Version 1.0

Redcar & Cleveland Joint Strategic Needs Assessment 2012-15

Unmet needs and commissioning intentions arising from JSNA

10th May 2013

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Learning disabilities

Learning disabilities – unmet needs

The majority of people with learning disabilities are not currently known to services. As there is a close correlation between the numbers of people with moderate and severe learning disabilities and the numbers of people known to services the people not known are likely to be predominantly people with mild learning disabilities and higher levels of social functioning. These people may live in the community with natural support and may only seek further assistance if their condition becomes more complex or if their support networks within the community change. There are also expected to be small numbers of people with moderate or severe learning disabilities who are supported in the community and only become known to services when family carers become unable to maintain their role.

Information about people with learning disabilities in Redcar & Cleveland is incomplete and a detailed mapping exercise to increase understanding of the circumstances of local people would assist with strategic planning.

There is currently a lack of support for people with more complex health needs to provide access to community-based resources.

Learning disabilities – commissioning intentions

2012/01
Develop services so that they can provide for the increase in the number of people with learning disabilities in need of support due to the increased prevention of premature death and the rise in life expectancy of people with learning disabilities.

2012/02
Work with partners to identify the large number of people with learning disabilities in the community that are not currently known to services but who may have a need for support in the future.

2012/03
Manage an increasing demand for more individualised support within available resources.

2012/04
Tackle the significant inequalities for people with learning disabilities and their families. The inequalities not only disadvantage people on an individual level but can contribute towards increased long-term support needs.

2012/05
Further engage with local people with learning disabilities, their families and carers to identify issues and develop services to meet needs.

2012/06
Strengthen joint working in Tees Valley and the North East to address strategic issues. The NHS is a key funding partner and a joint approach across Tees will be required to commission appropriate local services to move away from out of area placements.

2012/07
Further develop the multi-agency Transitions Forum and Independent Specialist Provider panel to contribute to an understanding of individual needs in shaping local provision. The Young People's Funding Agency, local education funding managers and Further Education providers are important for establishing a range of local education provision that is accessible and supportive of people, including those with both learning disabilities and autism.

2012/08
Work with service providers to adapt and develop new models of support to meet the diversity, flexibility and efficiency required to support people appropriately. Tees, Esk and Wear Valleys NHS Trust will be a key partner in the development of specialist assessment, treatment and provision for people with complex and additional needs arising from learning disabilities and/or associated conditions.

Physical disabilities

Physical disabilities – unmet needs

Independent assistance with support planning has been used in the past but is no longer widely available. This may be needed to maintain the continued high levels of uptake of direct payments.

Arrangements for the choice and support in the recruitment and employment of personal assistants could be improved.

There is an under supply of accessible single person and shared accommodation in suitable locations.

Physical disabilities – commissioning intentions

2012/01
Continue to support the uptake of individual budgets and use of direct payments by people with physical disabilities.

2012/02
Ensure local information about people with physical disabilities (including the support provided and intended outcomes) is complete. There is a gap in information on the use and outcomes from individual budgets and there is also a lack of specific information from local people about their experiences that can be used to inform strategic planning.

2012/03
Ensure that commissioned services and support through individual budgets meet the diverse needs of people in the community, including support for people from ethnic minorities.

2012/04
Develop further Telecare and Telehealth to support people with physical disabilities in promoting privacy, dignity and independence.

2012/05
Continue to support and develop third sector organisations to maintain support for people in the community when eligibility for statutory services is not met.

2012/06
Develop further the range of services that can be accessed through individual budgets that meet the support needs and preferences of people with physical disabilities. The market for recruitment of personal assistants requires particular development.

Sensory disabilities

Sensory disabilities – unmet needs

Local information about how people with visual and hearing disabilities access support (and the intended outcomes) is incomplete. There is a gap in information on the use of individual budgets and also a lack of information from local people about their experiences, which could be used to inform strategic planning.

Families of young disabled people comment on the difficulties they face in the transition from children's services to adult life.

The availability of speech and language therapy is recognised as a key factor in the reasons why young people with disabilities attend and achieve in out of area education placements.

More suitably located and adapted accommodation should be available.

Sensory disabilities – commissioning intentions

2012/01
Provision of equipment and/or Telecare is required to support people with sensory disabilities to promote privacy, dignity and independence. Evidence is needed to ensure that current commissioned services and support through individual budgets meet the diverse needs of people in the community (including support for people from ethnic minorities). An improvement in systems will enable this information to be collected.

2012/02
Develop an integrated approach from statutory, private and community organisations to ensure that increasing numbers of older people can be supported to maintain their independence in the community for as long as possible. A key factor will be access to appropriate services for older people who develop treatable conditions causing visual impairments.

2012/03
Continue to support and develop third sector organisations, to support people in the community who do not meet the criteria for statutory services.

2012/04
Increase awareness of universal services relating to the communication support required by deaf people to assist access to the community. Access to appropriately trained interpreters requires improvement.

2012/05
Provide people who have a sensory disability alongside other conditions with access to support for their sensory needs. All services providing support for older people will require the capacity to support people with sensory disabilities.

2012/06
Continue to support the needs and preferences of people with sensory disabilities, by developing the range of services that can be accessed through individual budgets.

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

At the moment there is no guaranteed funding secured for the provision of services to support victims or perpetrators of domestic violence.

There appears to be an increasing number of referrals to Multi-agency Risk Assessment Conferences (MARAC), which are not reported to the Police.

MARAC cases are only the tip of the iceberg. The full picture will be difficult to establish due to the large number of hidden victims, who do not come forward for help.

Domestic violence victims – commissioning intentions

2012/01
Develop a commissioning model for domestic and sexual violence services. This is to ensure provision of services to meet local needs, improvement in co-ordination between services and ensuring value for money.

2012/02
Create a co-ordinated service for domestic and sexual violence, which will support the entire family. This should include specialist workers to support victims, children and perpetrators, who will work together to meet the family's needs and have close working relationships with other contributory services, such as the police, local authority, health services and the voluntary sector.

Carers

Carers – unmet needs

Only a small proportion of the people who considered themselves to be carers in the 2001 census are known to Adult Social Care or are in receipt of services. This is unlikely to have changed in the past decade.

There is little information about the needs of carers from BME backgrounds; carers in work or seeking to return to work; and carers of people who have drug and alcohol problems.

Information services are provided at a higher level in Redcar & Cleveland and more tangible services at a lower level compared to other areas. Many carers may require additional, non-information services.

Carers – commissioning intentions

2012/01
Promote the role of carers by comprehensive communication which will increase recognition and awareness of carers, resulting in an increase in the registration of carers with Carers Together and on registers of carers in general practices.

2012/02
Promote carer involvement and participation by consulting and involving them in policy and other developments which may affect them.

2012/03
Increase the numbers of carer assessments which offer carers personal support to achieve choice and control.

2012/04
Support carers to identify their own needs so that more carers can decide upon their own support through a personal budget.

2012/05
Increase and extend the range of breaks for carers to include opportunities for carers to have a break to pursue their own interests.

2012/06
Develop an adequate range of planned respite care opportunities for carers.

2012/07
Educate and support GPs and health and social care professionals to ensure that they involve and support carers appropriately.

2012/08
Ensure carers can access educational opportunities.

2012/09
Ensure local employers have carer-friendly policies, in line with the equalities agenda.

2012/10
Identify carers' information and support services that are available outside of normal working hours (for example, evenings and weekends).

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
None identified.

Migrants – commissioning intentions
Commissioning priorities have yet to be determined.

Travellers

Travellers – unmet needs

Maintenance costs are rising (due to the age of the site), which has been exacerbated by poor winter weather in recent years. Existing units need to undergo complete internal and external refurbishment. This includes the replacement of wooden framed windows and doors, renewal of rainwater goods, a full rewire, installation of electric showers and shower cubicles and renewal of kitchen units.

Travellers – commissioning intentions

2012/01
Fund all the site maintenance costs (refurbishment and renewal).

2012/02
Extend the site lease upon its expiry, to ensure effect site management (supported by council officers).

2012/03
Increase the number of authorised encampments in Redcar & Cleveland.

2012/04
Change people's opinions of the Gypsy and travelling community, to ensure that the community can integrate within the settled community (supported by council officers).

2012/05
Residents should be encouraged to work in partnership with the contractor in the final design of the community facilities. It is also expected that they will take an active role in aspects of the site refurbishment to encourage a feeling of ownership and pride in their environment.

2012/06
Officers have also explored options for green energy provision on the site with colleagues in the Energy Service, particularly in relation to the installation of photovoltaic cells.

Offenders

Offenders – unmet needs

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

Learning difficulties/disabilities
As the full extent of the needs of the offender population is not known there remains a real possibility that offenders residing in prison or the community have learning difficulties/disabilities that are undiagnosed and therefore have unmet support needs.

Substance misuse
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.

The link between drug misuse and offending remains and as the drug(s) of choice changes the interventions offered will need to adapt accordingly. There are established pathways linking both prisons and the community and these need to be further developed to meet the changing profile in substances used.

Lifestyle
It is clear from the current local and national data that lifestyle choices are a major issue, especially 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 always meet the needs of the client group.

Housing and employment
Access to appropriate housing and to employment are consistently raised as key priorities by offenders and have a major impact on successful outcomes related to reducing offending and improving health. The current financial climate is seen to be affecting these issues, leading to potentially greater social isolation.

Females
Given the difficulties associated with engaging females into support and/or treatment, there remains the potential that vulnerable women will not access services and therefore remain at risk of poor health and imprisonment.

Young offenders
Young offenders face significant health risks including risks to mental health and substance misuse but also to general health. Currently Youth Offending Service officers receive specialist training to enable them to screen for the wide range of health issues. Without access to this training and associated support then it increases the possibility that these health needs will be unmet.

Children of offenders
As the current level of need is not currently known about the number and needs of children of offenders/prisoners, it is important to view this in terms of an emerging need that requires further investigation and effective interventions.

Offenders – commissioning intentions

2012/01
Ensure that the mental health needs of offenders are identified and supported.

2012/02
Ensure that the learning difficulties and/or disabilities of offenders are identified and supported.

2012/03
Ensure that effective interventions take place in respect of blood borne viruses in the prisons and the community.

2012/04
Ensure that all drug-related strategies and services continue to develop an outcome based focus in line with the outcomes described in the HM Government Drug Strategy 2010.

2012/05
Ensure that the needs of female offenders are identified and supported.

2012/06
Ensure that pathways into suitable and sustainable accommodation and employment continue to be developed and supported.

2012/07
Ensure that the needs of children of offenders are supported, giving particular reference to the following principles:

- The trauma experienced by children during the arrest of a family member(s) should be minimised;
- Parents should be placed in a prison near to their family base with an appropriate level of visits allowed;
- Specialist support (especially mental health) for children who have parents in contact with the criminal justice system should be provided.

Crime

Crime – unmet needs

The fear of crime and the perception of crime remains an issue. According to previous 'Place' surveys, the reporting of hate crime remains low. There needs to be increased awareness in relation to the impact of hate crime and social isolation. Consultations took place which resulted in concerns about young people and the impact of drug and alcohol on community safety and confidence within communities.

Crime – commissioning intentions

2012/01
Following completion of the annual Strategic Intelligence Assessment, the following priority areas have been identified for the next financial year:

- Acquisitive crimes (other theft & burglary);
- Anti-social behaviour and related crime/incidents;
- Drugs and alcohol misuse;
- Reducing offending and re-offending; and
- Violence (domestic, sexual and alcohol-related).

2012/02
Consultation with the public will now be carried out to ensure these priority areas still reflect the concerns of the community before being presented to the responsible authorities for ratification.

Education

Education – unmet needs

Intervention is needed in to secure improvement where schools are at risk of falling significantly below government targets.

In terms of participation in learning post 16, the rate for 16-year-olds is at 92.1%, the lowest in Tees Valley. Participation rates for 17-year-olds at 85.8% are the lowest in Tees Valley. Participation rates for 18-year-olds at 71.6% are also the lowest in Tees Valley.

Education – commissioning intentions

- Response to the government raising of the floor standards
- Planning for the expansion of the government's academies programme and its implications for local authority services
- Preparation of schools for the new Ofsted Inspection Framework
- Work with schools to deliver the new Department for Education Funding Reform

2012/01
Commission more innovative approaches to learning which will better engage with those vulnerable and hard to engage young people in Redcar & Cleveland.

2012/02
Develop more opportunities for vulnerable learners for apprenticeships and work experience placements throughout all Directorates in the Council.

2012/03
Ensure all education and training providers in Redcar & Cleveland maintain their Ofsted inspection grade of 'good' and to strive towards 'outstanding'.

2012/04
Ensure that the 14-19 Partnership delivers its strategy and action plan and that the Raising the Participation Age Strategy is supported by all key partners.

2012/05
Make more effective use of mainstream monies and the linking and pooling of resources.

Employment

Employment – unmet needs

The biggest issues for meeting the needs of those seeking employment is with the limited capacity of the programmes that are available. Since welfare reform is forcing more and more people into the labour market, these programmes are unlikely to be able to meet the needs of a growing number of clients.

The payment by results focus of the work programme also means that many of the organisations responsible for finding work for clients lack the capital to invest in clients in the short-term. There is therefore a greater emphasis on working with those clients most likely to gain employment and an often limited cash flow means that the needs of those furthest from the labour market are most likely to be unmet. Furthermore, once residents have been referred from Jobcentre Plus to the Work Programme, they become ineligible for assistance through other DWP-funded programmes. The only compulsory element is a requirement to engage with the programme every 39 days, so very little direct client support is required. Therefore, of the overwhelming number of residents being referred to the work programme, it is the most vulnerable whose needs are currently unmet. In addition, it was found for offenders that this position means that many have limited awareness of and access to the range of opportunities available. This is likely to be true for a number of groups far from the labour market.

Typically it is also those clients for whom other opportunities for gaining specialist help are diminishing as voluntary and community groups lose funding. Therefore, not only are the needs of these groups projected to rise, but the support in place to meet these needs is also likely to fall, increasing the number of clients whose needs will be unmet.

Employment – commissioning intentions

It is vital that public, private and voluntary sector organisations work in partnership to remove the barriers to employment facing many residents of Redcar & Cleveland. This needs to be tackled from multiple angles, providing appropriate training and

support for all those struggling to gain employment, but also seeking to increase the opportunities available, both for specific groups such as graduates, and for the labour market in general, to reduce competition for the jobs that are available.

2012/01
Grow the tertiary sector in Redcar & Cleveland by encouraging the growth of the tourism and related industries which bring greater volumes of entry level jobs.

2012/02
Continue to support a culture of enterprise and business creation by providing both practical and financial assistance.

2012/03
Increase support and funding for voluntary groups working with specific groups, particularly those furthest from the labour market.

2012/04
Increase awareness amongst young people of the variety of opportunities available to them, to prevent them from becoming NEET in the future.

2012/05
Increase the capacity of organisations working with residents to overcome barriers to employment to ensure that the level of support does not fall as the number of customers rises.

Environment

Environment – unmet needs

An estimated average of 88 people die each winter in Redcar & Cleveland because of th effects of cold. Their needs for more appropriate housing and care may contribute to this.

Higher energy costs, reduced incomes and unemployment are combining to increase the numbers of households in fuel poverty. Analysis of the proposed support through the Green Deal suggests a substantial reduction in funding to be directed at households experiencing fuel poverty.

National grant-based schemes such as Warmfront, CESP and CERT for improving home energy efficiency came to an end in December 2012, to be replaced by a national pay-as-you-save-scheme, Green Deal. It is unclear how the public will take to a loan scheme, and how the related Energy Company Obligation support measures for hard-to-treat properties and poor and vulnerable households will work.

Environment – commissioning intentions

2012/01
Develop a partnership approach, including small and medium enterprises as well as large industrial establishments to reduce emissions to air. A co-ordinated approach and investment in new technologies for many years to come is required.

2012/02
Ensure all public sector partners lead by example and reduce their own emissions through carbon management by:

- minimising heat loss from buildings and reducing electricity use;
- supporting the installation of renewable technologies;
- raising awareness in departments and service areas of the importance of reducing energy use.

2012/03
Ensure the Climate Change Adaptation Plan (Redcar & Cleveland Borough Council, 2011) is fully implemented.

Housing

Housing – unmet needs

When the figures for gross requirements are examined, there are significant affordable home needs in most areas of Redcar & Cleveland, equating to a requirement of total of 231 new homes per annum. This is more than double the current rate of development (in the last three years, around 100 new affordable homes per annum have been developed). There is an unmet need for about 130 affordable home each year. In five years, this would create a shortfall of 650 affordable homes.

Single people, aged under 25 are the largest client group approaching the council for advice and assistance in finding a home. However, they are significantly under-represented in terms of affordable housing tenancies. There is a significant mismatch between supply and demand, which is further exacerbated by reductions in single persons' accommodation through regeneration schemes. There is an unmet need for affordable housing for single people aged under 25.

The proposals to limit Housing Benefit for working-age households living in under-occupied social rented housing and to raise the threshold for the shared room rate of Local Housing Allowance from claimants aged up to 25 years to those aged up to 35 years, have the potential to severely limit the already pressurised supply of accommodation for this group.

Redcar & Cleveland Council aims to offer as much choice as possible for older people, enabling them to remain safely in their homes or the home of their choice for as long as possible. There is a need to rebalance the 'general needs' and 'specialist' accommodation for older people.

The council owns land throughout Redcar & Cleveland which could be disposed of to facilitate new housing development. In terms of marketing some of these sites, it may be necessary to consider prioritising the delivery of affordable housing above the requirement for significant capital receipts. There is an unmet need for land for affordable housing development, which the council is in a position to solve.

Although private lending has become much more restricted, registered providers are still generally able to successfully obtain private funding for new housing developments. There may be opportunities for the inclusion of affordable housing

and housing with care and support within some private housing developments, using the council's planning powers.

Housing – commissioning intentions

2012/01
Prioritise the delivery of affordable housing above the requirement for significant capital receipts on disposal of surplus land.

2012/02
Apply the council's planning powers systematically to include affordable housing and housing with care and support within private housing developments.

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 Redcar & Cleveland is similar, and that it has 0.224% of the population of Great Britain, the number of people not claiming benefits can be estimated.

Estimated take up of income-related benefits, Redcar & Cleveland, 2009/10		
Benefit	Estimated take-up (Great Britain)	Estimated number of people with unclaimed benefits in R&C.
Income Support and Employment and Support Allowance (Income Related)	77-89%	600 to 1,400
Pension Credit	62-68%	2,700 to 3,500
Housing Benefit (including Local Housing Allowance)	78-84%	1,700 to 2,600
Council Tax Benefit	62-69%	5,200 to 7,200
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 Redcar provides for households which cannot afford sufficient food (The Trussell Trust, 2012).

Employment needs
In Redcar & Cleveland, there are 8.7 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

Redcar & Cleveland Council has recently withdrawn its 'Dial a Ride' service and is developing a travel voucher scheme to support disabled residents to meet some of the costs of using alternative travel providers such as accessible taxis. It is not yet known if this has had an impact on the opportunities for disabled people to use services.

As the cost of oil continues to increase, low or no cost alternatives for the most at risk will need to be made available.

The Redcar & Cleveland Local Development Framework identifies a need for the construction of an additional 5,100 new homes by 2021 in addition to replacement properties in regeneration areas. It will be necessary to ensure that the locations for these developments have a satisfactory level of access to essential services. Emphasis needs to be placed on addressing the problems of the housing market collapse in some areas, particularly in terraced housing in South Bank and Grangetown.

Transport – commissioning intentions

2012/01
Facilitate and create increased opportunities for people of all ages to use sustainable modes of travel (especially walking and cycling) in their daily routine for accessing education, employment or services.

2012/02
Promote greater understanding of the health benefits of active travel and use events and programmes to introduce people to walking and cycling.

2012/03
Commission programmes of education, training and publicity targeted towards reductions in road traffic accidents involving vulnerable road users (elderly people, young people, cyclists and pedestrians).

2012/04
Improve understanding of local access issues by improving the walking and cycling network information.

2012/05
Carry out health impact assessments for transport projects which have the potential to influence health (especially physical activity) or such things as air quality and accessibility.

Alcohol misuse

Alcohol misuse – unmet needs

Local residents of Redcar and Cleveland need to receive adequate information about levels of drinking and associated risks. To ensure the local community receives these messages, all partnership staff need to undertake the e-learning Information and Brief Advice training

NICE public health guidance 24 recommends that commissioners should ensure at least one in seven dependent drinkers can get treatment locally. Preliminary analysis for Redcar and Cleveland equates to between one in ten and one in eighteen dependent drinkers has access to community-based treatment in 2010/11.

Alcohol misuse – commissioning intentions

2012/01
Reduce the number of alcohol-related hospital admissions.

2012/02
Improve community awareness of the health risks associated with alcohol consumption.

2012/03
Ensure adequate capacity for residents wishing to access community alcohol treatment.

2012/04
Collate qualitative and quantitative data to allow the partnership develop a better understanding of community needs.

2012/05
Young people's substance misuse

- Increase alcohol awareness/education to reduce substance misuse;
- Strengthen early intervention at Tier 1 and Tier 2 by workforce development with key stakeholders;
- Secure longer-term funded services to support young people with substance misuse problems;
- Determine inter-organisational issues (potential for integration/joint commissioning);
- Access critical areas of quality or service effectiveness (for example primary care access);
- Review current service provision in relation to the Targeted Youth Support Service;
- Consider developing an 'in house service' as part of the Targeted Youth Support Service.

Illicit drug use

Illicit drug use – unmet needs

Further consultation with service users and service providers is needed to fully understand the comprehensive list of needs which are currently unmet.

Illicit drug use – commissioning intentions

2012/01
Improve the awareness of drug treatment availability (in particular for users of opiate and/or crack who are aged 25 to 34-years-old).

2012/02
Ensure currently commissioned and future services provide appropriate support for those younger people presenting to drug treatment for use of alcohol, amphetamines, cannabis, cocaine and ecstasy.

2012/03
Consider engagement strategies targeted at people aged between 40 to 50-years-old to recruit more people in to drug treatment.

2012/04
Support all service users to exit from drug treatment successfully. However, specific strategies aimed at service users that have been in drug treatment for over six years should be developed to move these people on to living lives free from dependence.

2012/05
Review the support delivered to those using amphetamines, but also to those using opiates and/or crack given that re-presentation to treatment rates are higher than national averages amongst these primary drug users.

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. The pharmacies in Redcar & Cleveland operate 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 Redcar & Cleveland 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 also no formal shared care agreement between GPs in Redcar & Cleveland and the Stop Smoking Service which means that they have to rely on relationships which have been developed. Without a formal shared care agreement being developed and adopted the ability of specialist advisors prescribing varenicline could lessen.

Smoking – commissioning intentions

Smoking cessation
2012/01
Review the current stop smoking service model with the view to increase value for money and patient choice.

- Maximise opportunities for referral by training front line staff through the proposed CQUIN scheme

- Plan service provision around local need and aspirations by conducting an equity audit of current service provision to inform service planning
- Review voucher provision to increase access to services particularity in areas with high routine and manual populations and increase service provision for young people
- Review Stop Smoking Service prescribing varenicline
- Review current provision across all providers, including repeating the equity audit
- Conduct engagement activities with providers to ensure their knowledge is fed into service development
- Improve understanding of existing financial structures of service including prescribing costs to inform service planning
- Review tariff to make it more appealing for providers
- Enhanced support to providers whose data is indicating a drop in activity, increased Lost To Follow Up, reduced Carbon Monoxide validation, poor 4 week quit rates.
- Develop a maternal smoking action plan
- Develop a local marketing strategy for smoking cessation linked to the national one
- Ensure a whole health system approach to tackling smoking by developing service level agreements which:
    - Require all health professionals including primary and secondary care staff, midwifery and mental health staff to raise the issue of smoking through a brief intervention and refer to Stop Smoking Services for support
    - Stipulate that referral to Stop Smoking Services is included in relevant care pathways and rehabilitation services for smoking-related disease.

Tobacco Control
2012/02

Reducing the harm caused by tobacco and tobacco products requires many partners to have an active role and interest in reducing smoking. Partners can play a key role:

- To 'champion' tobacco control in Redcar & Cleveland, to help address health inequalities and deliver continued success in driving down smoking.
- To lobby and influence national and international decision-making on tobacco issues and ensure that Redcar & Cleveland has a clear, articulate voice that speaks out on behalf of our communities and presents the evidence base for effective action to continue to shift the social norms for tobacco use.
- To have representation on smoke-free Redcar & Cleveland to develop and implement a clear action plan to take forward the tobacco control agenda including: motivating and supporting smokers to stop; protection from second-hand smoke; effective media and communications; influencing and advocacy and skills and capacity development; reducing tobacco promotion; reducing availability and supply of tobacco; effective tobacco regulation; research, monitoring and evaluation.
- To establish robust accountability structures and monitoring and reporting measures.
- To tackle cheap and illicit tobacco by ensuring that Trading Standards and Environment Health Departments within the Council have the capacity to contribute to the tobacco control agenda.
- Helping young people not to smoke.
- Maintaining and promoting smoke-free environments.

2012/03
Engage a variety of other local authority departments in tobacco control work such as adult and children's services, housing, planning.

Diet and nutrition

Diet and nutrition – unmet needs

Breastfeeding
Redcar & Cleveland does not have a co-ordinated programme of peer support as recommended by UNICEF to support mothers to breastfeed.

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

There is no breastfeeding welcome scheme in the community which would enable local businesses to identify if they welcome breastfeeding mothers to feed their baby safely without the fear of being removed.

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 as often they lack the resources and knowledge to purchase and eat a balanced diet, particularly for 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 Redcar & Cleveland 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, funding and facilities.

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

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.

Activities currently taking place in school facilities or privately owned facilities may be reduced by removal of the opportunity, particularly arising from security and health and safety concerns.

Participation in active leisure in subsidised or commercial facilities, including pools and gyms, may be restricted by economic pressures and increased costs. The age and condition of some leisure centres is a concern and significant investment is required just to maintain these buildings at their current levels.

Reductions in subsidy to public transport may also increase barriers to participation for some forms of active leisure.

Increasingly inactive and increasingly overweight young people may feel excluded from traditional competitive or recreational group activities such as running, league football, tennis. There may be a lack of services aimed at beginners and people with low self-efficacy.

The increasing numbers of older people, as a proportion of the population, may require an increased number of activities designed to meet their tastes and lifestyles. These will represent an increased demand for subsidy at a time of declining resources.

Insufficient allotment provision and long waiting lists may prevent people taking part in this form of physical activity; the Council currently has 17 sites with 760 plots in total whilst some of the town and parish councils also have some provision. There are available plots in some areas, although these tend to be in the more deprived wards and have been subject to vandalism. Hence, there is a waiting list for plots in other more desirable areas with 746 people on the waiting list (January 2011).

Lack of awareness of the local environment and opportunities for active leisure may limit participation levels.

There is a lack of mechanisms for informal activities to take place with like-minded people.

Waiting times and potential capacity issues in the future for Exercise by Prescription are exacerbated by resource pressures, especially in the light of the cessation of grant funding for the programme.

Physical inactivity – commissioning intentions

2012/01
Facilitate and create increased opportunities for people of all ages to take part in sport and active leisure, wherever possible removing barriers of cost, transport, and perception. Programmes should focus on those who are currently inactive and seek to achieve moderate intensity activity levels.

2012/02
Commission programmes which link schools with community sport and leisure opportunities including those in the voluntary sector and leisure centres to provide performance pathways and to reduce the decline in participation which occurs through the 11-19 years range.

2012/03
Promote greater understanding of the health benefits of physical activity and use events as a focus to encourage people to get involved.

2012/04
Increase the capacity of voluntary sector groups running sport and active leisure programmes to sustain higher numbers of participants.

2012/05
Maximise use of facilities, including schools and green infrastructure, through community use agreements and clear information and guidance. A strategic review of the allotment provision across Redcar & Cleveland should be conducted, which should explore the potential to initiate food growing projects in other settings such as schools and workplaces (using HMP Holme House in Stockton as a case study) and linking volunteers with any such projects. The successes and progress of existing and recent work such as the "Dig It" project should be built upon.

2012/06
Improve detailed understanding of local population characteristics in relation to physical activity to enable better targeted interventions.

2012/07
Commission a single website that brings together the physical activity opportunities available in Redcar & Cleveland 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.

2012/08
Consider the use of health impact assessments for a wide range of Council and partner activities such as transport and housing projects – all of which have the potential to influence the physical activity environment.

2012/09
Use the 'wellness' system in the leisure centres to better track and analyse the local population.

Obesity

Obesity – unmet needs

Capability and capacity building within the workforce 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 particularly focusing on a life course approach.

Targeted weight management service provision is required for those identified at risk in adult and child populations (i.e. BME communities; learning disabilities; maternal obesity; men; under 5s; areas of high deprivation; specialist weight management support and for those 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.

If current prevalence trends continue, demand for weight management services will outstrip capacity.

Obesity – commissioning intentions

2012/01
Establish a Redcar & Cleveland Healthy Weight, Healthy Lives Partnership to ensure a co-ordinated approach to prevent and manage obesity in the borough.

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

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

2012/04
Balance the investment between prevention and treatment services ensuring targeted support for those people identified most at risk of overweight and obesity.

2012/05
Ensure the potential for physical activity and healthy eating is maximised through joint working with planning and transport departments 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

Sexual health services for people with learning disabilities do not follow NICE guidance.

It appears from 'You're Welcome' data that the current service delivered by Sexual Health Teesside does not provide a dedicated young person's service. This dedicated service is required to meet the needs of young people in Redcar & Cleveland.

Sexual health support services for boys, young men and teenage fathers are not being provided.

There is inequity of access to sexual health services in Redcar & Cleveland, including for BME groups and for people living in East Cleveland.

Sexual health – commissioning intentions

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

2012/02
Reduce sexually transmitted infections including HIV by increasing testing in high risk groups, maximising service contacts and contribute to regional work to reduce the late diagnosis of HIV.

2012/03
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.

2012/04
Improve equity of service provision in Redcar & Cleveland.

2012/05
Improve the quality of sex and relationship education by providing a programme of workforce development for those working with young people. This should ensure young people (aged 11 to 16, or up to age 25 if the young person has a disability or struggles to learn) receive education, advice and information in relation to their health and wellbeing especially for risk-taking behaviours, including from services such as housing and employment.

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 Redcar & Cleveland was 192.2 per 100,000 (387 admissions). This is lower 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. When they are, many people still continue to progress to develop diabetes.

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

Diabetes – commissioning intentions

2012/01
Further develop, implement and monitor strategies to identify people who do not know they have diabetes.

2012/02
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 May 2012 on preventing the progression from pre-diabetes is expected to support this progress.

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

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

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

2012/06
Reduce variation by encouraging and promoting peer review among general practices.

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, 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 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.

2012/14
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 oral health promoting practices scheme
- 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 5.9% 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 Redcar and Cleveland 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 e.g. children to adults
- No floating support services to provide immediate input whilst patients are waiting to be seen by other services
- Lack of services/pathways for people with long-term conditions and those with untreated depression
- Integrated pathway for dual diagnosis.

Population Issues

- Raising awareness and tackling stigma with the local population
- Suspected under-reporting of self-harm in BME, Asylum Seekers and LGBT communities
- Males are less likely to access traditional health services
- Media engagement is insufficient.

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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.