Version 2.0

Stockton-on-Tees
Joint Strategic Needs Assessment
2012-15

Unmet needs and commissioning intentions arising from JSNA

9th January 2013

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Learning disabilities

Learning disabilities – unmet needs

Respite provision for people with learning disabilities needs to be increased, as identified through consultation for the EIT review

Independent living housing options need to be increased for people with learning disabilities.

A diagnostic and care pathway for autism needs to be implemented.

Local services need to be developed to meet the needs of people with autism.

Services need to demonstrate the use of reasonable adjustments for this client group to improve fair and equitable access for people with a learning disability.

There is a need for more support for people with a learning disability who go into hospital (via acute liaison provision).

The needs of people with profound and multiple learning disabilities (PMLD) are not met.

People with a learning disability need to have more choice of, and easier access to, vocational training activities.

The needs of people with a learning disability from BME communities need to be better understood, and information and awareness raising about what services are available is needed.

For people in transition, further work is required to continue to map need. Partnership working is needed to ensure that people are receiving the necessary support, in line with changes in expectations of clients to move away from more traditional services.

Provision of more choice for clients, needs to be addressed via a Framework agreement to increase the number of providers and quality of services provided and by increasing the number of people using personal budgets.

There needs to be appropriate support for people with a learning disability in the criminal justice system.

There are eight general practices that have not signed up to the directed enhanced service (DES) to provide annual health checks for people with learning disabilities. Furthermore, in 2010/11, 26% of those eligible in Stockton-on-Tees received a health check, compared with 49% in England and 37% in the North East.

Learning disabilities – commissioning intentions

2012/01
Continue to commission and monitor the Learning Disabilities Directed Enhanced Service (DES), and ensure GP practices are offering high quality health checks to all eligible patients, including consideration of alternative methods of delivery for those patients registered at a practice not signed-up to the DES.

2012/02
Commission services in line with the expected increase in prevalence of adults with a learning disability over the next 10-15 years.

2012/03
Improve the quality of primary care learning disability registers, including improving the recording of people with mild learning disabilities.

2012/04
Ensure all requirements of *Six Lives*, *Healthcare for All* and *Improving the Health and Well-being of People with a Learning Disability* are delivered by local providers and commissioners.

2012/05
Implement the action plan arising from the annual health self-assessment framework to ensure continuing improvement in local services for adults with learning disabilities.

2012/06
Implement the diagnostic pathway for autism and improve the recording of people with ASD on GP practice registers.

2012/07
Investigate the needs of people with autism and ensure access to mainstream and universal services, enhancing independent living.

2012/08
Stimulate the local market and provide more respite provision within local communities including meeting the needs of people with challenging behaviour and autism.

2012/09
Reconfigure services so that there is a move towards provision in the community, including day services and supported housing.

2012/10
Increase the numbers of adults with learning disabilities who are in settled accommodation and employment.

2012/11
Investigate the demand and costs for specialist services to ensure that service provision is delivering value for money.

2012/12
Implement recommendations from the Stockton Borough Council efficiency, improvement and transformation review.

Physical disabilities

Physical disabilities – unmet needs

More appropriate accommodation to promote independent living is required.

There are insufficient placements for young people with physical disabilities.

There is insufficient / ineffective support to assist individuals in taking part in community life.

Individuals feel they are subjected to effects of prejudice in the community and workplace.

There is limited access to training, education and employment.

Mental health issues are often not identified at an early stage.

Physical disabilities – commissioning intentions

2012/01
Implement the goals set out in “Our health, our care, our say” to help people with a physical disability live fulfilling lives and achieve to their full potential by receiving the support they need.

2012/02
Stimulate the local market to provide more innovative and cost-effective ways of providing support and meeting the needs of people with physical disabilities.

2012/03
Involve people with physical disabilities fully in the planning of future services to ensure services meet their needs.

2012/04
Reduce prejudice against people with physical disabilities in the community and workplace.

2012/05
Continue to improve access to services, facilities, training and education for people with physical disabilities.

2012/06
Ensure the rise in the older population and associated increase in physical disability is taken into account when commissioning services.

2012/07
Implement the recommendations of the efficiency, improvement and transformation review of all services.

2012/08
Ensure services are providing quality and value for money.

Sensory disabilities

Sensory disabilities – unmet needs

The support that is needed to maximise independence is not provided.

The re-ablement services currently focus on physical disabilities. This service is not provided to people with sensory loss.

There are insufficient screening and preventative measures.

There is insufficient/ineffective support to help people take part in community life.

Mental health issues are not identified at an early stage.

There is a lack of awareness about prevention of sensory loss particularly amongst high risk groups.

The service uptake amongst specific ethnic groups who are at high risk needs to be improved.

People with dual sensory loss are not able to access the support they need.

There are not enough regular screening services for socially excluded groups.

Sensory disabilities – commissioning intentions

2012/01
Achieve the goals set out in “Our health, our care, our say”.

2012/02
Provide more innovative and cost-effective ways of providing support and meeting the needs of people with sensory loss.

2012/03
Involve people with sensory loss in the planning of future services to ensure services meet their needs.

2012/04
Improve access to services and facilities for people with sensory loss.

2012/05
Implement the recommendations of the efficiency, improvement and transformation review of all services.

2012/06
Ensure services are providing quality and value for money.

2012/07
Include services to cover areas such as how to adapt to sight loss or hearing loss, counselling and rehabilitation.

2012/08
Increase public awareness of sensory loss issues, who is at risk and prevention of sensory loss particularly for high risk groups such as older people and BME communities through public health campaigns.

2012/09
Incorporate eye health messages into other public health campaigns such as obesity and smoking cessation.

2012/10
Consider how to make the links to the new public health indicator for eyes in the Public Health Outcomes Framework, "Improving outcomes and supporting transparency".

2012/11
Use national eye health week to inform people of eye health issues and available services.

Sexual violence victims

Sexual violence victims – unmet needs

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

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

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

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

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

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

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

Sexual violence victims – commissioning intentions

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

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

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

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

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

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

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

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

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

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

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

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

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

Domestic violence victims

Domestic violence victims – unmet needs

At present there is no dedicated long-term funding available within Stockton-on-Tees to appoint an Independent Domestic Violence Advocate (IDVA). Following an increase in the number of cases discontinued at court and the number of complaints withdrawn, short-term funding was identified until 1st April 2012.

There is currently a gap in health data available in relation to domestic violence which may have an impact in the identification of issues and the time taken to signpost individuals to relevant support.

Domestic violence victims – commissioning intentions

2012/01
Research the costs of domestic violence to the NHS in Stockton-on-Tees, looking particularly at A&E attendances and GP contacts.

2012/02
Pilot an integrated offender management approach to tackling domestic violence, working with 10 families with a view to reducing the impact/frequency of health services as a result of intervention.

2012/03
Provide focussed support work in a one-to-one and group setting for individuals with substance misuse issues.

2012/04
Explore the feasibility of utilising specialist workers to work to support 'hard to reach' groups such as individuals with special needs and male victims.

2012/05
Improve the training and awareness of domestic violence for health professionals such as GPs, A&E staff, midwives and health visitors.

2012/06
Agree funding arrangements to ensure the continuation of the Safe at Home scheme for a further 12 months.

2012/07
Agree future independent domestic violence advocate arrangements for Stockton.

Carers

Carers – unmet needs

Although there are services in place to support carers' needs identified through consultation, carers felt more needs to be done to provide wider access to services.

There is a need to identify more carers as the carers presently accessing services are only a small proportion of the estimated number.

Carers – commissioning intentions

2012/01
Develop systems to identify carers and make them aware of available support. Health and social care services should routinely identify carers and provide information about or refer to carer support services.

2012/02
Ensure existing services for carers have sufficient capacity to manage anticipated increased need.

2012/03
Promote carers' issues and available carer support more widely, ensuring access to health services.

2012/04
Commission additional respite services which provide not only traditional respite but also innovative ways to provide regular respite.

2012/05
Increase provision of timely information and support for carers who care for terminally ill people to ensure they are central to the team which cares for the person coming to the end of their life but ensures support for the physical, psychological, social, financial and spiritual well-being of the carer.

2012/06
Implement the recommendations of the efficiency, improvement and transformation review.

End of life care

End of life care – unmet needs

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

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

End of life care – commissioning intentions

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

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

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

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

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

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

Ex-forces personnel

Ex-forces personnel – unmet needs

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

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

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

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

Ex-forces personnel – commissioning intentions

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

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

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

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

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

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

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

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

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

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

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

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

Migrants

Migrants – unmet needs

The needs of older migrants including problems of access to social care and social inclusion services, particularly those people of South Asian background.

There needs to be early identification of mental health problems and provision of appropriate support to reduce the risk of crisis and suicide.

Suitable temporary accommodation for asylum seekers at their 'transition period' is needed

Access to screening for chronic medical conditions allowing early identification and support to enable appropriate management thus avoiding preventable complications, A&E attendances and unnecessary hospital admission is needed.

Mental health needs of asylum seekers to handle and deal with their emotions and provide support with social inclusion.

Not all migrants have access to services due to travel difficulties (poverty), cultural and language barriers. For example, refused asylum seekers who obtain Section 4 Support are only provided housing and vouchers but no cash.

Migrants – commissioning intentions

2012/01
Develop awareness of migrants' problems and promote good practice within health and social care services, including social & private housing.

2012/02
Improve communication and mutual understanding about health and social care entitlements; advice, information and guidance for both front line staff and for migrants, particularly asylum seekers.

2012/03
Improve data collection between service providers including health and social care, housing, and school admissions to ensure more robust, timely and comprehensive data is available to support service development to meet the needs of migrants.

2012/04
Work closely with school admissions, education support services, the local interpreting service and Stockton & District Advice and Information service to understand the Stockton migrant profile.

2012/05
Provide better support for individuals on the prevention of mental ill-health and social exclusion by improving community cohesion and integration.

2012/06
Improve the access to and condition of, appropriate housing to reduce the dependence of migrant workers on poor quality tied accommodation and houses in multiple occupation.

2012/07
Provide information and advice on how to access local services and involve voluntary and faith organisations, employers and landlords.

Travellers

Travellers – unmet needs

There is a shortage of appropriate accommodation and a waiting list to get access the Bowesfield Traveller Site.

Members of the community lack confidence and knowledge on how to use mainstream services.

Racism and discrimination is still common, frequently overt and seen as justified due to abusive media coverage

There is a lack of knowledge of general lifestyle advice including such issues as alcohol misuse and dietary or nutrition information.

The uptake of services by Gypsies and travellers for health and social care is unclear because they are almost entirely absent from ethnic monitoring data.

Travellers – commissioning intentions

2012/01
Tackle wider determinants of health and well-being, in particular by addressing accommodation needs, employment and education.

2012/02
Avoid a 'single provider' approach and encourage the Gypsy and traveller community to access mainstream services, particularly screening opportunities and childhood immunisation services. This could be achieved by having an individual with a Gypsy or traveller background providing advocacy support at the Bowesfield traveller site.

2012/03
Improve community knowledge of mental health issues and reduce mental health stigma.

2012/04
Develop awareness of Gypsy and traveller cultural issues within health and social service providers.

2012/05
Ensure continuity of substance misuse and mental health services.

2012/06
Tackle domestic violence within these communities.

Offenders

Offenders – unmet needs

Mental health
There is clearly a high level of need amongst offenders in respect of mental health. It has already been identified in local and national needs assessments that this is an issue.

Learning difficulties/disabilities
It is unknown how many offenders have learning difficulties/disabilities that are undiagnosed and therefore have unmet support needs.

Substance misuse
Alcohol misuse remains a major problem with long-term consequences for health care. Access to support via primary, secondary and specialist care is available, but this needs to be extended (especially in relation to early interventions). The types of drug(s) an offender uses dictates the intervention(s) offered to them. This process needs to be further developed to meet the changing profile in substances used.

Smoking
Smoking remains a major risk to health. There are some processes in place for dealing with smoking and other lifestyle risks (staff working within the criminal justice system or via referral to community services) but this does not meet all needs of offenders.

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

Female offenders
There are difficulties associated with engaging females into support and/or treatment and there is the possibility that vulnerable women will not use services.

Young offenders
If youth offending service officers do not have access to the relevant training and associated support then it increases the possibility that young offenders health needs will be unmet.

Children of offenders
The level of need is not currently known for children of offenders. Investigation, effective interventions and integrated working is required.

Needs analysis
There is a need to improve processes for identifying unmet needs. There is an under-reporting of mental illness, learning disabilities and blood borne viruses.

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 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; and

- Specialist support (especially mental health) for children who have parents in contact with the criminal justice system should be provided.

Crime

Crime – unmet needs

While there is a commitment to maintain high levels of service and support, it is clear that the pressures on budgets and the impact this will have on capacity within partner agencies will affect the level of service. This in turn could potentially lead to a lack of community reassurance linked with the wider feeling that public services are stretched at a time where issues such as high unemployment are prevalent within communities.

The future role of the Police Crime Commissioner will also have an impact on the development and delivery of services to meet local needs but this is difficult to assess at this stage.

Crime – commissioning intentions

2012/01
Extend the emerging issues priority to include burglary of dwelling and non-dwelling, as well as ‘other theft’. The main issue seems to be metal thefts.

2012/02
Assess all current targets within the Community Safety Plan and re-set the plan for 2012/13.

2012/03
Look at first time offenders and try to establish their motivation for offending. The first step would be to monitor the number of first time offenders in the forthcoming year to see if there is a big enough problem to warrant further research.

2012/04
Prioritise offenders committing burglary offences as they have the highest rate of repeat offending.

2012/05
Re-establish and agree the terms of reference for the drugs 'Reducing Harm' group.

2012/06
Raise the profile of alcohol and assess the role of all current alcohol-related working groups as well as current procedures to ensure that nothing is being missed.

2012/07
Ensure that domestic violence services are well publicised in Stockton, especially in more affluent areas where services are not currently utilised.

2012/08
Look at the current transition processes between youth and adult services for offenders and drug and alcohol misusers to ensure that people are not dropping out of treatment/support.

2012/09
Ensure that problem profiles and more in-depth analysis are commissioned for specific issues throughout the year. Issues identified for exploration so far are the possible reasons for the changes to crime and deprivation levels within Parkfield and Oxbridge electoral ward and the 'most serious violence' category.

Education

Education – unmet needs

Traveller Families
The consistency of educational provision for children of traveller families beyond the primary phase needs attention.

The provision for families electing for home education needs attention.

The more complex needs of the GRT communities. GRT communities are identified as 'vulnerable' for such things as: housing/ site provision; health; and education. A multi-agency group would need to reflect these needs, to ensure that barriers to learning are considered in their entirety.

English as an additional language
The language needs of some pupils because the range of linguistic backgrounds is diverse and it is not always possible for schools to provide first language support to overcome the language barriers of the pupils and families who have limited English.

Risk-taking behaviour
Provision needs to be made for those with sexually harmful behaviour.

Education – commissioning intentions

2012/01
Deliver a co-ordinated programme of school improvement focused on school in danger of falling below current floor standards. This should involve the work of local authority school improvement advisers (SIAs, school to school support and involvement of appropriate external agencies;

2012/02
Implement a highly focussed intervention plan with measurable targets set against clearly defined success criteria where a school is a cause for concern.

2012/03
Support schools in analysing their outcomes for vulnerable groups and issue an inclusion profile to every school. This will be a valuable tool for senior leaders to inform their strategies and interventions to narrow these gaps. Provide training to support the launch of the inclusion profile for governors, senior staff and special education needs co-ordinators. Implement a revised inclusion quality mark.

2012/04
Improve attainment in reading in primary schools at both Level 4 and Level 5 to ensure pupils' preparedness for secondary education and beyond by implementing universal training in the teaching and improvement of reading throughout the academic year;

2012/05
Deliver a co-ordinated approach to teenage pregnancy through education to ensure positive impact on outcomes;

2012/06
Provide an appropriate level of speech and language therapy in schools to enable the pupils to fully access the curriculum and maximise learning potential;

2012/07
Commission education and welfare support for traveller families through the service of a dedicated officer;

2012/08
Deliver targeted support for schools to address those with levels of attendance and high rates of exclusion;

2012/09
Increase the number of young people from Stockton progressing to and remaining in education, training or employment from age 16 onwards. Ensure post-16 providers receive the 'soft' information about individual pupils which will help them to put in place effective pastoral support mechanisms. Improve pre-16 providers'

understanding of the qualifications and skills needed for post-16 progression. Ensure post-16 providers are kept abreast of curriculum change pre-16 and understand implications for their own provision.

2012/10
Commission education and welfare support for new arrivals to the UK with English as an additional language, through the service of a dedicated officer.

2012/11
Develop a rolling programme for promoting sexual health for young people with learning difficulties/disabilities. Parent classes/workshops, individual work are needed, also forensic/psychiatry services and more local provision for young people with sexually harmful behaviour.

Employment

Employment – unmet needs

Each resident from the working age population does not have an opportunity for paid work.

Identification of the sector-specific business needs for education and training to address any projected skills shortages needs to be earlier.

There is an insufficient number of available training and work-based learning opportunities (apprenticeships).

Some school leavers do not have the required skills that employers need and are unable to deal with the key transition phases from education to employment.

There are not enough higher paid jobs to alleviate the issues associated with low pay, job stability and short-term contracts.

People with a learning disability do not have the increased choice of, and easier access to, the vocational training activities they want.

Employment – commissioning intentions

2012/01
Reduce the levels of benefit dependency and unemployment, particularly within the priority age groups of 16-18 and 50+ years.

2012/02
Reduce the numbers of those young people who are not in education, employment or training (NEET)

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 in disadvantaged areas.

2012/05
Raise awareness with employers in respect of the issues faced by carers in the workplace to provide an understanding of how they can be supported

2012/06
To increase the number of adults with learning disabilities in settled employment

Environment

Environment – unmet needs

An estimated average of 72 people die each winter in Stockton-on-Tees because of the effects of cold. Their needs for appropriate housing and care may contribute to this.

Increasing levels of fuel poverty - increased 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 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.

Currently, cases of contaminated land are dealt with using a risk-based process as set out in the Contaminated Land Inspection Strategy. The strategy relies on progress being made by developers in developing previously used land and carrying out remediation under the planning regime and proactive detailed inspections. The investigation and remediation of potentially contaminated sites receives funding from central government and funding from this source has been reduced significantly over recent years, which has slowed down progress.

Noise Action Planning requires plans to improve the noise climate in priority areas; this national scheme will need co-ordination with several partners including Highways Agency, transportation and engineering departments. There are funding problems to initiate Noise Action Plans, which leads to long lead times for improvement works.

The possibility of improving open space and facilities for the increasing population in Ingleby Barwick will be limited through the use of planning obligations as development there already has planning permission. However, future provision in Ingleby Barwick and all housing developments should be considered particularly in light of standards that currently are not met.

Environment – commissioning intentions

2012/01
Develop and implement a revised Reducing Seasonal Excess Deaths Strategy to take into account the current changes in national policies, effects of the economic climate, and changes to the support mechanisms.

2012/02
Develop climate change risk assessments and implement strategies by education, social care, transport, emergency and environmental services, based upon Stockton Borough Council's Climate Change Impacts Risk Assessment, including flooding and heat wave action plans, and planning for energy supply disruption.

2012/03
Provide additional funding to maintain air monitoring networks and initiate Noise Action Plans.

2012/04
Increase provision of accessible green spaces and explore ways of maximising the use of existing spaces to maintain the public health benefits of these spaces.

2012/05
Improve recycling services in public areas, and investigate offering recycling to commercial properties to further divert waste from landfill.

Housing

Housing – unmet needs

Funding to address disrepair in the private sector stock and Category 1 hazards.

Funding for the provision of disabled adaptations to meet waiting list demand.

Housing-related support services.

Funding for the Home Improvement Agency and Handyperson service.

Emergency accommodation for homeless households.

Emergency accommodation and resettlement/move on accommodation for persons with chaotic lifestyles.

Appropriate housing for vulnerable and older people which would allow them to stay independent for longer.

Affordable housing to address the identified shortfall for both general needs and specialist accommodation.

Housing – commissioning intentions

2012/01
Raise housing standards as follows:
a. Reduce the number of non-decent/Category 1 hazards in the private sector and make the stock 'fit for purpose'
b. Invest in all housing sectors to reduce fuel poverty (and the number of seasonal deaths).
c. Raise standards (property management and condition) in the private sector.

2012/02
Seek additional funding to provide an adequate disabled adaptations service.
a. Fund adaptations thereby enabling people in need to stay in their homes longer and reduce stays in hospitals and care facilities.
b. Fund a 'housing' Occupational Therapist service (to ensure appropriate housing advice/support/best use of stock).

2012/03
Invest in appropriate 'housing-related' support services (for a range of client needs; care leavers, those with learning disabilities, those with complex needs, families with a history of tenancy failure) to ensure individuals/households can live independently.

2012/04
Invest in the Home Improvement Agency and the Handy Person Service to assist people to stay in their homes through the provision of low cost works and advice services.

2012/05
Invest in Telecare services to enable independent living.

2012/06
Build new housing for rent (general needs and specialist housing such as extra care/housing with care schemes for the elderly and those with special housing needs) to address the identified housing need.

2012/07
Bring empty homes back into use (thereby increasing the level of affordable rented accommodation).

2012/08
Tackle financial exclusion.

Poverty

Poverty – unmet needs

Life expectancy in the most deprived areas of Stockton-on-Tees is 15.3 years lower for men and 11.3 years lower for women compared to the least deprived areas.

Many people do not claim benefits to which they are entitled, including income support, pension credit, housing benefit, council tax benefit and job seekers allowance.

People may not have received the education and training necessary for them to obtain employment.

Not enough higher paid jobs exist to alleviate issues associated with low-pay, job instability and short-term contracts.

Some people are excluded from mainstream financial services.

Poverty – commissioning intentions

2012/01
Ensure people claim all benefits to which they are entitled.

2012/02
Reduce the number of those young people who are not in education, employment or training (NEET).

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

Casualty reduction
The current economic climate has placed severe pressures upon levels of investment into transport infrastructure. Traditional traffic engineering interventions on the road network are capital intensive and becoming increasingly difficult to fund, particularly as all of the 'easy wins' have already been made. There are thus fewer higher-return sites available in an already highly engineered environment, and those that remain are costly, and with poorer returns. Major reductions in the capital budget therefore mean that far fewer schemes can be delivered.

Softer measures in education, training and publicity will have a crucial role to play in making the Borough's roads safer, however public sector revenue budget cuts and the removal of specific funding streams such as the Road Safety Grant have placed pressure on this area too. Beyond the current programmes for vulnerable road users there is particular need to support the needs of young drivers, and the needs of an aging population with more older people driving.

Active travel/casualty reduction
The Borough's cycle route infrastructure has developed substantially over recent years. However there are still some key links to be made to outlying communities such as Wynyard. Similarly there remain some significant barriers which divide communities and restrict active travel e.g. the rivers Leven and Tees between Ingleby Barwick and Yarm.

Whereas the policy is for all Y3 and Y4 pupils to have access to pedestrian training, there is a current shortfall in provision due to budget restrictions, with only two trainers in place. To meet demand, a further 3 to 4 trainers are needed.

Cyclist training for Y5 and Y6 is well covered by the Council's training provision, and funded both from internal resources and the Department for Transport's allocation for Bikeability levels 1 & 2. Turning young, basic-level cyclists into capable and regular commuters does however require further investment and there is currently a shortfall in provision for on-road training at Y7-11 (ages 11-16) for Bikeability Level 3. DfT funding for this is now becoming available but it does require local match funding to gain access to a DfT Bikeability grant.

Results from the Big Lottery-funded Active Travel project, based at The Hub have shown that there is latent demand for higher levels of cycling and walking amongst adults, for both workplace commuting and also leisure and everyday transport. Pilot schemes for older cyclists ('Silver Cyclists'), have proven both popular and effective *(Active Travel Monitoring Report, Sustrans 2011)*, however pilot funding has come to an end, and an alternative funding stream needs to be found.

The Government's Local Transport White Paper *Cutting Carbon, Creating Growth: Making Sustainable Local Transport Happen DfT 2011* sets out the Government's vision for a sustainable local transport system that supports the economy and reduces carbon emissions, but highlights that the principal focus for action will be at local level. The key points in the Paper are reducing the number of grant-making schemes and decentralising decision-making powers to local authorities, Local Economic Partnerships and Voluntary Community and Social Enterprise. The main concern is that the Local Sustainable Transport Fund is unlikely to meet the reductions in local authority budgets.

Transport – commissioning intentions

2012/01
Facilitate and create increased opportunities for people of all ages to use 'active travel' within their daily routine for getting to 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
Increase the capacity of voluntary sector groups to provide active travel programmes to sustain more people being active

2012/04
Improve detailed understanding of local accessibility by improvement of walking and cycling network information.

2012/05
Consider health impact assessments for transport projects which have the potential to influence the physical activity environment or such issues as air quality and accessibility.

2012/06
Commission programmes of education, training and publicity aimed at reductions in road traffic accidents involving vulnerable road users.

Alcohol misuse

Alcohol misuse – unmet needs

The number of GPs referring people to treatment services varies greatly as does the information available regarding population alcohol consumption and patients being prescribed chlordiazepoxide.

Crime
Although 188 clients accessing the arrest referral service were deemed as being suitable for and requiring a referral into community alcohol treatment, only 23 were shown to have been in tier 3 treatment with a treatment provider in Stockton-on-Tees in 2010/11.

Mental health
Alcohol-related admissions for Stockton-on-Tees have increased 149% since 2002/03 for people with mental and behavioural disorders.

Substance misuse
It is a priority to address alcohol use amongst problematic drug users, as evidence suggests many drug treatment clients are drinking at harmful levels.

Housing
There continues to be a link between those requiring treatment for alcohol misuse and the need for settled and/or suitable accommodation. There is a need for accommodation support for alcohol clients in Stockton-on-Tees.

Children & families of alcohol users
More robust data is required in respect to the number of children affected by parental alcohol misuse.

Alcohol misuse – commissioning intentions

2012/01
Reduce alcohol-related harm to young people, families and communities, through the delivery of sustained and consistent messages about alcohol consumption to influence attitudinal change and create a cultural shift.

2012/02
Reduce the number of alcohol-related hospital attendances and admissions.

2012/03
Deliver treatment services which are evidenced-based, cost-effective and are responsive to and accessible for all individuals who require treatment.

2012/04
Target alcohol-related crime offenders, with a focus upon violent crime, anti-social behaviour and domestic violence.

2012/05
Enable frontline staff to identify early problematic alcohol use, provide brief interventions and make appropriate referrals.

2012/06
Reduce the availability of alcohol with a particular emphasis on sales to young people.

Illicit drug use

Illicit drug use – unmet needs

None identified.

Illicit drug use – commissioning intentions

2012/01
Ensure that the four principles for commissioning a drug treatment system that promotes successful recovery journeys are thoroughly embedded in Stockton-on-Tees. These four principles are:

- Recovery is initiated by maintaining (and where necessary improving) access to early and preventative interventions and to treatment;
- Treatment is recovery-orientated, high quality and effective;
- Treatment delivers continued benefit and achieves appropriate recovery-orientated outcomes (including successful completions); and
- Treatment supports people to achieve sustained recovery.

2012/02
Ensure that all strategies and services continue to develop an outcomes-based focus in line with the outcomes described in the HM Government Drug Strategy 2010.

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

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

Smoking – commissioning intentions

Smoking Cessation
2012/01
Develop and strengthen local Stop Smoking Services (SSS) in Stockton-on-Tees to:

Identify and commission key SSS hub functions including quality assurance for all providers; training, mentoring and competency assessment for health and health-related professionals who are working in partnership with the Service; central data co-ordination and monitoring; authorisation and payment of tariff systems for providers.

Commission delivery services as appropriate for Stockton-on-Tees. This would include a mix of nurse-led provision, pharmacy provision, and provision within the secondary care setting.

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 SSS for support; and

Stipulate that referral to SSS is included in relevant care pathways and rehabilitation services for smoking-related disease.

2012/02
Consider payment by results using a tariff payment system for SSS.
Pharmacies are only able to offer stop smoking support to people aged 16 and over. However the intention 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 people aged between 12 and 16.

2012/03
Develop suitable training for 12 to 16-year-olds and deliver 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.

Tobacco Control
2012/04
Ensure trading standards and environmental health departments within the local authority have the capacity to contribute fully to the tobacco control agenda.

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

2012/06
Implement test purchase programmes for under age tobacco sales.

2012/07
Support lobbying for a ban on smoking in cars carrying children.

2012/08
Support work on early interventions and the implementation of the Risk-Taking Toolkit , which includes stop smoking messages to support personal, social and health education (PSHE).

Young People
2012/09
Focus on interventions to prevent the uptake of smoking by teenagers as research shows that 39% of smokers and ex-smokers said that they were smoking regularly before the age of 16 and almost two-thirds of them stated that they started smoking regularly before they were 18 years old. Very few people start smoking for the first time after the age of 25.

Diet and nutrition

Diet and nutrition – unmet needs

Interventions for families such as antenatal classes (including breastfeeding), breastfeeding support groups and weaning groups are often not attended by those most in need. Their need for appropriate support is not being met.

There is a lack of uptake of preventative services particularly by those at most risk of diet-related disease.

As the Healthy Start scheme is significantly under utilised for vitamin supplements there is a need to raise the awareness of the scheme, particularly in relation to the vitamin element, both with professionals and families.

With the increase in adults living in supported living accommodation there will be an increase in the need for support and education about diet.

Currently, there are no malnutrition audits conducted within community settings to understand the level of need.

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 in 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.

Reductions in subsidy to public transport may also increase barriers to participation in 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 and 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 need 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.

Lack of awareness of 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 in the future for Active Health (exercise on prescription) are exacerbated by resource pressures.

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 school-based and voluntary sector run sport and leisure to provide performance pathways and to reduce the decline in participation which occurs through the 11-19 years age 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.

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

2012/07
Consider 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.

Obesity

Obesity – unmet needs

There is insufficient 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 uptake of preventative services particularly by those at most risk of obesity-related diseases.

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
Review care pathways and the obesity service model.

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

2012/03
Balance investment between prevention and treatment services ensuring targeted support for those identified most at risk of overweight and obesity.

2012/04
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.

2012/05
Ensure the National Child Measurement Programme (NCMP) meets the emerging evidence base and that families are appropriately supported.

2012/06
Enable joint working with key sectors, such as planning and transport departments to ensure that the potential for physical activity and healthy eating is maximised, including the use of health impact assessments to address the obesogenic environment.

2012/07
Improve the availability of data on obesity for certain sub-groups of the population, such as borough levels of maternal obesity and learning disabilities.

Sexual health

Sexual health – unmet needs

There is late presentation in primary care of people 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 Stockton-on-Tees. 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.

Capacity to provide dedicated preventative work has reduced with the loss of the Stockton Teenage Pregnancy Support Service. Further work is needed to ensure that targeted preventative work is delivered in Stockton-on-Tees. Sexual health support services for boys, young men and teenage fathers are not being provided.

Sexual health – commissioning intentions

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

2012/02
Reduce sexually transmitted infections by increasing testing in high risk groups and maximising service contacts

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

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

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

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

2012/07
Ensure termination of pregnancy services are available to all and that post-termination support and contraception advice are delivered.

Cancer

Cancer – unmet needs

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

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

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

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

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

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

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

Cancer – commissioning intentions

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

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

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

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

Circulatory diseases

Circulatory diseases – unmet needs

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

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

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

Emergency admissions
Emergency admissions indicate unmet need. While decreasing in some cases, they still remain significantly above the England average, and also highlight intra-district inequalities. In 2009/10, the emergency admission rate for CHD, all persons, in Stockton-on-Tees was 255.9 per 100,000 (635 admissions). This is significantly higher than England (205.3 per 100,000) and lower than the North East (259.5 per 100,000). Male CHD emergency admission rates are significantly higher than female CHD emergency admission rates.

Circulatory diseases – commissioning intentions

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

2012/02
Monitor anticoagulant therapy in primary care.

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

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

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

Diabetes

Diabetes – unmet needs

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

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

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

Diabetes – commissioning intentions

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

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

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

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

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

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

Injuries

Injuries – unmet needs

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

Injuries – commissioning intentions

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

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

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

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

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

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

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

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

Mental and behavioural disorders

Mental and behavioural disorders – unmet needs
Comprehensive rehabilitation and recovery support pathway.

Long-term innovative support opportunities.

Access to diagnosis and support for autism in adults.

Specialist support for complex dementia care.

Limited resources at Tier 1 and 2 in child and adolescent mental health services.

A range of crisis provision.

Specialist in-patient and rehabilitation personality disorder services.

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

Mental health support for poorly served communities.

Early detection and intervention for people with mental health problems accessing acute hospital services

Lack of self-help/support groups – hearing voices, obsessive compulsive disorder, panic attacks.

Physical, sexual and domestic abuse.

Advocacy services are felt to be not widely available.

Information and signposting.

Mental and behavioural disorders – commissioning intentions

2012/01
Increase access to talking therapies.

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

2012/03
Recognition of mental health needs across whole system, mental resilience, early intervention - across all age groups or morbidities.

2012/04
Improve physical health care.

2012/05
Improve awareness of safeguarding and risk.

2012/06
Increase in 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
Promote better mental health by combating stigma.

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

2012/12
Address the lack of specialist complex dementia care.

2012/13
Implement the national dementia strategy with 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 service 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 by:

Implementing recommendations from the needs assessment undertaken for older people in nursing homes.

Undertaking a needs assessment/health equity audit for people with learning disabilities, drug misusers and young offenders.

Respiratory diseases

Respiratory diseases – unmet needs

The capacity and capability of current services is insufficient to cope with the projected increase in the number of people with COPD, from a registered prevalence of 2.1% in 2010 to 5.4% in 2020.

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

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

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

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

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

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

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

Respiratory diseases – commissioning intentions

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

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

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

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

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

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

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

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

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

Self-harm and suicide

Self-harm and suicide – unmet needs

Professional issues

Workforce development needs to address:

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

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

Patient issues

Postvention services and counselling may be insufficient.

Inconsistent pathway development and awareness between services.

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

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

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

Integrated pathway for dual diagnosis.

Population issues

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

Self-harm and suicide – commissioning intentions

2012/01
Maintain and improve the early alert system to identify potential suicide clusters.

2012/02
Provide a comprehensive understanding of self-harm, suicide, and further identify levels of unmet need, building on existing local research evidence.

2012/03
Put in place robust protocols to ensure integrated service provision between agencies.

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

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

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

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

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

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