Version 1.0

Middlesbrough
Joint Strategic Needs Assessment
2012-15

Unmet needs and commissioning intentions arising from JSNA

18th July 2013

Table of contents

	Page
Vulnerable groups	
Learning disabilities	1
Physical disabilities	2
Sensory disabilities	4
Sexual violence victims	5
Domestic violence victims	6
Carers	9
End of life care	9
Ex-forces personnel	10
Migrants	12
Travellers	13
Offenders	14
Wider determinants	
Crime	16
Education	18
Employment	19
Environment	20
Housing	23
Poverty	25
Transport	26
Behaviour and lifestyle	
Alcohol misuse	28
Illicit drug use	29
Smoking	31
Diet and nutrition	34
Physical inactivity	35
Obesity	37
Sexual health	38
Illness and death	
Cancer	40
Circulatory diseases	41
Diabetes	42
Injuries	44
Mental and behavioural disorders	45
Oral health	46
Respiratory diseases	47
Self-harm and suicide	49

Learning disabilities

Learning disabilities – unmet needs

At present there are no specialist services for people with both learning disabilities and dementia. It is forecast that the number of people in Middlesbrough with learning disabilities aged fifty and above will increase by almost ten percent by 2021.

Autism is not a learning disability. As such, services for people who are autistic and have other social care needs, for example, a physical disability, are not always designed to cater to the specific needs that are present in people with autism.

Learning disabilities – commissioning intentions

2012/01
Stimulate local markets to ensure the availability of choice and cost-effective provision which meets needs locally:

- Introduce a new learning disabilities respite facility on the former Levick Site.
- Seek to bring people back home or to prevent others from being placed out of area relating to autism through remodelling local services including the development of supported living options, links to education and day opportunities.

2012/02
Promote supported living, reduce dependencies and foster reablement resulting in a reduction of hospital admissions and a reduced reliance upon residential care:

- Develop a three year programme for move on options for individuals within learning disabilities forensics services identified as ready to move on.
- Promote, improve and increase supported living opportunities as the strategic direction for accommodating people with learning disabilities.

2012/03
Promote personalised systems which place the person at the heart of any process, provide information and advice, and stimulate universal access to all services:

- Ensure that government targets for the implementation of personalised budgets are met.
- Align services in conjunction with the introduction of personal health budgets.
- Introduce a Universal Information, Advice and Advocacy service.

2012/04
Promote health and wellbeing including early intervention, to prevent/reduce reliance on service provision:

- Introduce personal budgets for carers.
- Improve the public health of residents within residential care settings through improved nutrition, hydration and social inclusion.

2012/05
Ensure that the principles of quality, equality and value for money are embedded within processes and service provision:

- Seek to renegotiate home care contracts and/or conduct market testing on service provision and cost.
- Scope the re-provision of day services as part of the community building review.
- Undertake a review of the 'Fairer Charging' policy.
- Review all out of area placements, developing local services where possible and renegotiating placement costs. This should be carried out in conjunction with the NHS to agree risk share on high cost placements and plans for move on.
- Rationalise day service provision for individuals in residential care settings.
- Implement a single resource allocation system.

Physical disabilities

Physical disabilities – unmet needs

- Services for people with physical disabilities and complex needs.
- Services for people with acquired brain injuries.
- Specially adapted housing in the right locations.

Physical disabilities – commissioning intentions

Middlesbrough Council's commissioning intentions are based upon a number of factors including national policy, local demographic analysis and intelligence, corporate requirements including the ongoing efficiency programme and analysis of the impact of partner decisions and actions.

The department currently has a number of over-arching goals which we hope to meet by achieving a number of planned actions.

2012/01
Stimulate local markets to ensure the availability of choice and cost-effective provision which meets needs locally:

- Provide intelligence to encourage the new development of provision to meet emerging needs.
- Develop a model for extra care housing using private financing arrangements on the old St Paul site.

2012/02
Promote supported living, reduce dependencies and foster reablement resulting in a reduction of hospital admissions and a reduced reliance upon residential care:

- Develop option for supported living within community settings for people with physical disabilities.
- Review advocacy provision and determine future demands.
- Progress proposals for delivering assisted living lifestyles at scale.
- Agree strategy for improving health and wellbeing of people in care homes through development of "virtual wards" concept and the alignment of GPs to care home clusters.
- Participate in and implement agreed actions from joint groups/meetings with South Tees Hospitals NHS Trust to improve discharge arrangements and reduce unnecessary admissions.

2012/03
Promote personalised systems which place the person at the heart of any process, provide information and advice and stimulate universal access to all services:

- Establish a Physical Disability Partnership Forum to oversee and implement the Physical Disabilities Strategy.
- Implement recommendations from the scrutiny process regarding stroke services. Ensure that government targets for the implementation of personalised budgets are met.
- Align services in conjunction with the introduction of personal health budgets.
- Introduce a Universal Information, Advice and Advocacy service.

2012/04
Promote health and well-being including early intervention, to prevent/reduce reliance on service provision:

- Introduce personal budgets for carers.
- Improve the public health of residents within residential care settings through improved nutrition, hydration and social inclusion.

2012/05
Ensure that the principles of quality, equality and value for money are embedded within processes and service provision:

- Seek to renegotiate home care contracts and/or conduct market testing on service provision and cost.
- Scope the re-provision of day services as part of the community building review.
- Review and re-provide services from the current deaf centre site.
- Undertake a review of the departments 'Fairer Charging' policy.
- Review all out of area placements, developing local services where possible and renegotiating placement costs. This should be carried out in conjunction with NHS Tees to agree risk share on high cost placements and plans for move on.
- Rationalise day service provision for individuals in residential care settings.
- Implement a single resource allocation system.

Sensory disabilities

Sensory disabilities – unmet needs

Specially adapted housing is required in certain locations.

Sensory disabilities – commissioning intentions

2012/01
Stimulate local markets to ensure the availability and choice of cost-effective provision which meets needs locally by:

- Making information and advice on support services available (including making costs available to service users and carers in appropriate formats);
- Working alongside providers to ensure their practices comply with the outcomes-based aspirations of service users.

2012/02
Promote personalised systems that place the person at the heart of any process, provide information & advice and stimulate universal access to all services by:

- Developing and implementing a 'Citizens Portal' (an online resource that acts as a gateway to information in Middlesbrough);
- Carrying out research into how social media can be used in social care as a communication tool;
- Providing training and awareness of information delivery strategy, sources and their responsibilities (social workers, staff in provider services, VCS organisations, local authority staff);
- Ensuring that the government targets for the implementation of personalised budgets are met;
- Reconfiguring management structures within social care to develop locality-based services;
- Reviewing the 'Integrated Occupational Therapy Service' arrangements in light of vertical integration between South Tees Hospitals Foundation Trust and MRCCS;
- Introducing universal information, advice and advocacy service to meet the needs of customers;
- Implementing changes to the first contact point in social care to improve response to the public.

2012/03
Promote health and well-being (including early intervention) to prevent/reduce reliance on service provision by:

- Reviewing Middlesbrough Council's approach to the use of Telecare and its Carelink services (including remodelling and marketing where applicable and link to Telehealth);
- Implementing the Combined Delivery Plan in affiliation with the members of the Safer Middlesbrough Partnership (SMP).

2012/04
Ensure that the principles of quality, equality and value for money are embedded within processes and service provision by:

- Implementing an alternative and improved model of support for Deaf Centre users;
- Implementing a single resource allocation system;
- Giving all new service users, those within existing services and those in transition a resource allocation and the opportunity to take up an individual budget if appropriate.

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.

2012/9
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

There is a need for better data collection and analysis in several areas to inform the local understanding of unmet needs. Areas where there is little prevalence data available include:

- Victims of abuse who are men;
- Victims of abuse who are in LGBT groups;
- Teenager abuse (intimate partner violence);
- Elder abuse;
- The relationship between mental health and abuse.

Health needs
The health needs of local families affected by abuse are also not fully understood. There is no routine data available on the number of people attending either their GP or the local Accident and Emergency department for issues related to abuse.

Children and young people
Children are currently being prioritised according to their level of assessed risk of significant harm. This means that a large number of children who are not known to social care are potentially missing out services that could be most effective at the early intervention stage.

Perpetrator work
A pilot project is currently in place to trial an education intervention with low/medium risk perpetrators of abuse. This intervention aims to raise motivation to change and to support self-insight by perpetrators. This initiative will only be suitable for a number of perpetrators and further group work will need to be in place to support higher risk cases and longer term behaviour change.

Substance misuse and domestic violence
More information is required on the number of clients within alcohol and substance misuse services that are affected by abuse.

Teenage pregnancy
The rate of teenage conception in Middlesbrough is higher than the England average. The most significant risk factors for domestic violence are known to be gender (females), pregnancy, and age (16-25) which places this group of young people in the higher risk category. There is a need to map the work that takes place with this group for domestic abuse both in terms of victims and perpetrators.

Domestic violence victims – commissioning intentions

2012/01
Commissioning

- Multi-agency partners should continue to support the domestic violence sector to secure funding for those initiatives identified as priorities through the Domestic Violence Strategy Group (DVSG);
- Agencies should continue to support the DVSG to strengthen the commissioning arrangements for domestic violence to ensure joint commissioning decisions are made through the group in order to strengthen the delivery of the strategy and improve outcomes for victims of abuse;
- Improve data in areas with information gaps: teenage pregnancy, accident and emergency, alcohol and substance misuse, and diverse community groups affected by abuse;
- Data collection should be strengthened to ensure quarterly arrangements are in place to inform performance and identify trends;
- A co-ordinated approach should be taken to ensure capacity issues within work to support children and young people affected by abuse are addressed;
- The findings from the 'pilot' perpetrator education intervention should be reviewed and used to inform the commissioning of further perpetrator work;
- There is a need to understand the arrangements for the commissioning of female genital mutilation initiatives and further scoping work to identify the work that takes place to address this issue.

2012/02
Interventions

- Continue to review and develop family-focused interventions to strengthen the response to low/medium risk domestic abuse cases;
- Consider ways of better understanding the needs in complex MARAC cases to put in place longer term support packages;
- Improve the Special Domestic Violence Court (SDVC) process to ensure more successful prosecutions;
- Improve the number of unsupported prosecutions for domestic abuse to take the onus away from the victim.

2012/03
Prevention

- Continue to support a domestic abuse training programme and ensure that this includes the relationship between substance misuse and alcohol and working with domestic abuse perpetrators;
- Complete a scanning exercise of the provision in place in mainstream and voluntary sector services to support the work with children and young people;
- Develop a children's workforce and develop ways of strengthening early interventions;
- Consider developing locality-based approaches to tackling the abuse agenda in areas of high prevalence.

Carers

Carers – unmet needs

None identified to date

Carers – commissioning intentions

None identified to date.

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
The Joint Health Overview and Scrutiny Committee of North East Local Authorities report on the regional review of the health needs of the ex-service community 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
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

Interpreter services
There is an increase in preventable diseases due to lack of awareness (i.e. diabetes within the Asian communities).

Misdiagnosis may occur due to the use of unqualified and untrained interpreters.

Language and communication skills
The availability of English language provision is key both for health and community integration. Evidence suggests that English language learning has a significant and positive impact on individuals, communities and the productivity and safety of workplaces with lack of fluency in the language condemning most migrants to poverty or being marginalized.

Housing
Suitable temporary accommodation is not available (and for long-term periods in some cases).

Access to decent, settled and affordable accommodation in the private and social sectors that meet the social, cultural wellbeing needs of migrant households are not always available.

Transport
Access to services is hampered by lack of affordable transport.

Migrants – commissioning intentions

2012/01
Enhance the assessment of the health needs of the migrant population.

2012/02
Improve communication and mutual understanding about the health and social care entitlements of migrants, such as advice, information and guidance for both front line staff and migrants (particularly asylum seekers).

2012/03
Work closely with the voluntary sector, faith organisations, employers and landlords to ensure the migrant population receive the information and advice on how to access local services.

2012/04
Work closely with the local interpreting service, school admission and/or education support services to understand the profile of Middlesbrough migrants.

2012/05
Improve access to (and conditions of) migrant workers' housing.

2012/06
Devise and implement a plan to increase GP registrations by migrant workers.

2012/07
Work with Clinical Commissioning Groups to ensure that primary care contracts and specialised services are negotiated with the consideration of the health of migrants.

2012/08
Develop a plan to ensure the early diagnosis of blood borne viruses (HIV, Hep A, B and C), prevent onward transmission and improve outcomes.

2012/09
Target asylum seekers and refugees to encourage them to access mainstream mental health services.

2012/10
Encourage migrants to be screened for chronic medical conditions. This may improve early identification and support and avoid preventable complications, A&E attendances and avoidable hospital admission.

2012/11
Develop a plan to identify mental health problems and provision of appropriate support to reduce risk of crisis and suicide.

2012/12
Early identification of mental health problems of migrants and the provision of appropriate support are required, to reduce their risk of suicide or need for crisis interventions.

2012/13
Targeting of populations at risk of developing Type 2 diabetes and CVD is required to lead to the delivery brief intervention programmes. This will raise the community's awareness and ensure sustainable changes for their physical activity/dietary behaviours.

2012/14
Work closely with existing BME networks, community groups, leisure services and primary care services to develop culturally sensitive health schemes.

Travellers

Travellers – unmet needs

None identified to date.

Travellers – commissioning intentions

None identified to date.

Offenders

Offenders – unmet needs

Mental health
There is clearly a high level of need amongst offenders in relation to mental health. It has already been identified in local and national needs assessments that this is an issue and will be addressed predominantly through developments related to the 'Big Diversion' project.

Lifestyle issues
Lifestyle choices are a major issue, most notably smoking. There are some processes in place for dealing with these by staff working within the criminal justice system or via referral to community services but this does not meet the needs of the client group.

Alcohol misuse remains a major issue with the long term consequences yet to impact fully on the health system. Access to support via primary, secondary and specialist care is available but needs to be extended especially in relation to early interventions.

Deprivation
Access to appropriate housing and to employment is a key priority. This has a major impact on reducing offending and improving health.

Needs analysis
There is a need to improve processes for identifying unmet needs. Ensuring that health needs assessment is appropriate is a priority.

Families/relationships
The level of need that families of offenders require is very high and impacts heavily on local resources.

Offenders – commissioning intentions

2012/01
Offender health should be viewed in the context of broader health and social care and public health issues with much closer working relationships strategically and operationally, especially in primary care.

2012/02
The public health outcomes framework should be reflected in local reducing re-offending strategies and action plans.

2012/03
Family/social isolation issues should be at the forefront of local care planning processes.

2012/04
The assessment of offender health needs and the action plans that develop from these should be much more closely co-ordinated between organisations.

2012/05
Offenders should be seen as a priority group within health commissioning processes, with appropriate resources targeted at them. Full use of access to this socially isolated group should be made through the criminal justice and drug amd alcohol treatment services.

2012/06
Local housing and employment strategies/action plans need to reflect the needs of offenders.

2012/07
The development of local services and approaches should be more closely aligned with the 'Big Diversion' project and with commissioning processes within the The North East Offender Health Commissioning Unit.

2012/08
Recommendations within the prison and probation health needs assessments should be built into local partnership action plans.

Crime

Crime – unmet needs

Victim
There is very little information for people who are victims and perpetrators.

Victims of particular crimes are more vulnerable than others but interventions are not focused on specific crime groups.

Victimisation is addressed by distinct thematic groups, which leaves gaps for complex cases and victims of multiple, low to medium impact offences.

Offender
Independent consultation with offenders shows that access to employment and housing remain a major issue for them and that they see these as priorities in achieving a crime free life.

'Other theft' is on an increasing trend but has low detection rates.

Peer support for offenders has been identified as a priority need by service providers and service users but there is currently no capacity to provide this. This is being addressed through a newly commissioned service but there is a need to identify and train up to 150 appropriate ex-offenders/substance users to meet demand.

Location
Gresham, North Ormesby and Grove Hill have been identified as areas that impact disproportionately on local crime figures, and there are now multi-agency processes being developed to tackle local issues. However, this can be hampered by the lack of resource available at a local level and the way that services are organised to deal with district issues rather than locality-specific issues.

There are no clear pathways for accountability for locality-related issues.

Consultation and engagement processes with residents are not robust.

Crime – commissioning intentions

2012/01
Victims

- Reducing repeat victimisation should remain a strategic priority;
- Set baselines to reduce the prevalence and extent of victimisation and repeat victimisation within Middlesbrough;
- Target repeat victimisation within the town centre;
- Improve processes for dealing with complex cases;
- Review current information systems to ensure effective monitoring of repeat victimisation;
- Analyse common victim/perpetrator groups to see how and where they can come into contact with services, and determine the level of need;
- Target specific groups of victims based on crime type.

2012/02
Offenders

- Agree on robust local means to measure offending and re-offending;
- Enhance measures to reduce alcohol-related crime;
- The Integrated Offender Management (IOM) scheme should continue, but caseload mix should be reviewed against those committing most crimes;
- Testing on arrest should continue but may need to be revised to encompass a wider range of drugs and become more targeted;
- Address the needs of offenders in local employment and housing strategies;
- Develop a means to harden the targets of 'other theft' as it is increasing, has low detection rates and has links to both the day and night time economies;
- Provide peer support for offenders.

2012/03
Families

- Agree on a definition that clearly outlines what constitutes a troubled family;
- Estimate how many troubled families reside in Middlesbrough;
- Agree on a multi-agency process to address the needs of troubled families;
- Agree on performance criteria and monitoring process to measure success.

2012/04
Location

- The problem solving groups need sharper focus and representation;
- Criminal damage should have increased ownership and oversight;
- Data quality issues, system issues and appropriate ownership need to be addressed for ASB (specifically within the town centre);
- Strategies to combat town centre violence need to be developed further;
- The Safer Neighbourhoods Group needs to have clear accountability for location-based problem solving through the Problem Solving Groups or their equivalent;
- Representation of residents is scarce within the location-based problem solving arena and means of including views should be considered. This may identify where the majority of victims are resident;
- Substance misuse and reducing re-offending related services should focus on priority locations, ensuring they are active within locality-based action plans.

Education

Education – unmet needs

Immigrant groups
A number of relatively small transient immigrant groups appear amongst the local population of school-age children, which have been loosely grouped together into two broad categories - Middle Eastern and Eastern European. Whilst the numbers of children in these groups do not appear to be growing significantly, they are concentrated in a small number of schools and the rate of turnover within these groups from one year to the next is very high, presenting a particular problem for the schools involved. The majority of the children in these groups are of primary school age, which means their English language skills may not be strong enough when they start at school to enable them to fully participate in and benefit from their time in school. Additional, specialist support resources may be beneficial for these groups of children and the schools they attend.

Pregnant teenagers and teenage parents
Young people who are the most likely to become teenage parents are already very likely to be at risk of achieving the poorest outcomes by the time they leave school. Early pregnancy and parenthood can have a further, detrimental impact on young people's education and subsequent employment opportunities. Planning and delivering the sorts of flexible and accessible services that this group needs can be very difficult to achieve, making them one of the hardest to reach groups of young people.

Young carers
As a group of young people and individually, young carers tend to have very low visibility. Typically, school staff will not be aware of the caring burden being faced by the young carers attending their school. Being a young carer can be a hidden cause of poor attendance, under achievement and bullying, with many young carers dropping out of school or achieving no qualifications.

Traveller children
The nature of the travellers' lifestyle can present particular difficulties for traveller children in terms of continuity in their education. Whilst services try to work around established patterns of family movement by holding school places for children as they move between home locations, older traveller children may struggle to match subject and syllabus choices across schools in different locations.

Education – commissioning intentions

2012/01
Develop early intervention strategies to tackle the barriers to learning identified for behaviour, attendance, literacy and numeracy and monitor their effectiveness. More specifically, monitor the fall in maths results in 2011 to identify whether this is an emerging trend.

2012/02
Maintain literacy development as the central theme for education improvement to unlock learning for all children.

2012/03
Improve the identification of the needs of young people who require additional support for their education provision.

2012/04
Develop support programmes to help the workforce to acquire the skills needed in a rapidly changing labour market to remain in, and progress in, work.

2012/05
Develop initiatives to raise the aspirations of young people and adults to enter higher education and develop flexible pathways to higher education, with a focus on increasing the work done with younger children.

2012/06
Ensure that strong arrangements are in place to support looked after children to continue their education and training as they make the transition to adulthood.

Employment

Employment – unmet needs

There is a need to ensure that training or employment opportunities offered to young people (18-24) reflects the local labour market and acts as a starting point for a career rather than a short-term fix. It should offer young people the key skills and learning they will need to lead to sustainable employment with opportunities for progression.

Although the Fit for Work process is likely to lead to the reassessment of thousands of ESA or IB claimants across the North East, the Work Programme is likely to provide support for a comparatively limited volume of ESA/IB claimants.

The Work Programme has been designed to focus on long-term JSA claimants (18-24 year olds who have been on JSA for more than 9 months and those aged 25+ in receipt of JSA for more than 12 months). A much lower volume of EB/ISA claimants are expected to be mandated onto the programme.

The loss of key funding programmes (e.g. Working Neighbourhoods Fund, Future Jobs Fund, Single Programme) will have a significant impact on the ability to plug gaps in provision for those groups that may not be prioritised for Work Programme support.

Employment – commissioning intentions

Priorities identified by the Employment, Learning and Skills Framework (ELSF) and seen as key recommendations are:

2012/01
Engage with private, public and voluntary sector employers to optimise opportunities for job creation, work placement, volunteering, self-employment, sector route ways and other options, including those provided through 'Get Britain Working' initiatives from the Department of Work and Pensions (DWP) (for example, Work Clubs, Work Together, New Enterprise Allowance).

2012/02
Work with Jobcentre Plus to develop appropriate referral mechanisms into the Work Programme for those customers who would benefit but are not mandated to the programme

2012/03
Align resources to identify and sustain employment support and fill gaps for those groups unlikely to benefit from the Work Programme and other mainstream initiatives (for example, ESF Support for Families) by using other opportunities such as the Innovation Fund and Regional Growth Fund.

2012/04
Encourage employers to assist the existing workforce to stay in work by supporting initiatives such as 'Workplace Health', Fit for Work, and the Tees Valley In Work Support Project.

2012/05
Retain a strategic role in commissioning provision for people aged 14 -19 years, ensuring young people are given the best possible opportunity to make the best career choices at the right time.

Environment

Environment – unmet needs

Climate change
There are a number of prioritised actions to tackle climate change and encourage the adoption of sustainable behaviours and One Planet lifestyles that are included within the Climate Change Community Action Plan (Middlesbrough Borough Council, 2010) and the One Planet Living Action Plan (Middlesbrough Borough Council, 2010). There is a risk that Middlesbrough-based organisations do not address climate change. In addition, there is a risk that residents will be provided with insufficient opportunities to adopt a One Planet lifestyle. The Department of Health recognises that climate change poses unprecedented challenges ranging from global policy challenges to personal and social action (DH, 2008).

Noise
Most nuisance noise occurs in the evening and overnight. Recent budget savings have resulted in a reduced out-of-hours service, and the out-of-hours service is likely to cease. As a result, noise nuisance investigations will take longer to conclude and

nuisance will go undetected. The Government noise mapping exercise is incomplete and local issues cannot be quantified at this stage. The level of noise is thought to be above the threshold of 'light traffic' (threshold for cardiovascular effects) in some areas and the costs of reducing traffic noise (for example, through the use of special road surfaces) are significant.

Contaminated land
Health issues are uncovered as this work progresses. The extent is not fully known.

Pest control
Currently the Council's pest control service is chargeable for all pests. Financially disadvantaged members of the public may struggle to afford such a service and so choose to try to eradicate the problem themselves (often unsuccessfully) or ignore the matter putting their health at risk.

Responsible dog ownership
The cost of owning a dog is rising and with the current economic climate the cost of feeding, training, vaccinating and treating a dog can become prohibitive to financially disadvantaged people. The consequence of this is either the dog is thrown out, re-homed or is left untrained, unvaccinated and untreated leading to increases in stray dogs, fouling, disease and an un-social or dangerous dog.

Food safety
The current national review of the food law service by the Food Standards Agency may result in a change of delivery. Currently, the reduced staffing resource in Middlesbrough has resulted in an approach which focuses on businesses complying with the law. In relation to advice and support, which encourages higher standards beyond legal compliance, businesses are directed to other information sources, leaflets and websites. Enquiries from the public in relation to food hygiene are also now directed to other information sources and response times have been extended. With a high level of staff turnover in small food businesses, there is continuous need for low cost food hygiene training.

Workplace safety
In Middlesbrough, staffing has been reduced and delivery of the health and safety function is now combined with food and safety inspections. Officers have undergone training to ensure their competency. Officers focus on high risk inspections and accident investigation, whilst the delivery of advisory visits, responding to low risk service requests and training, has been reviewed to be dealt with by other means.

Environment – commissioning intentions

2012/01
Reduce the impact of climate change by:

- Implementing through partnership working the One Planet Living Action Plan to bring public health benefits, enhance quality of life and reduce burdens on health services.
- Raising awareness about the importance of greater integration of the climate change, One Planet Living and public health agendas to recognise mutual benefits of greater joint working.
- Ensuring that health professionals play a greater role in the development and implementation of One Planet Living and sustainable lifestyles.

- Ensuring that public services lead by example to encourage more people to adopt more active and sustainable lifestyles through behaviour choices and commitment to the ten principles of One Planet Living.

2012/02
Tackle noise pollution by:
- Completing a noise mapping exercise and implement necessary plans to protect residents from unacceptable noise.
- Investigating and remedying public noise nuisance to protect public health.

2012/03
Ensure good air quality by:
- Continuing to monitor air quality within Middlesbrough and investigating when pollution is identified.
- Informing the public of steps they can take to reduce pollution caused by their activities and the impact that this has upon greenhouse gas emission.
- Using development control to encourage the use of new technology which reduces pollution for developments in Middlesbrough.
- Enforcing pollution legislation to minimise harmful emissions.

2012/04
Tackle contaminated land by:
- Developing the contaminated land database to have a transparent evidence-based prioritisation of potentially contaminated sites.
- Investigating contaminated land through the planning process and recommending planning permission when needed.

2012/05
Ensure environmental pests are controlled by:
- Considering the affordability of pest control treatments to control pests of public health significance when setting prices.
- Monitoring the prevalence of pests and their geographic distribution, enabling the introduction of targeted control measures.

2012/06
Continue to encourage responsible dog ownership through information, education, and enforcement.

2012/07
Ensure food safety by:
- Regulating food safety and standards, giving priority to higher risk businesses in Middlesbrough.
- Delivering interventions which improve food safety and focus on local intelligence.
- Delivering interventions which improve food standards and focus on local priorities in the nutritional quality of food.

2012/08
Improve workplace health and safety by:
- Regulating local business, focusing on higher risk businesses in Middlesbrough.
- Delivering workplace interventions by using local intelligence to reduce workplace accidents.

2012/09
Control communicable diseases by:

- Ensuring continuity of disease outbreak control during the transition of the public health and emergency planning function from the NHS to the local authority.
- Continuing to investigate cases of both food and environmentally borne infections in relation to the risk of spread.
- Implementing targeted education and awareness raising to the public and business, responding to emerging food safety and environmental risks.

2012/10
Ensure port health is maintained by supporting the River Tees Port Health Authority Partnership and conducting annual reviews to establish public health benefits.

Housing

Housing – unmet needs

Affordable housing
At current annual build rates, and given public spending cuts, it will be impossible to deliver the required annual output of affordable housing.

Housing requirements of older people, those with disabilities and those who are otherwise vulnerable
The reduction in public funding for affordable homes will impact on the ability to deliver specialist housing, in particular expensive new build provision such as Extra Care housing.

Homelessness and other vulnerable groups
Accommodation and associated support services for chronically excluded adults, young people with intensive support needs and access to health care at point of contact in supported accommodation facilities will be affected.

Unsuitable homes
This applies particularly to homes which fail to meet the needs of older people and people with physical disabilities. Projected demand for disabled facilities grants far outstrips available resources and there is a projected £600,000 shortfall in 2013/14.

Owner occupied homes in disrepair
The inability of the most economically disadvantaged and vulnerable owner-occupiers, coupled with the inability/unwillingness of landlords to maintain homes to decent standards, will mean more disrepair

Private rented sector properties in disrepair
Affordable and decent homes will be at a premium as demand rises. The increase in costs will put private rented properties beyond the reach of the some of the most vulnerable groups. An effective regulation and enforcement regime is required to ensure that all housing in the private rented sector meets legal requirements.

Fuel poverty
Population needs in this area will only be addressed by a combination of improving economic circumstances, lower fuel prices and improvements to the energy efficiency of the worst affected homes. This emphasises the need to maximise the potential of energy efficiency funding programmes.

The Council's Private Sector Stock Condition Survey (2008) found that:

- 38.7% of homes within the private rented sector (PRS) in Middlesbrough are deemed to be non-decent dwellings.
- 35.7% of dwellings within PRS have category 1 or 2 hazards within premises.
- 41.2% of dwellings are in need of some repair.
- 49.4% of dwellings in PRS have a poor degree of thermal comfort.

Housing – commissioning intentions

2012/01
Provide housing and support services, including home adaptations, for an increasingly ageing population and people with disabilities, including children with complex and/or serious inherited medical conditions, whose homes may require multiple adaptation as they become adults and their requirements change.

2012/02
Provide high quality housing, advice and support services to enable vulnerable individuals to meet their housing needs, develop or sustain their capacity to live independently and contribute to the economic and social life of their community. This will include homelessness prevention and associated support services, with multiple and compelling pathways to help people engage with services.

2012/03
Provide, secure, good quality, affordable and well managed homes, including creative and innovative schemes to bring empty homes back into use, particularly for the benefit of the homeless and other vulnerable groups. Effective regulation, targeted intervention and enforcement within the private rented sector will be a key component.

2012/04
Enable the most vulnerable and disadvantaged households to maintain safe, warm and healthy homes. This will include targeted intervention to improve the life chances of the most vulnerable households living in the poorest housing in the most deprived areas by engaging them with health, education and other services so as to achieve the same health outcomes as other people. Effective regulation, targeted intervention and enforcement within the private rented sector will be key component.

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 Middlesbrough is similar, and that it has 0.229% of the population of Great Britain, the number of people not claiming benefits can be estimated.

Estimated take up of income-related benefits, Middlesbrough, 2009/10		
Benefit	Estimated take-up (Great Britain)	Estimated number of people with unclaimed benefits in Middlesbrough
Income Support and Employment and Support Allowance (Income Related)	77-89%	600 to 1,400
Pension Credit	62-68%	2,800 to 3,600
Housing Benefit (including Local Housing Allowance)	78-84%	1,700 to 2,600
Council Tax Benefit	62-69%	5,400 to 7,300
Jobseeker's Allowance (Income-based)	60-67%	1,000 to 1,400
		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 Middlesbrough provides for households which cannot afford sufficient food (The Trussell Trust, 2012).

Employment needs
In Middlesbrough, there are 13.6 people seeking work for every job centre vacancy (Nomis, 2012).

Poverty – commissioning intentions

2012/01
Ensure people claim all benefits to which they are entitled by providing sound benefits advice, proactively finding people who are entitled to benefits and encouraging rightful benefit uptake.

2012/02
Reduce the number of those young people who are not in education, employment or training (NEET) by providing high quality education and training opportunities for all children and young people.

2012/03
Support enterprise creation and business growth, enabling businesses to have access to the most appropriate training and education; and to ensure there is the skilled workforce to match the existing and future economic growth sectors.

2012/04
Tackle and improve issues relating to employability and worklessness.

Transport

Transport – unmet needs

Current services meet the needs of both existing and potential service users. However, the current financial climate could result in a number of needs being unmet.

Middlesbrough Council has submitted a funding bid to the Department for Transport, for the Local Sustainable Transport Fund. This includes adult cycle training, independent travel training, and community access audits. If the Council is unsuccessful in this application, the need will remain unmet. Certain access audit and safety scheme work can be undertaken as part of the Local Transport Plan, but will be more intermittent and undertaken incrementally over a much longer period of time.

The Shopmobility service currently accommodates the level of demand within the town centre unit. As this increases, the likelihood of a secondary satellite unit will be required. There was a successful pilot programme launched in Stewart Park in 2011 over the summer months. There is now a new local authority training centre located at Stewart Park, together with the recent Heritage Lottery Fund refurbishment, the park is now seeing a substantial increase in visitors. As a result, a secondary premise for the loan equipment may also be required to cater for future demand but a location has currently not been identified. The risk will be if the funding for the service is reduced. The community access audits are dependent on Shopmobility being able to provide support for co-ordinating the audit work on behalf of the Council.

Adult cycle training has been catered for via the incentivised bike scheme initiative. However, due to this stream of funding ceasing in 2011, there are few opportunities for adults to engage in cycle training in Middlesbrough. If the Council is unsuccessful in its application to the Department for Transport, there is the potential that this need will remain unmet.

Middlesbrough Council supports some public transport services, where bus operators do not provide routes that are not commercially viable. This is a result of where there is an identified need and duty upon the local authority to provide a service. The current financial climate places significant pressures on local authority budgets and, as a result, such services are currently under assessment.

Transport – commissioning intentions

2012/01
Develop a robust, holistic approach to incorporating and managing transport initiatives in Middlesbrough.

2012/02
Create a strategy to help plan, co-ordinate and manage transport-related issues that could reduce obesity. This strategy should be developed jointly by the Council, Cleveland Police, the emergency services, the injury prevention co-ordinator, the NHS, local education authorities and local safeguarding children boards. The partnership will need to further expand the foundations of the hugely successful Healthy Towns programme.

2012/03
Create a health and transport impact assessment with the local planning authority when undertaking accessibility planning for new development sites in Middlesbrough. This could include recommendations to place limits on the numbers of fast food outlets in those areas with higher levels of obesity, poor health and lack of sustainable transport alternatives.

2012/04
Monitor speed and casualties following the introduction of the new speed limits to assess their effectiveness. In areas where speeding continues to be a problem, the use of targeted interventions will be considered (such as the introduction of 20mph speed limits) over a three-year period. The programme will provide an analysis of current vehicle speeds and recorded casualties, with the highest priority areas identified for a 20mph limit implementation in 2012 (covering a total of 678 streets).

2012/05
Use a partnership approach to seek 'invest to save' revenue funding to establish a cohesive programme of independent travel training in Middlesbrough (based at the purpose-built facility located at Priory Woods School), with a view to create a Tees Valley-wide training programme that can address some of the associated health and social inclusion needs.

2012/06
Pursue improved partnership working with Middlesbrough Shopmobility with a view to establishing a joint funding agreement for future delivery. This will improve stakeholder engagement to promote walking initiatives in Middlesbrough.

2012/07
Promote carbon reduction through transport-related initiatives that will result in a cleaner and healthier environment.

2012/08
Develop a partnership with all schools in Middlesbrough to incorporate public health and transport in curriculum activities.

2012/09
Establish joint working and investment between the highways & transportation and public health professionals.

Alcohol misuse

Alcohol misuse – unmet needs

Children and young people

- Two-thirds of young dependent drinkers do not present to treatment;
- Transitional issues between young persons and adult treatment need to be addressed;
- The needs of young people living with drug and/or alcohol using parents in treatment are not being met.

Adult treatment demand

- About 9 in 10 dependent drinkers are not in treatment;
- About 97% of dependent drinkers would benefit from a brief intervention who do not receive one;
- Demand, as seen by GPs, is not reflected in referrals to treatment in the community;
- There could be an under-representation of BME communities in treatment;
- Dependency in higher socioeconomic groups is not reflected in treatment;
- Demand for detoxification heavily outweighs provision;
- The needs of domestic violence victims and perpetrators may not be met.

Adult service provision and delivery

- There is insufficient provision for inpatient detoxification at James Cook University Hospital;
- Intra-agency referrals are low, which may affect sustained improvement;
- Current models of care may not correspond with NICE guidelines;
- Best packages of care may not be deliverable within existing funding;
- There are data gaps in respect of treatment outcomes, specifically concerning impacts on wider health, reduced offending and re-attendances.

Wider determinants and control measures

- Joint working with the private sector is required to change the culture and develop an alternative evening and late night experience;
- Minimum unit pricing needs co-ordination;
- Co-ordinated action is needed to implement the new powers in the Police Reform and Social Responsibility Act 2011;
- There is a need to refine late night public transport services and develop suitable parking options.

Alcohol misuse – commissioning intentions

2012/01
Children and young people

- Ensure early identification and effective management of children and young people with alcohol problems;
- Ensure seamless transition and effective management and safeguarding of young people during transition to adult services.

2012/02
Adults

- Reduce alcohol admissions by joint working with primary and secondary care clinicians and the voluntary and community sector;
- Develop strong links with the Big Diversion Project, implementing recommendations where possible;
- Increase and ensure equitable access to treatment for dependent drinkers;
- Ensure the local model of delivering services includes:
    - Asset-based community approaches;
    - A family approach;
    - A targeted approach for location and individuals.
- Tackle a broad base of health issues of clients;
- Utilise social marketing approaches to raise awareness and raise the profile of prevention.

2012/03
Social marketing and public education

- Continue to support co-ordinated regional approaches to lobby and advocate reducing alcohol-related harm through national, regional and local policies;
- Build upon the experience gained from the current social marketing and by commissioning further work if appropriate.

2012/04
Wider determinants and control measures

- Ensure a co-ordinated approach to tackle alcohol-related harm by agencies and partners;
- Explore together with neighbouring authorities the possibility of introducing minimum unit pricing for alcohol.

2012/05
Improve partnership work between sectors to:

- Develop an evening and late night offer that is broader than youth-oriented and alcohol-based activity;
- Promote responsible drinking;
- Reduce alcohol violence and alcohol-related harm in the town centre;
- See a reduction in standing venues.

Illicit drug use

Illicit drug use – unmet needs

There is a cohort of clients who repeatedly re-present within treatment services, whose drug use appears to be linked to offending behaviour, and whose multiple needs do not appear to be addressed.

There is a cohort of clients who have remained in treatment for the longest time, and whose care does not appear to have been co-ordinated according to any other need besides prescribed medication.

There appears to be a cultural gap in what users consider to be recreational use. This causes harm both to themselves and the community. This is more evident in the benzodiazepine/hypnotic use and perhaps less so in the high levels of cocaine users who test positive.

Broader strategies may be required to address the long-term issues for the client group including wider determinants such as education, housing and employment.

Since successful exits are already comparatively low for those with children, this is likely to be further adversely affected during the economic downturn as local support services wither.

The low number of referrals into treatment by some agencies demonstrates that despite training across agencies, screening questions are not necessarily being asked and early interventions are not made by appropriate referrals.

The latest needs assessment estimates that there are likely to be around 450 young people requiring tier-3 structured treatment, yet there were only 129 young people in treatment during 2010/11. This leaves a possible 321 young people with an unmet need.

The transitions between young people's services and adult services need reviewing.

The needs of young people living with drug and/or alcohol-using parents in treatment are not being met.

Illicit drug use – commissioning intentions

Adults
2012/01
Consider a new integrated service model from 2013 that builds on good practice but takes into account broader public health issues.

2012/02
Clarify and agree the long-term role of primary care services in relation to drug misuse.

2012/03
Identify drug-related issues within local housing strategies.

2012/04
Address employment needs of clients in local employment strategies.

2012/05
Review processes for a multi-agency approach to the local drug markets.

2012/06
Ensure the engagement of the local voluntary and community sector at an early stage in the development of new initiatives. This will maximise integration of activity and opportunities to attract new resources to the area.

Young people
2012/07
Review processes for the protection of children and young people from harm caused by parents who misuse drugs and alcohol.

2012/08
Continue to develop and review the combined 'risk-taking behaviour' approach.

2012/09
Review processes for delivering more targeted outreach and detached work with those who are not involved with services.

2012/10
Review the 'risk management group' to ensure targeted work is effective.

2012/11
Review the transitions between young people services and adult services.

2012/12
Consider core funding for young people's specialist treatment services to allow continuity of commissioning and service delivery.

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 a number of pharmacies in Middlesbrough 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 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
A number of 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 Middlesbrough 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.

Payment by results
Currently only GPs and Pharmacies provide a stop smoking service through a tariff system. The development of a non-clinical stop smoking service delivered via a voucher scheme would offer greater choice of services in local communities whilst stimulating the marker.

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 Middlesbrough and Redcar & Cleveland 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 continuing pressure on the SSS to reduce prescribing costs.

Smoking – commissioning intentions

Smoking Cessation
2012/01
Review the current stop smoking service model and decide on a service model for Tees Stop Smoking Services (SSS) to go out to tender.

Reduce smoking variability across localities by commissioning local service delivery appropriate to need.

Commission services to increase access and reduce smoking rates for specific populations such as:

- pregnant smokers and their families;
- BME communities;
- mental health service users.

Ensure a whole system approach to tackling smoking across Middlesbrough including:

- primary and secondary care health professionals;
- local authorities;
- voluntary sector and communities.

Incorporate brief interventions and lifestyle referral into relevant care pathways.

Tobacco Control
2012/02

- Ensure Trading Standards, Environment Health and Public Health Departments have the capacity to contribute to the tobacco control agenda;
- Tackle cheap and illicit tobacco in Middlesbrough;
- Ensure retailers comply with under-age sales legislation;
- Help young people not to smoke;
- Maintain and promote smoke-free environments;
- Ensure alliance partners sign up to the plain packaging campaign;
- Ensure retailers comply with the Point of Sale regulations.

Diet and nutrition

Diet and nutrition – unmet needs

Breastfeeding
Middlesbrough does not have a co-ordinated programme of peer support as recommended by UNICEF to support mothers to breastfeed. This is further supported by evidence from NICE where women said that breastfeeding peer support groups would have helped them to continue breastfeeding.

Interventions for families such as antenatal classes, breastfeeding support groups and weaning groups are underutilised by those least likely to follow advice.

Healthy Start
As the Healthy Start scheme is significantly underutilised for vitamin supplements, there is a need to ensure a co-ordinated approach to raise the awareness of the scheme, particularly in relation to the vitamin element both with health professionals and families.

Vulnerable adults and children
Increased support and education for adults who move from a care setting to independent living and those already in supported living is needed. They often lack the resources and knowledge to purchase and eat a balanced diet, particularly those adults with learning disabilities and mental ill health.

Black and minority ethnic groups
There is a need for targeted healthy eating and weight management services for the BME population.

Training and capacity building
There is a need for capacity and capability building in Middlesbrough for frontline staff to ensure every contact maximises the health improvement opportunity, and to ensure consistent nutrition advice and support, particularly for those who care for vulnerable children and adults.

There is no consistent approach to educational needs and standards of practice for nutritional care and support in care settings, particularly linked to malnutrition.

Demand for cooking skills development and practical advice on healthy eating is high, but meeting this demand is subject to available staffing resources and funding.

Food poverty
It is likely that people living in deprived areas may face additional barriers to a healthy diet putting them at greater risk of diet-related disease such as obesity; type two diabetes; CVD; and poor oral health.

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

There may be a gap in services for children in early year settings and for pregnant women.

Declining participation in organised group sport and active leisure could undermine the viability of clubs and leagues, leading to a further decline in opportunities and participation levels.

Participation in active leisure in subsidised or commercial facilities, including swimming pools and gyms, may be restricted by economic pressures and increased costs.

Reductions in subsidy to public transport may also increase barriers to participation in some forms of active leisure, particularly for older people who cite transport as a potential barrier to sport and leisure. Furthermore, the increasing numbers of older people, as a proportion of the population, may require an increased number of activities designed to meet their needs and lifestyles. These will represent an increased demand for subsidy at a time of declining resources.

Increasingly inactive and overweight children, young people and adults may feel excluded from traditional, competitive or recreational group activities such as running, league football and tennis. The lack of targeted weight management service provision (of which physical activity is an integral element) and the lack of services aimed at beginners and people with low self-efficacy and for those with a limiting

illness/disability; and from BME communities may present a barrier to engaging in physical activity programmes and initiatives.

Lack of awareness of the local environment and opportunities for active leisure may limit participation levels. In particular, insufficient allotment provision and long waiting lists may prevent people taking part in this form of physical activity. The Council currently has 8 sites with 900 plots in total with a waiting list for plots totalling 208 people.

Increased waiting times and potential capacity issues for Exercise by Referral is exacerbated by resource pressures and capacity issues. Recent insight demonstrates that 47% of referrals are for weight management reducing access for those who may be more at risk and require more specialist support demonstrating a need to re-evaluate the service model and pathway.

Physical inactivity – commissioning intentions

2012/01
Adopt a life-course approach and engage people in physical activity throughout the life-course through a better understanding of the barriers to and potential motivating factors for physical activity within sedentary groups. Work needs to be undertaken to identify and address social, cultural, economic and environmental barriers to being physically active through engagement with the local community.

2012/02
Improve links between the NHS, social care and physical activity pathways to target high risk, vulnerable and disadvantaged populations at risk of chronic disease due to inactive lifestyles. This may involve re-designing service models to ensure services are responsive to needs and are cost-effective and efficient.

2012/03
Maximise opportunities in local planning and transport strategies for physical activity when developing the built environment ensuring that all major planning decisions are subject to health impact assessments.

2012/04
Improve detailed understanding of local population characteristics, particularly those with limiting disabilities and from BME groups, in relation to physical activity to enable better targeted interventions.

2012/05
Maximise use of facilities, including schools and green infrastructure, through community use agreements and clear information and guidance.

2012/06
Encourage workplaces to adopt policies that enable staff to become more physically active during and outside of work hours.

2012/07
Commission a single website that brings together the physical activity opportunities available in Middlesbrough 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

There is a need for training to build workforce capacity and capability to ensure frontline staff are trained to raise the issue of weight consistently and sensitively and offer appropriate interventions and support.

There is a lack of preventative services for those identified at risk of overweight and obesity, particularly focusing on a lifecourse approach. Alongside this, there is limited support for children, young people and families at Tier 2 and Tier 3 highlighting an unmet need. Further work is required to assess the needs at each of these tiers and develop appropriate services.

Targeted weight management service provision is required for those identified at risk in adult and child populations (ie. BME communities; people with learning disabilities; maternal obesity; men; children aged under 5 years; areas of high deprivation; specialist weight management support; and for those people with mental health needs).

Connection of weight management pathways and services is required, and stronger links to be made with Map of Medicine and Clinical Commissioning Groups to ensure a co-ordinated and integrated approach.

Obesity – commissioning intentions

2012/01
Establish a strong local partnership from a variety of organisations to develop an informed and shared vision to prevent and manage obesity in Middlesbrough. This should build on the partnerships and outcomes achieved through the Healthy Towns Partnership.

2012/02
Adopt a life course approach to ensure health inequalities are addressed at all stages of the life course.

2012/03
Review care pathways and obesity service model in line with evidence that suggests different BMI cut-off points for different ethnic groups should be considered as points for public health action, particularly for those of South Asian origin.

2012/04
Create a balance of investment between prevention and treatment services ensuring targeted support for those identified most at risk of overweight and obesity.

2012/05
Promote joint working with 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 obesogenic environment.

2012/06
Increase capacity across the different sectors to ensure every contact becomes a health improvement opportunity and to ensure increased capacity and capability in the workforce to support children, young people and adults to achieve and maintain a healthy weight.

Sexual health

Sexual health – unmet needs

Late presentation in primary care with HIV - significant numbers of HIV cases remain undiagnosed. In the North East, the highest prevalence is in the black African population and significantly higher than the prevalence in other ethnic groups.

It is unclear whether there is adequate access to sexual health services for people with learning disabilities.

Sexual health services for young people – current integrated sexual health services do not adequately meet the needs of all young people in Middlesbrough. Work is required to:

- make existing services 'young people friendly' in line with the "You're Welcome" quality criteria;
- establish and maintain dedicated sexual health services for young people in areas of greatest need.

Current provision for preventative work is limited to that provided by the Teenage Pregnancy Support Team and the limited sexual health preventative work delivered by youth services. Further work is needed to ensure that delivery of preventative work is maintained and is consistent across Middlesbrough.

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
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.

2012/03
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
Reduce sexually transmitted infections by increasing testing in high risk groups and maximising service contacts.

2012/05
Make sure that service provision is in line with need by combating discrimination and stigmatisation and reducing barriers to access sexual health information.

2012/06
Increase long-acting reversible contraception (LARC) provision and ensure the workforce is trained to offer and provide LARC.

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 outlined 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 diagnostics 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 Middlesbrough was 211.6 per 100,000 (364 admissions). This is higher than England

(205.3 per 100,000) and significantly lower than the North East (259.5 per 100,000). Male CHD emergency admission rates are significantly higher than female 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 limited to those newly diagnosed.

People at risk of developing diabetes are not being systematically identified and their risks managed appropriately. When they are dignosed, many people still continue to progress to develop diabetes.

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

Focused work needs to be carried out to further understand the high rate of diabetic complications (i.e. diabetic ketoacidosis and coma) and what can be done to reduce them.

The needs of children and young people with diabetes need to be assessed in detail and the information used to inform service improvements.

Diabetes – commissioning intentions

2012/01
Further develop, implement and monitor strategies to identify and offer effective management to patients with pre-diagnosed diabetes or who are at high risk of developing diabetes.

2012/02
Prevent diabetes and tackle health inequalities by:

- Developing population wide, multi-agency and multi-faceted approach to address the risk factors for diabetes (obesity, nutrition, physical activity, smoking).
- Investing in evidence-based services which support people to reduce the risk of developing diabetes (including gestational diabetes) especially targeting at risk groups.
- 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.

2012/03
Ensure diabetes services have the capacity and capability to cope with the increasing prevalence of diabetes:

- Develop a systematic and integrated approach to prevention and effective management of diabetes and other related long-term conditions with primary care, public health, secondary care, community services, voluntary sector and the community.
- Ensure existing commissioned services are sufficiently resourced to accommodate an increase in the diabetic population.

2012/04
Reduce diabetes complications by developing, implementing and monitoring protocols to manage the complications of diabetes effectively.

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

2012/06
Improve quality of diabetes care by:

- Reducing variation in the quality of care by encouraging and promoting peer review among general practices.
- Ensuring that there are clear referral pathways between services for people with diabetes (including structured education courses and antenatal care) and services supporting lifestyle behaviour change.

2012/07
Ensure the emotional wellbeing and mental health needs of patients with diabetes are addressed in a systematic way as part of the care pathways.

2012/08
Ensure that all women of reproductive age with diabetes receive appropriate advice, treatment and support. (NICE clinical guideline 63: diabetes in pregnancy).

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 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 no comprehensive rehabilitation and recovery support pathway.

There are limited long-term innovative support opportunities.

Access to diagnosis and support for autism in adults is restricted.

There is an unmet need for specialist support for complex dementia care.

There are limited resources at tiers 1 and 2 in Child and Adolescent Mental Health Services.

There is a limited range of crisis provision.

There is a need for specialist inpatient and rehabilitation personality disorder services.

Access to all NICE accredited talking therapies across all tiers of mental health is required.

Some communities are poorly served by mental health support services.

There is a need for early detection and intervention for people with mental health problems accessing acute hospital services.

Mental and behavioural disorders – commissioning intentions

2012/01
Increase access to talking therapies.

2012/02
Implement 'No Health Without Mental Health'.

2012/03
Recognise mental health needs throughout the health and social care system, mental resilience, and early intervention.

2012/04
Improve physical health care for people with mental ill-health.

2012/05
Improve awareness of safeguarding and risks.

2012/06
Increase choice and control.

2012/07
Implement personal health budgets in mental health.

2012/08

Develop specialist autism services.

2012/09
Improve comprehensive rehabilitation and recovery services based on the recovery model pathway.

2012/10
Develop mental health promotion to combat stigma.

2012/11
Encourage specific groups to come forward and access treatment and early intervention services, particularly men, black and minority ethnic communities and young people.

2012/12
Commission specialist complex dementia care for people with challenging behaviour.

2012/13
Implement the multi-agency Telecare Strategy for Middlesbrough

2012/14
Implement the National Dementia Strategy four priority areas:

- Good quality early diagnosis and intervention for all.
- Improved quality of care in general hospitals.
- Living well with dementia in care homes.
- Reduced use of antipsychotic medication.

2012/15
Increase the proportion of people in contact with secondary mental health services who are in settled accommodation.

2012/15
Improve meaningful employment opportunities for people in contact with secondary mental health services.

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
Tackle the determinants of poor oral health by working with key stakeholders to consult on the implementation of water fluoridation throughout the region.

2012/02
Commission prevention services to improve oral health and reduce inequalities by:

- Implementing a fluoride varnish programme in targeted schools.
- Implementing a fissure sealant programme in targeted schools.
- Extending the school tooth brushing programmes.
- Supporting practices to reorient their services to follow evidence-based care pathways.

2012/03
Improve access for children to preventive health care by:

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

2012/04
Improve waiting times for specialist services in:

- Orthodontics (hospital services).
- Community Dental Service - general anaesthetic services.
- Paediatric anxiety management services.

2012/05
Implement a targeted systematic oral cancer screening programme as part of the early cancer diagnosis initiative.

2012/06
Improve oral health for vulnerable groups.

- 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 prevalence of 2.5% in 2010 to 6.5% in 2020.

There is low awareness of lung health and COPD in communities 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 generally better in Middlesbrough 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 better self-manage their conditions.

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 (eg. 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.