risk of developing type-2 diabetes and to reduce the inequalities in the risk of developing type-2 diabetes. NICE guidance expected in 2012 on preventing the progression from pre-diabetes is expected to support this progress.

2012/02
Further develop, implement and monitor strategies to identify people who do not know they have diabetes.

2012/03
Ensure existing commissioned services are sufficiently resourced to accommodate increase in diabetic population.

2012/04
Develop, implement and monitor protocols to further reduce and effectively manage diabetes complications.

2012/05
Provide more life-long opportunities for education and self-management for those with diabetes.

2012/06
Reduce treatment and outcome variation by encouraging and promoting peer review of diabetes management amongst general practices with sharing of best practice.

Injuries

Injuries – unmet needs

Pedestrian and cycling training
Not all schools take up the offer. If all schools did respond positively to the offer it would be unlikely that the local authority would have the capacity to deliver in all schools.

Injuries – commissioning intentions

2012/01
Ensure unintentional injury prevention is included in local plans and strategies.

2012/02
Ensure adequate resources are available for local partnerships and prevention strategies.

2012/03
Ensure that in local plans, the home safety assessments and education is aimed at vulnerable families with a child under-5 years old.

2012/04
Consider outdoor play, leisure and road safety in local plans.

2012/05
Consider the role of housing associations and landlords as key partners.

2012/06
Develop a standardised data collection method that enables sharing within and between organisations.

2012/07
Improve identification of vulnerable families and strengthen planning and co-ordination of prevention activities.

2012/08
Develop guidelines for management and pro-active follow-up of childhood injuries.

Mental and behavioural disorders

Mental and behavioural disorders – unmet needs

There is evidence of a short waiting list (averaging 1 or 2 people) for people with mental ill-health who need supported accommodation in Hartlepool.

There are 7 people placed out of area due to their specialist / complex / dual diagnosis needs. Further analysis should take place to determine whether it would be cost-effective to consider commissioning suitable services locally.

The numbers of people with mental ill-health who have a personal budget and use a direct payment to commission their own support services is growing. There was 1 personal budget in mental health services in 2007 and 140 in November 2011. These numbers are expected to continue to increase significantly over the next 3 years. As these numbers increase commissioners will need to identify appropriate services for de-commissioning otherwise there will be a significant risk of double running costs.

Waiting lists for IAPT and talking therapies indicate the need for additional services to meet need. In February 2012 there were 45 people waiting for assessment and 22 people waiting for therapy with a waiting time of approximately 8 weeks. In 2010/2011 the waiting list was 2 weeks (Source: Hartlepool MIND).

The CAMHS service has seen an increase in the number of bereavement referrals over the year due to funding pressures being felt by local bereavement services. There is a need for Autistic Spectrum Disorder services in Hartlepool and a requirement for improving access to the CAMHS service through extended opening hours and alternative venues to accommodate young people and families. The current service opens 8am–6pm, Monday to Friday.

Mental and behavioural disorders – commissioning intentions

Priorities for 3-5 years

2012/01
Increase the numbers of people with a mental health problem who have a personal budget.

2012/02
Increase the numbers of people in settled employment.

2012/03
Increase the numbers of people in their own settled accommodation. Commissioners in Hartlepool should consider increasing accommodation for people with mental ill-health who need supported accommodation by 2 units in the short-term.

2012/04
Increase the availability of psychological therapies and early intervention services.

Long-term priorities

2012/05
Ensure physical and mental well-being are seen as equal priorities.

2012/06
Ensure wellbeing services, psychological and family therapies are widely available.

2012/07
Ensure people receive personalised services and plan their own outcomes.

2012/08
Ensure people are brought home from out-of-area placements into their communities.

Oral health

Oral health – unmet needs

If preventive services are not commissioned, there will be an increase in decay levels in children.

Oral cancer screening may be targeted insufficiently.

The needs assessments that are proposed/waiting analysis for people with learning disabilities and older people in nursing homes will give further insight into unmet needs.

There is a need for behaviour management services to reduce sedation rates.

There are long waiting times for children needing urgent general anaesthetic services.

Oral health – commissioning intentions

2012/01
Commission prevention services to improve oral health and reduce inequalities by:

- Extending the school tooth brushing programmes.
- Supporting practices to reorient their services to follow evidence-based care pathways.

2012/02
Improve access for children to preventive health care by:

- Implementing 2nd birthday card scheme.
- Extending “adopt a school” scheme by practices.

2012/03
Improve waiting times for specialist services in:

- Orthodontics (hospital services).
- Community dental service - general anaesthetic services.
- Paediatric anxiety management services.

2012/04
Implement a targeted systematic oral cancer screening programme as part of the early cancer diagnosis initiative.

2012/05
Improve oral health for vulnerable groups by:

- Implementing recommendations from the needs assessment undertaken for older people in nursing homes.
- Undertaking a needs assessment/health equity audit for people with learning disabilities, drug misusers and young offenders.

Respiratory diseases

Respiratory diseases – unmet needs

The capacity and capability of current services is insufficient to cope with the projected increase in the number of people with COPD, from a registered prevalence of 2.7% in 2010 to 4.5% in 2020.

There is low awareness of lung health and COPD in sub-groups that are at high risk (for example current and ex-smokers and women).

There is inequitable access to high quality spirometry in primary care and community settings.

Inappropriate admissions imply unmet need for continuing care and education and support for patients.

Care process measures for asthma and COPD are generally better in Hartlepool than the England average but emergency admission rates are higher and there is a need to understand why.

There is limited access in terms of capacity and location to supported self-management programmes based on Expert Patient evidence.

There are insufficient patient support groups especially for young people with asthma.

Many people with COPD don't have an end of life care plan.

Respiratory diseases – commissioning intentions

2012/01
Develop proactive, systematic and sustainable approaches to increasing the numbers of people diagnosed and treated for COPD.

2012/02
Reduce smoking prevalence by targeting high risk groups, including improving access to smoking cessation services for people with asthma and COPD.

2012/03
Improve public and professional awareness of asthma and COPD prevention, diagnosis and treatment.

2012/04
Reduce variation in clinical management of asthma and COPD to ensure that people with COPD, across all social groups, receive safe and effective care, which minimises progression, enhances recovery and promotes independence.

2012/05
Implement a systematic and co-ordinated proactive approach to early identification, diagnosis and intervention, and proactive care and management at all stages of the disease, with a particular focus on the disadvantaged groups and areas with high prevalence.

2012/06
Provide co-ordinated support for people with asthma and COPD to self-manage their conditions more effectively.

2012/07
Ensure resources for respiratory disease reflect the rising number of people with the condition and the demand on health and social care.

2012/08
Develop, implement and monitor strategies for tackling the wider issues that increase the risk of asthma attacks and exacerbation of COPD through effective partnership working.

2012/09
Improve secondary prevention for people with asthma and COPD through increasing uptake of seasonal flu immunisations, smoking cessation and other lifestyle interventions.

Self-harm and suicide

Self-harm and suicide – unmet needs

Professional issues

Workforce development needs to address:

- Awareness of suicide prevention/mental health
- Knowledge of services/pathways
- Providing support to individuals in need
- Improving confidence to raise the issue of suicide prevention and self-harm

Commissioning issues (eg. non-recurrently funded services) means a lack of ability to plan services commissioned on traditional opening hours.

Patient issues

Postvention services and counselling may be insufficient.

Inconsistent pathway development and awareness between services.

Robust pathways for those in transition between services e.g. children to adults.

No floating support services to provide immediate input whilst patients are waiting to be seen by other services.

Lack of services/pathways for people with long-term conditions and those with untreated depression.

Integrated pathway for dual diagnosis.

Population issues

Raising awareness and tackling stigma with the local population.

Suspected under reporting of self-harm in BME, Asylum Seekers and LGBT communities.

Males are less likely to access traditional health services.

Media engagement is insufficient.

Self-harm and suicide – commissioning intentions

2012/01

Maintain and improve the early alert system to identify potential suicide clusters.

2012/02

Provide a comprehensive understanding of self-harm, suicide, and further identify levels of unmet need, building on existing local research evidence.

2012/03

Put in place robust protocols to ensure integrated service provision between agencies.

2012/04
Map all existing services/pathways, compare them against examples of best practice, identify gaps and make recommendations for improvement including.

- Develop and commission a specific pathway of care for those people who are identified as “frequent flyers”;
- Introduce a standardised tool for the assessment of risk in primary care and develop appropriate protocols;
- Commission postvention services; and
- Explore options for a floating support provision for high risk individuals.

2012/05
The Tees suicide prevention taskforce should develop a revised suicide/self-harm prevention multi-agency action plan, including a communication plan.

2012/06
Agree a multi-agency pooled budget for the implementation of the plan.

2012/07
Agree future approach and commissioning intentions relating to awareness raising and skills development, based on a local training needs analysis.

2012/08
Ensure that Local HealthWatch organisations signpost to appropriate services for those at risk of suicide and self-harm.