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Legal and Governance

SOUTH TEES HEALTH SCRUTINY JOINT COMMITTEE

Date: **Wednesday 20th March, 2024**
Time: **4.30 pm**
Venue: **Mandela Room, Town Hall, Middlesbrough**

AGENDA

1. Apologies for Absence

2. Declarations of Interest

3. Minutes - South Tees Health Scrutiny Joint Committee - 13 December 2023 — 3 - 10

4. Live Well South Tees Health and Wellbeing Board — 11 - 34

   The Joint Committee will receive an update on the Board's work programme, the performance framework and priority indicators.

5. Social Prescribing — 35 - 42

   Representatives from Public Health and MIND will be in attendance to present:
   - the aim and core principles of social prescribing and community-based support;
   - the schemes that are in place locally (across South Tees); and
   - the impact of social prescribing on the person, the health and care system and community groups.

6. Any other urgent items which in the opinion of the Chair, may be considered.

Charlotte Benjamin
Director of Legal and Governance Services

Town Hall
Middlesbrough
Date Not Specified

MEMBERSHIP

Councillors M Storey (Chair), J Banks (Vice-Chair) and K Evans (Vice-Chair), J Craven, J Hart, D Jackson, D Jones, S Kay, J Lavan and L Mason

Assistance in accessing information

Should you have any queries on accessing the Agenda and associated information please contact Georgina Moore, (01642) 729711, Georgina_Moore@middlesbrough.gov.uk

SOUTH TEES HEALTH SCRUTINY JOINT COMMITTEE

A meeting of the South Tees Health Scrutiny Joint Committee was held on Wednesday 13 December 2023.

PRESENT: Councillors M Storey (Chair), K Evans (Vice-Chair), J Craven, D Jackson, S Kay and J Lavan

ALSO IN ATTENDANCE: C Blair (Director) (North East & North Cumbria Integrated Care Board), T Innes (Commissioning Delivery Manager) (North East & North Cumbria Integrated Care Board), A Rowlands (Head of Commissioning Unplanned Care) (North East & North Cumbria Integrated Care Board) and K Warnock (South Tees Integration Programme Manager) (North East & North Cumbria Integrated Care Board)

OFFICERS: M Adams, S Connolly and G Moore

APOLOGIES FOR ABSENCE: Councillors J Banks, J Hart, D Jones and L Mason

23/8 **DECLARATIONS OF INTEREST**

Name of Member	Type of Interest	Item/Nature of Interest
Councillor K Evans	Non-Pecuniary	Agenda Item 4 (An Overview of Public Health), Agenda Item 5 (Live Well South Tees Health and Wellbeing Board), Agenda Item 6 (Winter Planning) and Agenda Item 7 (Urgent Treatment Centre (UTC) Developments) - Works as a Nurse at James Cook University Hospital.
Councillor J Lavan	Non-Pecuniary	Agenda Item 4 (An Overview of Public Health), Agenda Item 5 (Live Well South Tees Health and Wellbeing Board), Agenda Item 6 (Winter Planning) and Agenda Item 7 (Urgent Treatment Centre (UTC) Developments) - Works as an Admiral Nurse across the areas of Redcar & Cleveland and Middlesbrough.

23/9 **MINUTES - SOUTH TEES HEALTH SCRUTINY JOINT COMMITTEE - 27 SEPTEMBER 2023**

The minutes of the South Tees Health Scrutiny Joint Committee meeting held on 13 December 2023 were submitted and approved as a correct record.

SUSPENSION OF COUNCIL PROCEDURE RULES - ORDER OF BUSINESS

ORDERED: That in accordance with section 4.57 of the Council Procedure Rules, the committee agreed to vary the order of business as follows:

23/10 **LIVE WELL SOUTH TEES HEALTH AND WELLBEING BOARD**

The South Tees Integration Programme Manager was in attendance to present an update on the Board's work programme, the performance framework and priority indicators.

It was outlined that, at the meeting of the Live Well South Tees Board (held in October 2023), the following items had been considered and discussed:

- Housing and Homelessness - South Tees Joint Action Plan
- Tees Valley Place Plan
- South Tees Hospitals NHS Foundation Trust - Update on Group Development and CQC Well Led Outcome
- South Tees Health Protection Assurance Report 2022-23

- South Tees Health and Wellbeing Executive Assurance Report (including updates on the Pharmaceutical Needs Assessment and an update from Healthwatch South Tees)

At its next meeting, scheduled to be held in January 2024, it was planned that the Board would consider/discuss the following items:

- Best Start in Life
- South Tees Safeguarding Children Partnership - Annual Report
- Thrive at Five
- The Joint Strategic Needs Assessment (JSNA)

Members were advised that, following the publication of the JSNA, more detailed updates and performance information would be presented to the committee in terms of the delivery of the joint local health and wellbeing strategy.

A Member raised a query regarding the actions and reported outcomes of the Live Well South Tees Board. In response, the South Tees Integration Programme Manager advised that there was an infrastructure that sat beneath the Board, which ensured the delivery of key pieces of work. It was commented that the Board had a number of mandatory/statutory functions, such as assessing the health and wellbeing needs of the population, publishing a JSNA, publishing a Joint Local Health and Wellbeing Strategy (JLHWS), having oversight of the Pharmaceutical Needs Assessment (PNA) and signing off Better Care Funds. It was explained that although the Board only met on a quarterly basis, it was a partnership that provided strategic direction, a platform and an impetus for officers to deliver new ways of working.

A Member commented that the Board provided a useful function, as it enabled key stakeholders to work collaboratively to identify solutions and develop new ways of working. The Board also enabled shared ownership and direct accountability.

AGREED - That the information presented to the South Tees Health Scrutiny Joint Committee be noted.

23/11 **WINTER PLANNING**

The Director of Place Based Delivery and the Head of Commissioning Unplanned Care from the North East and North Cumbria Integrated Care Board (NE&NC ICB) were in attendance to provide information on the actions being taken across the health service to mitigate the risk of winter pressures.

The Director of Place Based Delivery advised that the Tees Valley Urgent Emergency Care (UEC) system, like UEC services in the rest of the region and the country, remained under significant and sustained pressure. There were staffing issues across all partners and high/increased activity levels within primary and secondary care (linked to elective backlog in primary care access). There was also a higher acuity of patients, resulting in longer Length of Stay (LOS), which was also impacting on flow. Discharge delays (associated with the Trust, social care and capacity in care homes) were causing pressure.

Work had been undertaken by the NE&NC ICB and its partners to develop solutions/innovations to reduce delays with patient discharges. As a result of the work, there had been a significant reduction in the number of individuals who were occupying beds who no longer needed to be in hospital. In December 2022, there was around 150 patients in James Cook University Hospital (JCUH), currently (December 23) there was less than a third of that. In comparison with the rest of the country, JCUH was performing exceptionally well.

Members heard that over the past 12 months, 4 key documents had been published:

- NHS 2023/24 priorities and operational planning guidance - December 2022
- Delivery Plan for recovering urgent and emergency care services - January 2023
- Delivery Plan for recovering access to primary care - May 2023
- NHS England letter to Senior Health Leaders across the country - July 2023

The delivery plan for recovering urgent and emergency services had been published in January 2023, as a result of urgent and emergency services being subjected to the most testing time in NHS history. To support recovery, the plan set out a number of ambitions,

including:

- Patients being seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25.
- Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.

The plan stated that, to succeed and enable the improvement of waiting times and patient experience, the NHS was committed to sustaining focus across the health and social care sectors on five key areas:

1. Increasing urgent and emergency care capacity
2. Increasing workforce size and flexibility
3. Improving discharge
4. Expanding care outside hospital
5. Making it easier to access the right care

The plan had identified 10 high-impact interventions. It was commented that across South Tees, the NE&NC ICB had worked with its partners to ensure robust responses were in place to increase capacity and resilience.

In terms of winter planning across South Tees, the following measures were in place:

- Tees Valley Local Accident & Emergency Delivery Board (LADB) acted as a forum where partners across the health and social care sector came together to collaborate on the integration of high-quality services to support the wider urgent emergency care system and improve emergency care delivery.
- System Control Centres (SCC) existed to be a central co-ordination service to providers of care across the NE&NC ICB footprint, with the aim to support patient access to the safest and best quality of care possible.
- Incident Command Coordination Centre (ICCC) considered current and predicted capacity and demand pressures, supporting stakeholders on how best to navigate pressures across the Tees Valley ICP footprint. The ICCC used collective expertise with the support of the North of England Commissioning Support Surge Team to agree a plan of action to manage emerging demand and the potential surge over an agreed period of time.

In addition to the above, the Tees Valley LADB monitored the key performance metrics and data from partners to determine key risks and formulate a robust response.

Working alongside Tees Valley LADB partners, a system resilience template had been developed to ensure the system was prepared for the risks ahead for the coming winter. The template built in Key Lines of Enquiries (KLOEs), based upon the asks within the various planning guidance documents, alongside other local intelligence. From the 66 KLOEs identified for the Tees Valley system, 12 were rated as amber (in plans, but risks associated with delivery) and 0 were rated as red (no evidence of existing implementation or in system plans).

The 12 areas rated as amber were associated with the following priorities:

- Ambulance handover delays - plans were in place to ensure that no delays exceeded 59 minutes.
- Improving the primary-secondary care interface - plans were in place to manage onward referrals more efficiently.
- Improving joint discharge processes - plans were in place to reduce longest stays, implement best practice interventions and increase staffing capacity.
- Expanding and better joining-up new types of care outside hospital - plans were in place to further utilise the Urgent Community Response Services.
- Expanding virtual wards - plans were in place to increase capacity, increase utilisation and develop new models.
- Making it easier to access the right care - plans were in place to improve timescales

for those being admitted, transferred or discharged.

The NE&NC ICB had worked with Tees Valley LADB system partners to develop business cases that would have a measurable impact. A fully prioritised list of schemes had been developed, which could be utilised, should future funding become available from the Government. One example of such schemes was the development of Acute Respiratory Infection (ARI) hubs, which offered prompt and timely assessment and management of patients outside of general practice.

A full list of schemes/developments that planned to support the system during winter 2023 were referenced in the presentation slides.

In terms of long-term plans, a complex procurement process was currently underway to commission a standardised Integrated Urgent Care (IUC) model across North and South Tees. From 1 April 2024, there would be a new Urgent Treatment Centre (UTC) at James Cook University Hospital (JCUH) and the opening hours of the UTC at Redcar Primary Care Hospital (RPCH) would be extended. Building work had started onsite. Once, the contract had been awarded to the provider, work would be undertaken to mobilise and deliver the service.

Currently, there were two performance specific risks that related to ambulance handover delays and Category 2 ambulance response times. It was commented that the NE&NC ICB was scheduled to undertake work with the North East Ambulance Service (NEAS) and the South Tees Hospitals NHS Trust in January 2024 to make arrangements for the delivery of a rapid process improvement workshop, with an aim to improve handovers and response times.

In terms of other risks and challenges, the following information was outlined:

- The on-going key risk across all system partners, was staffing, with workforce being the limiting factor with most issues across the health and social care sector.
- There were competing priorities and those needed to be balanced so not to create or increase inequalities.
- There were capacity issues in respect of delivering services and responding to the demand from the population to access services across both health (primary and secondary care) and social care.
- There was a need to determine how further variants or waves of Covid-19 would be responded to both locally and nationally.
- There was a need to examine the impact and implications of further industrial action and how that would be managed.

A Member raised a query regarding those experiencing delayed discharges and the reasons. In response, the South Tees Integration Programme Manager advised that those experiencing delays were typically older people, who were waiting for social care services in terms of home care, a care home place or intermediate care. It was commented that the work undertaken by the NE&NC ICB and its partners to improve that pathway had resulted in reduction in the number of patients experiencing delays. It was added that homeless patients and those with complex mental health needs also experienced delayed discharges.

A Member requested further information on the 66 KLOEs that had been identified within the Tees Valley system. It was confirmed that those would be circulated to the committee members.

A Member raised a query about unsafe discharges. In response, the South Tees Integration Programme Manager advised that a multi-disciplinary team, which included a number of assessors, worked to improve processes and reduce the number of unsafe discharges. The Director of Place Based Delivery advised that a discharge lounge had been implemented at JCUH, which had been very effective in ensuring ward beds were released and improving patient flow through the hospital. It was explained that relatives and carers who were collecting patients could drive right up to the discharge suite.

A Member requested the published figures in respect of operational response and handover times. It was confirmed that those would be circulated to the committee members.

A discussion ensued regarding the current demands on JCUH's accident and emergency (A&E) department. In response, the Director of Place Based Delivery advised that the

development of the UTC planned to relieve pressure on the department. It was explained that having an UTC on site at JCUH would help ensure more patients were treated in the right place for their needs, while helping ensure the emergency department was kept free for emergencies. It was advised that the UTC would operate 365 days a year with a 24/7 GP presence. Also, to improve care in the area, opening hours at Redcar Primary Care Hospital on West Dyke Road, Redcar, would also be extended.

A Member commented on the benefits of the children and young people's emergency department (CYPED) at JCUH, which was based next to the main emergency department. In response, the Director of Place Based Delivery advised that when the CYPED had first been introduced, data had evidenced a positive impact on pressures and waiting times experienced in the adults A&E department. However, it was explained that due to increasing demand, that initial positive impact had now become less apparent.

A Member raised a query regarding Covid-19. In response, the Director of Place Based Delivery advised that Covid-19 was now recognised as a typical respiratory illness, but it was acknowledged that it could have significant implications for the population as it was extremely contagious/infectious. It was explained that the rates of Covid-19 would continue to be monitored in hospital settings and the latest intelligence would be shared by UK Health Security Agency.

AGREED - That the information presented to the South Tees Health Scrutiny Joint Committee be noted.

23/12 **URGENT TREATMENT CENTRE (UTC) DEVELOPMENTS**

As referenced during consideration of the previous item, the information below was outlined by the Director of Place Based Delivery:

- £10m worth of NHS investment had been secured to develop an Urgent Treatment Centre (UTC) in Middlesbrough, on the site of James Cook University Hospital (JCUH).
- The aim of the UTC was to relieve pressure on the hospital's accident and emergency department.
- Construction work had commenced, and the UTC would be fully operational from 1 April 2024.
- A complex procurement process was currently underway to commission a standardised Integrated Urgent Care (IUC) model across North and South Tees, with an expected outcome later in December. As a result, due to legal reasons, the NE&NC ICB was limited with what information could be shared publicly.

AGREED - That the information presented to the South Tees Health Scrutiny Joint Committee be noted.

23/13 **AN OVERVIEW OF PUBLIC HEALTH**

The Director of Public Health was in attendance to provide information on Public Health South Tees, including the main duties and areas within its remit and an outline of the key priorities, issues and challenges for the year ahead.

It was explained that the South Tees area had many challenges and those were referenced in the presentation slides.

Members heard that life expectancy was socially patterned and those from more deprived areas had a lower life expectancy than those from more affluent areas. The following data was outlined:

- In terms of average life expectancy for men, in Middlesbrough it was 75.4 years, in Redcar & Cleveland it was 77.5 years and in England it was 79.4 years.
- In terms of average life expectancy for women, in Middlesbrough it was 79.8 years, in Redcar & Cleveland it was 81.5 years and in England it was 83.1 years.

In terms of male life expectancy, a 14.9-year gap had been reported between the least deprived ward across South Tees, which was Hutton ward (84.3) in Redcar and Cleveland

and one of the most deprived wards being Central ward (69.4) in Middlesbrough.

In terms of healthy life expectancy of Middlesbrough's population, there was a 16.6-year window of need for men and a 19.2-year window of need for women.

It was advised that Section 12 of the Health and Social Care Act 2012 had placed a duty on both local authorities, via the Director of Public Health, to improve public health. Both local authorities had a number of mandated and non-mandated functions that they were responsible for. It was advised that across the area of South Tees, the three areas of biggest spend for Public Health were:

- sexual health services;
- drug and alcohol provision; and
- health visiting and school nursing.

Members heard that both local authorities had a responsibility to publish a Joint Strategic Needs Assessment (JSNA), a Joint Local Health and Wellbeing Strategy (JLHWS) and a Pharmaceutical Needs Assessment (PNA). To ensure best practice was shared across Middlesbrough and Redcar & Cleveland, Public Health South Tees had the following priorities:

- 5 programmes:
    - Creating environments for healthy food choices and physical activity;
    - Protecting health;
    - Preventing ill-health;
    - Reducing vulnerability at a population level; and
    - Promoting positive mental health and emotional resilience.
- 4 business imperatives:
    - Address health inequalities with a determined focus on the best start in life;
    - Better use of intelligence to inform decision-making;
    - Building purposeful relationships with key partners; and
    - Improved financial efficiencies.
- 3 levels of intervention across the life course.
    - Civic-level - healthy public policy;
    - Service-level - evidence-based, effective, efficient and accessible services; and
    - Community-level - family of community centred approaches.

The aims of the 5 programmes were:

- To create healthy environments by developing a system-led approach and creating places that promote healthy eating and moving more.
- To protect health by protecting the South Tees population from the spread of communicable disease, outbreaks and environmental hazards.
- To prevent ill-health by reducing inequalities in population health through the prevention and early detection of disease and providing effective support to enable residents to manage their long-term conditions.
- To reduce vulnerabilities at a population level by developing a person-centred approach and providing a co-ordinated and high-quality holistic package of support.
- To promote positive health and emotional resilience by working with key partners to ensure the population of South Tees was supported to be more resilient, achieve positive mental health and good emotional wellbeing.

In respect of each of the 5 programmes, the committee was provided with information on the work that was being undertaken to tackle/address challenges and improve the health and wellbeing of the South Tees population.

Members heard that the JSNA provided an intelligence platform to assess the current and future health and care needs of the local population. The JSNA was vital to inform and guide service planning, commissioning and delivery of health, well-being and social care services to ensure the needs of local communities were met.

Members heard that the development of the JSNA was a statutory responsibility of the Live Well South Tees Board with an expectation that key partners and organisations would work

together to gain a greater understanding of community needs, agree key local action and encourage a system-wide approach to tackling local challenges.

The Live Well South Tees Board had agreed to a 'mission-led' approach for the development of the JSNA, which was structured across the life course. The following areas were outlined to the committee:

- In terms of Start Well, the missions were - to narrow the outcome gap between children growing up in disadvantage and the national average by 2030; improve education, training and work prospects for young people; and prioritise and improve mental health and outcomes for young people.
- In terms of Live Well, the missions were - to reduce the proportion of families who were living in poverty; create places and systems that promote wellbeing; support people and communities to build better health; and build an inclusive model of care for people suffering from multiple disadvantage across all partners.
- In terms of Age Well, the missions were - to promote independence for older people and ensure everyone had a right to a dignified death.

In terms of those missions referenced, it was explained that each had associated goals, which were informed by the JSNA.

Members heard that, in 2022, Middlesbrough Council (as lead bidder), Redcar & Cleveland Council and Teesside University were granted funding (£5.2 Million over 5 years) to establish a Health Determinants Research Collaboration (HDRC) across the local authority areas. Members heard that the funding planned to boost the capacity and capability to conduct high-quality research to tackle health inequalities and identify local solutions that address the most difficult challenges across the health and care system. The missions associated with the HDRC included:

- creating a sustainable and inclusive economy to minimise and reduce health inequalities;
- giving every child the best start in life; and
- enabling all children, young people and adults to maximise their capabilities and control over their lives.

A Member raised a query regarding suicide rates across South Tees. In response, the Director of Public Health advised that rates had peaked in 2020. It was added that a Tees Suicide Prevention Awareness Conference had recently taken place and information would be shared with the committee in respect data collection systems used in local suicide prevention, high-frequency locations and strategies on how to reduce suicides across the region and beyond. The importance of multi-agency action to prevent suicides was highlighted.

AGREED - That the information presented to the South Tees Health Scrutiny Joint Committee be noted.

23/14 **ANY OTHER URGENT ITEMS WHICH IN THE OPINION OF THE CHAIR, MAY BE CONSIDERED.**

Suggestion for the Work Programme

A Member had submitted a suggestion that the topic of Social Prescribing be added to the committee's work programme for the current municipal year.

A discussion ensued and Members agreed that the topic should be added to the 2023/24 work programme.

AGREED - That the topic of Social Prescribing be added to the 2023/24 work programme for the South Tees Health Scrutiny Joint Committee.

Meeting schedule

Following discussion, Members agreed that meetings should continue to be held on Wednesdays at 4.30pm.

AGREED - That the next meeting be scheduled to take place in March, on a Wednesday at 4.30pm.

Live Well South Tees Health and Wellbeing Board
Report to South Tees Health Scrutiny Joint Committee

To:	South Tees Health Scrutiny Joint Committee	**Date:**	March 2024
From:	Live Well South Tees Board		
Purpose of the Item	To provide the South Tees Health Scrutiny Joint Committee with an update on the Board's work programme, performance framework and priority indicators		
Summary of Recommendations	That South Tees Health Scrutiny Joint Committee: • Are assured that the Live Well South Tees Board is fulfilling its statutory obligations • Note the progress made in implementing the Board's Vision and Priorities		

1. Purpose and Statutory Functions of Health and Wellbeing Boards:

Health and Wellbeing Boards are a formal statutory committee of the local authority and provide a forum where political, clinical, professional and community leaders from across the health and care system come together to improve the health and wellbeing of their local population and reduce health inequalities. HWBs:

- provide a strong focus on establishing a sense of place
- instil a mechanism for joint working and improving the wellbeing of their local population
- set strategic direction to improve health and wellbeing

Statutory functions include:

- Assessing the health and wellbeing needs of their population and publishing a joint strategic needs assessment (JSNA)
- Publishing a joint local health and wellbeing strategy (JLHWS), which sets out the priorities for improving the health and wellbeing of its local population and how the identified needs will be addressed, including addressing health inequalities, and which reflects the evidence of the JSNA
- Oversight of Pharmaceutical Needs Assessments
- Sign off of Better Care Funds

Source: https://www.gov.uk/government/publications/health-and-wellbeing-boards-guidance/health-and-wellbeing-boards-guidance#role-and-purpose-of-health-and-wellbeing-boards

2. Live Well South Tees Board Strategy / Missions

The Live Well South Tees Board has agreed the vision and aims summarised in the table below:

Vision	**Empower the citizens of South Tees to live longer and healthier lives**		
Aims	**Start Well**	**Live Well**	**Age Well**
Aspiration	**Children and Young People have the Best Start in Life** We want children and young people to grow up in a community that promotes safety, aspiration, resilience and healthy lifestyles	**People live healthier and longer lives** We want to improve the quality of life by providing opportunities and support so more people can choose and sustain a healthier lifestyle.	**More people lead safe, independent lives** We want more people leading independent lives through integrated and sustainable support.

Further details of the goals and links to the JSNA are shown in Appendix 1.

3. Work Programme

The South Tees Health and Wellbeing Executive was formed to oversee the work programme for the Live Well South Tees Board, promoting joint working and ensuring statutory functions are met. The Board receives an Executive Assurance Report each meeting.

3.1 At the Live Well South Tees Board Meeting in January, members received updates and discussed:

a) The Joint Strategic Needs Assessment (JSNA)
b) South Tees Safeguarding Children Partnership Annual Report
c) Oral Health Needs Assessment Summary and Water Fluoridation Consultation
d) The Health and Wellbeing Executive Assurance Report which included updates on:
   - Better Care Fund Quarterly Returns and current performance against metrics
   - Government Consultation for Creating a SmokeFree Generation and Tackling Youth Vaping
   - South Tees Carers Strategy
   - Healthwatch South Tees activity

3.2 The provisional **Forward Work Programme** for the remainder of 2023-24 is outlined below. An updated FWP for 2024/25 will be developed when the Health and Wellbeing Strategy is discussed and agreed at the June meeting of the Live Well South Tees Board.

Area of Focus	Lead Organisation/ System Group	Agenda Item Live Well South Tees Board	HWB Executive Assurance Report
Start Well			
Best Start in Life / Thrive at Five	Best Start in Life Programme Board	March 2024	
Live Well			
Prevention Board Update	Prevention Board	March 2024	
Statutory Functions			
BCF Plans and Additional Discharge Funding Quarterly and End of Year Returns	BCF Implementation and Monitoring Group South Tees Executive Governance Board	As required by national timelines	BCF Quarterly updates
Healthwatch Update and Annual Reports	Healthwatch	June 2024	Quarterly updates
HWB Vision and Priorities and Forward Work Programme	HWB Executive	June 2024	
Joint Strategic Needs Assessment Updates	JSNA Project Board	As required	
Pharmaceutical Needs Assessment – Endorsement and Noting of Any Issues	PNA Steering Group		As required
Teeswide Safeguarding Adults Board (TSAB) Annual Report	TSAB	March 2024	

4. Performance Framework and Priority Indicators

Start Well: Children and Young People have the Best Start in Life

Mission	Goals	JSNA Areas of Exploration
We will narrow the outcome gap between children growing up in disadvantage and the national average by 2030	1. We want to eliminate the school readiness gap between those born into deprivation and their peers. 2. We want to eliminate the attainment gap at 16 among students receiving free school meals	▪ Distribution of free school meals uptake ▪ Distribution of free nursery places uptake ▪ Parental and Perinatal mental health and wellbeing ▪ Children in absolute low income families ▪ Teenage parents ▪ Distribution of attainment levels ▪ Distribution of vaccs & imms uptake
We want to improve education, training and work prospects for young people	3. Extend offers of apprenticeships, training and work placements for young people to make the most of current and future local opportunities 4. We will have no NEETs in South Tees through extended employment, apprenticeship or training offers for 18–25 year olds.	▪ Anchor Institutions within LIveWell Partnership (targeted recruitment, apprenticeships, training, volunteering and placement opportunities); ▪ Social value & community wealth building (employers); ▪ Persistent absentees & school exclusions ▪ Pupils with social, emotional and mental health needs ▪ Pupils with SEND needs ▪ Young people providing unpaid care ▪ Children entering the youth justice system ▪ Teenage conception rate
We will prioritise and improve mental health and outcomes for young people	5. Scale up school based mental health support and support education partners in the establishment of whole school based programmes 6. Improve access to mental health care and support for children and young people rapidly at place, led by needs.	▪ Pupils with social, emotional and mental health needs ▪ Hospital admissions as a result of self-harm (10-24) ▪ New referrals to secondary mental health services (<18 yrs) ▪ Parental and Perinatal mental health and wellbeing ▪ Children in absolute low income families ▪ Children entering the youth justice system

Live Well: People live healthier and longer lives

Mission	Goals	JSNA Areas of Exploration
We will reduce the proportion of our families who are living in poverty	1. We want to reduce levels of harmful debt in our communities	▪ Level of debt and impact on communities ▪ Impact of programmes to maximize incomes ▪ Local authority, social housing and PSL rent arrears ▪ Foodbank usage
	2. We want to improve the levels of high quality employment and increase skills in the employed population.	▪ People engaged in poor quality work – particularly precarious and insecure work ▪ Job density ▪ Average weekly earnings ▪ Gap in employment rate between for those with LTC ▪ Economic inactivity rate ▪ Workless households ▪ Adult education availability and access and connection to job market demands ▪ Gender pay gap (by workplace location) ▪ Scope and impact of Individual Placement and Support (IPS) schemes
We will create places and systems that promote wellbeing	3. We want to create a housing stock that is of high quality, reflects the needs of the life course and is affordable to buy, rent and run.	▪ Affordable housing supply ▪ Homelessness - households owed a duty & on waiting lists ▪ Over-crowded households ▪ Fuel poverty & excess winter deaths ▪ Conditions of dwelling stock
	4. We want to create places with high quality green spaces that reflect community needs, provide space for nature and are well connected.	▪ Utilisation of outdoor space for exercise/health reasons ▪ Access to woodlands ▪ Number of premises licensed to sell alcohol/sqkm ▪ Density of fast food outlets ▪ Air pollution - fine particulate matter ▪ Mortality attributed to air pollution ▪ Access to health assets and hazards index

Mission	Goals	JSNA Areas of Exploration
	5. We want to create a transport system that promotes active and sustainable transport and has minimal impact on air quality.	▪ Adults walking for travel at least 3 days per week ▪ Adults cycling for travel at least 3 days per week ▪ Public transport utilisation ▪ Killed and seriously injured (KSI) on roads ▪ The rate of complaints about noise ▪ Air pollution - fine particulate matter
	6. We will support the development of social capital to increase community cohesion, resilience and engagement	▪ Teesside University community consultations on Covid Recovery ▪ Strong and weak ties and development of social capital evidence base ▪ Art & health evidence base ▪ YGT evidence base (participation) ▪ Level of community participation in the development of [Partner] plans and initiatives
We will support people and communities to build better health (aka Prevention!)	7. We want to reduce the prevalence of the leading risk factors for ill health and premature mortality	▪ Density of fast food outlets ▪ Utilisation of outdoor space for exercise/health reasons ▪ Adults cycling or walking for travel at least 3 days per week ▪ Smoking in pregnancy ▪ Smoking prevalence in adults ▪ Percentage of adults classified as overweight or obese ▪ Obesity: QOF prevalence (18+) ▪ Admissions where obesity was a factor ▪ Alcohol related hospital admissions rate ▪ Adult physical activity levels ▪ Percentage reporting a long-term Musculoskeletal (MSK) problem ▪ Admissions for COPD
	8. We want to find more diseases and ill health earlier and promote clinical prevention interventions and pathways across the system	Distribution, prevalence and social gradient of: ▪ Cancer (& by site) ▪ Hypertension ▪ Diabetes ▪ CHD ▪ COPD ▪ Primary care QOF registers

Mission	Goals	JSNA Areas of Exploration
		▪ Screening programmes, including healthy heart checks
We will build an inclusive model of care for people suffering from multiple disadvantage across all partners	9. We want to reduce the prevalence and impact of violence in South Tees	▪ Connection to CURV needs assessment ▪
	10. We want to improve outcomes for inclusion health groups	▪ Healthy life expectancy & life expectancy for inclusion health groups ▪ SMR for inclusion health groups ▪ Risk factors – poverty, insecure housing, violence ▪ Understand barriers to access ▪ Understand the impact of frailty in this group ▪ Deaths from drug misuse ▪ Suicide rate
	11. We want to understand and reduce the impact of parental substance misuse and trauma on children	

Age Well: More people lead safe, independent lives

Mission	Goals	JSNA Areas of Exploration
We will promote independence for older people	1. We want to understand and reduce the levels of loneliness and isolation in our communities	▪ Older people living alone ▪ Anti-depressant prescribing ▪ Health related quality of life for people with 3 or more LTCs ▪ Emergency admissions for acute conditions that should not usually require admission ▪ Emergency readmissions within 30 days discharge from hospital ▪ Crime against older people
	2. We want to ensure our places promote healthy ageing	
We will narrow the gap in Healthy Life Expectancy Draft ICB Strategy:	3. We want to reduce the rate of under 75 premature mortality	▪ Under 75 mortality rate from causes considered preventable ▪ Physically active adults ▪ Adults classified as overweight or obese ▪ Prevalence of various conditions ▪ Admission rates for various conditions

Mission	Goals	JSNA Areas of Exploration
"*We will reduce the gap in healthy life expectancy between our ICP and the England average by 25% by 2030, and aim to raise the average healthy life expectancy to a minimum of 60 years in every Local Authority by 2030*"		▪ Screening coverage ▪ Fuel poverty ▪ Index of multiple deprivation score (IMD) ▪ Older people in poverty ▪ Inequality in life expectancy at 65
	4. We want to reduce the level of frailty to improve healthy ageing	▪ Estimated prevalence of hearing loss ▪ Preventable sight loss - age related macular degeneration (AMD) ▪ % reporting a long-term Musculoskeletal (MSK) problem ▪ % reporting at least two long-term conditions, at least one of which is MSK related ▪ Prevalence of knee & hip osteoarthritis in people aged 45 and over ▪ Rheumatoid Arthritis: QOF prevalence ▪ Prevalence of common mental disorders: aged 65 & over ▪ Hip fractures in people aged 65 and over & % recovering ▪ Dementia recorded prevalence (aged 65+) ▪ Admissions for Dementia ▪ Permanent admissions to residential and nursing care aged 65+

BCF Performance Metrics:

Metric	Indicator
Avoidable Admissions	Standardised rate of admissions per 100,000 population
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.
Discharge to Usual Place of Residence	Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence
Residential Admissions	Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Briefing Note Appendix 1

JSNA Progress Update

To:	South Tees Health and Wellbeing Board	**Date:08/01/24**	
From:	Rebecca Scott – Public Health Principal Alistair Stewart – Public Health Intelligence Specialist	**Ref:**	V1

1.0 Purpose

To update the South Tees Health and Wellbeing Board on the development journey of the Joint Strategic Needs Assessment and present the key recommendations across the 21 goals.

2.0 Background

The LiveWell South Tees Board (HWBB) agreed to a "mission-led" approach for the development of the JSNA, structured across the life course. Each mission is a response to a significant local challenge, one where innovation, working together and aligning resources has a big part to play in driving large-scale change – missions cannot be resolved by any single agency acting in isolation. The missions each have a set of ambitious goals that further articulate and explain the mission.

The JSNA will provide the intelligence behind the missions – it will develop our collective understanding of the missions and broad contributing factors to the current outcomes experienced.

Lifecourse	Mission	Goals
Start Well *Children and Young People have the Best Start in Life*	We will narrow the outcome gap between children growing up in disadvantage and the national average by 2030	We want to eliminate the **school readiness** gap between those born into deprivation and their peers.
		We want to eliminate the **attainment** gap at 16 among students receiving free school meals
	We want to improve education, training and work prospects for young people	Extend offers of **apprenticeships, training and work placements** for young people to make the most of current and future local opportunities
		We will significantly reduce the number of **NEETs** in South Tees by preventing disengagement and reducing/removing barriers to engagement in employment, education and training.
	We will prioritise and improve mental health and outcomes for young people	Embed suistainible **school based mental health support** and support education partners in the establishment of whole school based programmes
		Improve **access to mental health care and support** for children, young people and families, led by needs.
Live Well *People live healthier and longer lives*	We will reduce the proportion of our families who are living in poverty	We want to reduce levels of **harmful debt** in our communities
		We want to improve the levels of high quality **employment and increase skills** in the employed population.
	We will create places and systems that promote wellbeing	We want to create a **housing stock** that is of high quality, reflects the needs of the life course and is affordable to buy, rent and run.
		We want to create places with **high quality green spaces** that reflect community needs, provide space for nature and are well connected.
		We want to create a **transport system** that promotes active and sustainable transport and has minimal impact on air quality.
		We will support the **development of social capital** to increase community cohesion, resilience and engagement
	We will support people and communities to build better health	We want to reduce the prevalence of the leading **risk factors for ill health and premature mortality**
		We want to find more diseases and ill health earlier and promote clinical **prevention** interventions and pathways across the system
	We will build an inclusive model of care for people suffering from multiple disadvantage across all partners	We want to reduce the prevalence and impact of **violence** in South Tees
		We want to improve outcomes for **inclusion health groups**
		We want to understand and reduce the impact of **parental substance misuse** and trauma on children
Age Well *More people lead safe, independent lives*	We will promote independence for older people	We want to reduce the levels of **loneliness and isolation** in our communities and ensure our places promote healthy ageing
		We want to reduce the level of **frailty** to improve healthy ageing
		We want to ensue our communities are **dementia** friendly
	We will ensure everone has the right to a dignified death	We want to improve the identification of people who are approaching **end of life** and enable choice - relating to personalised and coordinated care.

The JSNA has been developed on a South Tees footprint and the recommendations will inform the development of the South Tees Health and Well-being Strategy.

3.0 Journey to date

3.1 Process

Strategic leads (Public Health DMT/SMT) have been identified and consulted with for each of the 21 goals under the 9 missions. Following feedback from partners the goals have been slightly modified to support the development. The role of the identified lead was to support the facilitation of the development of the JSNA by:

- Identifying any other key sources of data which may support the development
- Identifying and liaising with key partners and community groups/VCS to support the development
- Lead forward the steering group for the mission/goal
- Play a key role in developing the content and end product

3.2 Data Themes/Drivers

A mapping exercise on each of the 21 goals was conducted identifying key data themes and drivers that have been further explored in the steering groups. Requirements were then identified and data requests put forward to various organisations. A number of current needs assessments supported by Public Health and key partners have also been identified as part of this process to feed into the development of the JSNA including but not exclusive of;

- Family hubs needs assessments
- CURVE needs assessment
- Domestic Abuse needs assessment
- Combatting Drugs Unit Needs Assessment
- Ageing better consultation
- Dementia Friendly Consultation
- Best Start in Life Community Insights

3.3 Work with Partners

We liaised with a number of different colleagues within the council organisations, wider partner and VCS organisation to collect a range of datasets dependent on the topic. The Public Health intelligence team engaged with the intelligence teams at both South Tees NHS Foundation Trust and North East Commissioning Support Unit (NECS) on behalf of the Tees Valley Integrated Care Board (ICB) to consider what NHS datasets from primary and secondary care best support the JSNA goals as well as helping to identify leads within the organisation relevant to each goal.

Both organisations committed to undertaking a data gathering exercise, analysis of the data and intelligence and providing interpretation and understanding for the key findings. This multi-agency cooperation across public health, the ICB and the Trust ensured that the most important and informative datasets have been included within the JSNA process.

Teesside University also committed to supporting the development of the evidence base behind the goals with a focus on the causes and impact on inequalities and the evidence base for recommendations in terms prevention and harm minimisation.

4.0 Development of the JSNA goals across the life course themes

The JSNA Missions and Goals are aligned across the Life Course areas; Start Well, Live Well and Age Well. This section of the report describes the engagement and collaboration which has taken place in the development of the narrative for each goal.

4.1 *Best Start in Life*

4.1.1 We will narrow the outcome gap between children growing up in disadvantage and the national average by 2030

To support the development of the BSIL goals a workshop was held with wider key partners on the 21st September with invitations going out to all members of Middlesbrough Childrens Trust and Redcar & Cleveland's Children and Young People's Partnership. RCVDA and MVDA were also asked to forward details of the event to their distribution lists.

Although not all invited were able to attend updates following the workshop were send out via email offering further opportunity input and feedback on content. A further review session was held on the 24th of November with invites going out to all key partners.

4.1.2 We will prioritise and improve mental health and outcomes for young people

Input and development of both goals was achieved by engagement with various stakeholders who form part of wider children and young peoples workforce, examples include; Education, ICB, VCS Emotional Health Service Providers, NHS ICB, TEWV, Schools/Colleges, Local Authority etc, and including children and young people (HeadStarters). Participation was achieved through established governance arrangements such as CYP Emotional Wellbeing Board, Mental Health Leads in School Network, South Tees Emotional Health Commissioning Forums (were JSNA specific sessions were facilitated), and Partner Templates circulated for population and collation. In addition to this several JSNA in person focus workshops/events were facilitated to increase wider sector participation. Important insights from our CYP

came from our South Tees HeadStarters and Emotional Health Service provider evaluations and feedback.

4.1.3 We want to improve education, training and work prospects for young people

In relation to this goal a structured questionnaire was sent to various stakeholders and providers of related services throughout the area. The survey asked various questions following the structure of the JSNA to inform the development. Once this questionnaire was returned Public Health South Tees then contacted the individual organisations to get further knowledge around the subject and services that were being provided. All recommendations from the section were provided by the organisation and experts in the field from this area.

4.2 Live Well

4.2.1 We will reduce the proportion of our families who are living in poverty

For the harmful debt goal an initial email was sent to key Council/VCS partners and networks (including both Middlesbrough and Redcar & Cleveland Financial Inclusion Groups, Localmotion and Health Champions Network) asking if they would be willing to contribute to the creation of the Debt JSNA. All responded positively and completed a survey template with views, data and case studies which was then developed into a draft and shared with all partners (including the above networks, MIND, Citizens Advice Bureau, Middlesbrough Environment City, Welfare Rights, Thirteen Housing, MVDA, RCVDA, Teesside University, Thrive, National Illegal Money Lending Team and My Sisters Place) to make further comments before a final draft was approved.

As part of the JSNA goal to **improve the levels of high-quality employment and increase skills in those of working age,** Public Health colleagues held engagement meetings to collate a contact list, to send key engagement questions to gauge what services were being delivered in the area around this subject. Once the responses were received, Public Health then met with the key contacts to receive further detail about the organisations, services or work related this goal. Further meetings were held to ensure the validity of the information received as well meeting other partners and stakeholders that engaged with such key partners. Key partners contacted included; internal Middlesbrough and Redcar and Cleveland Council staff, The MFC foundation, Middlesbrough College, Dept. of Health and Social Care, Tees Valley Combined Authority, The Widening Participation Group, Middlesbrough Community Learning, The ICS Workforce programme and Middlesbrough and Stockton MIND.

4.2.2 We will create places and systems that promote wellbeing

Green spaces – Initial one to one and small group interviews with a range of partners including Middlesbrough Council: Leisure/Culture, Planning, Allotments, Green Strategy, Redcar and Cleveland Borough Council: Culture, Planning, Climate/Green Strategy, Beyond Housing, Thirteen Group, Tees Valley Nature Partnership, Natural England, Tees Valley Wildlife Trust and Middlesbrough Environment City. Once the interviews were completed a workshop was held at which the quantitative and

qualitative data collation was presented for prioritisation. Further representation at the workshop included; Public Health South Tees, Teesside University, North York Moors National Park, You've Got This, National Trust, Community Ventures Tees Valley, Groundwork North East and Cumbria and Tees Valley Sport.

Transport - Initial one to one interviews were held with the following partners; Middlesbrough Council: Transport, Environmental Protection, Holiday Activity Fund, Redcar and Cleveland Borough Council: Environmental Protection, Sustrans, Stagecoach, CIMSPA, Redcar and Eston School Sport Partnership, North York Moors National Park, Tees Valley Combined Authority and Groundwork North East and Cumbria. Once the interviews were completed a workshop was held at which the quantitative and qualitative data collation was presented for prioritisation. Further representation at the workshop included; You've Got This, Redcar and Cleveland Borough Council: Climate/Green Strategy, Transport, Arriva North East,

Social Capital – this goal followed a different approach, due to no previous JSNA content a more exploratory approach was taken to uncover lines for inquiry which were shared and explored at two workshops within November. Workshops were attended by the following; Public Health South Tees, You've Got This, The Hope Foundation, Middlesbrough Council: Transport, Redcar and Cleveland Borough Council: Communities and Health, Culture, North East Wellbeing, Lloyds Bank Foundation, Redcar and Eston School Sport Partnership, MFC Foundation, MVDA, RCVDA, North York Moors National Park, Recovery Connections and Everyone Active.

4.2.3 We will support people and communities to build better health

With regard to the JSNAs for the mission to support people and communities to build better health, an initial meeting was held in November 23, a wide range of partners including the Integrated care Board, Healthwatch, the acute trust, GPs, pharmacy, public health, mental health trust, local authority, NHSE, were engaged with. Current data was presented to those who could attend and discussions were captured and included in the JSNAs. Following this one to one meetings were held and correspondence was had with theme leads and long term condition leads to ensure all system contributions were included. Both goals were then circulated widely for further comment.

4.2.4 We will build an inclusive model of care for people suffering from multiple disadvantage across all partners

A workshop was held with key partners from the local authority (Adult and Childrens Social Care and Community Safety), Cleveland Police, The Probation Service and The South Tees Youth Justice Service to look at the goal of reducing prevalence and impact of violence across South Tees. Links with James Cook Hospital Foundation Trust were facilitated via the Public Health Consultant, ideally more consultation across the Trust and ICB would have taken place, but this was limited due to timescales. The lead for the goal did work closely with representatives from Curv and added in information from their very detailed response strategy which was produced in April 23.

In terms of impact of parental substance misuse and health inclusion goals, the processes were the same. A range of engagement efforts were made across public sector, VCS and key partners and stakeholders, including people with lived experience. Two initial Teams meetings were held in order to promote discussion, enable queries and to shape the priorities and key elements to focus on in terms of the pressing, local issues. Summaries of these meetings were shared via email and information was requested for inclusion. The final draft goals were then shared for comments and to identify if there were any omissions that needed to be addressed. This feedback was then actioned for the final versions.

4.3 Age Well

Due to pending CQC inspections a key focus was the completion of the Age Well missions/goals. A steering group was established to lead forward the development of the goals with a wider stakeholder workshop taking place on the 20*th* July which was attended by over 30 organisations to ensure a wide range of partners fed into the development process.

4.3.1 We will promote independence for older people

Frailty Goal – The narrative for the goal was developed following the workshop with further conversations and input from the following: STHFT (Clinical Lead for Falls, Palliative Care Lead, Senior Lead for Frailty Transforming Care), North East Ambulance Service, Specialist Physical Activity Team, You've Got This, MUST Team, Everyone Active, NECS, Local Authority Care Home Commissioners, Local Authority Adult Social Care and ICB leads.

Loneliness and Isolation – The narrative for the goal was developed following the workshop with further conversations and input from the following: Local Authorities, Adult Social Care, Age Friendly Middlesbrough Programme Leads, ICB, Middlesbrough and Stockton Mind.

Dementia – The narrative for the goal was developed following the workshop with further conversations and input from the following: NECS, TEWVT and ICLS Team at the Woodside Dementia Hub, Dementia UK, ICB, Dementia Action Teesside (commissioned provider) and Primary Care Networks.

4.3.2 We will ensure everyone has the right to a dignified death

The narrative for the goal was developed following the workshop with further conversations and input from the following: Teesside Hospice, ICB, NECS, South Tees Hospital Foundation Trust (Including the Consultant in Palliative Medicine and Academic Palliative Care Consultant) Representative from the Royal College of Nursing and end of life care researcher.

6 Recommendations and Next Steps

A JSNA should not be thought of as a performance dashboard but instead considered a living document which may change overtime and need updating. Public Health will develop a review process to ensure that the goals are regularly reviewed and updated to reflect changes in the populations health needs, emerging issues and shifts in priorities.

The recommendations produced for each goal (appendix 1) will be shared and discussed further at a workshop on the 17th January in the view of turning the recommendations into transferable actions for the development of the Health and Wellbeing Strategy.

Appendix 1 – JSNA mission and goal recommendations

Lifecourse	**Start Well** - *Children and Young People have the Best Start in Life*					
Mission	**We will narrow the outcome gap between children growing up in disadvantage and the national average by 2030**		**We want to improve education, training and work prospects for young people**		**We will prioritise and improve mental health and outcomes for young people**	
Goal	**We want to eliminate the school readiness gap between those born into deprivation and their peers.**	**We want to eliminate the attainment gap at 16 among students receiving free school meals**	**Extend offers of apprenticeships, training and work placements for young people to make the most of current and future local opportunities**	**We will significantly reduce the number of NEETs in South Tees by preventing disengagement and reducing/removing barriers to engagement in employment, education and training.**	**Embed suistainible school based mental health support and support education partners in the establishment of whole school based programmes**	**Improve access to mental health care and support for children, young people and families, led by needs.**
1	It is recommended that resource is provided to enable a South Tees partnership that will focus on tackling high-level issues that cause inequalities in school readiness.	It is recommended that resource is provided to enable a South Tees partnership that will focus on tackling high level issues that cause the attainment gap.	**Create a joint strategic working group** – that will be a partnership working to identify a joined-up delivery approach to avoid duplication of programmes, provide a pathway for people, and avoid churn of participants.	**Create or enhance a Family and 'at home' conditions and support role** – to ensure that a wraparound support service is available to address any home life issues or barriers.	**Commissioning -** A joint long term commissioning approach needs to be taken to maintain this vital service.	**Community Based Support -** To explore opportunities to improve access to community-based support including extending Family Hub provision.
2	It is recommended that resource is directed into the following priority areas that are key to making a difference: 1.1 Building parental confidence, skills and capacity 2.2 Cultural enrichment 3.3 Better transitions into primary school	It is recommended that resource is directed into the following priority areas that are key to making a difference: 1.1 Improving attendance and inclusion 2.2 Cultural enrichment 3.3 Better transitions into secondary school	**Create a minimum of in-school and college support for personalised Careers Guidance** for young people and one to one support available to support young people with placing into suitable AND attainable opportunities.	**Ensure Effective policy intervention is in place**, as any design and delivery of service clearly needs to be underpinned by a thorough understanding of the scale of the problem, as well as the extent and 'triggers' of disengagement among young people, by Data led research and decision making	**Parental Support/Co-production -** An explicit and easily understood explanation, including a glossary of terms and explanation of roles and responsibilities of support workers, needs to be developed and maintained.	**System Data -** To develop a greater understanding of the data collected across the system.
3			**Create a South Tees Compact/advisory grou**p to raise awareness and create centralisation of about careers/employment/initiatives/ information.	**Adopt lessons learned** ensuring measures designed to reduce the NEET population should include: (a) policies which tackle NEET prevention. (b) re-engagement strategies for the hardest to reach groups; and (c) active labour market policies for the young unemployed.	**Parental Support/Co-production -** More formal routes of engagement need to be developed to ensure a representational view from parents and families.	**Data Sharing -** To develop data sharing agreements across sectors to facilitate a greater understanding of need and more effective design and commissioning of services.
4			**Provide education to families around the importance of friends and family support to young people to ensure their success**. Family and 'at home' conditions and support – for those that have chaotic homelives - a wraparound support service for parents and family giving education, ensuring commitment and support and how vital that support is for a young person's success.		**System Data -** To develop a greater understanding of the data collected across the system	**Getting Help Offer** – Community Settings - Explore opportunities to model the school mental health Getting Help offer in community settings.
5					**System Data -** To develop data sharing agreements across sectors to facilitate a greater understanding of need and more effective design and commissioning of services.	**Workforce Development -** Consult on and review current training pathways. Develop a training model to meet needs for all professionals and settings and includes access to trauma informed and attachment aware training.

6					**Workforce Development -** Develop a training model to meet needs for all professionals and settings and includes universal access to trauma informed and attachment aware training.	**Navigating the System** - Develop a comprehensive, easily understood guide on services within the system using the ithrive framework
7					**Getting More Help -** Use the principles of whole pathway commissioning to seek to expand the current Getting Help model.	**Parent Family Offer -** A full understanding of the needs of families and available support across the system.
8					**School Attendance -** Develop and improve working practices between education and health to improve school attendance.	**Parent Family Offer -** Develop a comprehensive offer for parents/families to enable them to better support their children and young people's mental health and well-being.
9					**Transition Points -** Develop and improve working practices between education and health to support transition.	**Poverty Proofing -** To introduce the concept of poverty proofing as standard practice with all service providers.

Lifecourse	**Live Well** - *People live healthier and longer lives*					
Mission	**We will reduce the proportion of our families who are living in poverty**		**We will create places and systems that promote wellbeing**			
Goal	**We want to reduce levels of harmful debt in our communities**	**We want to improve the levels of high quality employment and increase skills in the employed population.**	**We want to create a housing stock that is of high quality, reflects the needs of the life course and is affordable to buy, rent and run.**	**We want to create places with high quality green spaces that reflect community needs, provide space for nature and are well connected.**	**We want to create a transport system that promotes active and sustainable transport and has minimal impact on air quality.**	**We will support the development of social capital to increase community cohesion, resilience and engagement**
1	**Collaboration** - Collaboration with Primary and Secondary Care signposting (GPs and Hospitals). Greater connection between primary and secondary care and financial support agencies	**Develop community wealth building in collaboration with local employers and anchor organisation**s (improving employment opportunities but also workers' rights. Overall giving employees a chance to lead a dignified life, with access to the opportunities and choices needed to fully participate in society)	**Delivering a quality retirement living** - Increase the proportion of older person's accommodation within residential developments	**Build a more comprehensive and meaningful set of data assets** that expand our understanding beyond the physical assets of green and blue spaces	**Cultural Shift and Tackling Perceptions:** Foster a paradigm shift in perceptions and culture surrounding transportation.	**Defining Social Capital** – There is a need to better define what social capital means in South Tees and grow local understanding and value of it.
2	**Collaboration** - Strategic Approach between Financial Inclusion Groups and Partners - Alignment and cross pollination of key strategic action plans	**The learning gained from the evaluations of employability projects** about 'what works best to support people into learning and work' needs to be shared to inform future employability programmes.	**Delivering a quality retirement living -** Maximise the coverage of extra care housing schemes for older people	**Building a value of green and blue spaces locally to improve physical and mental health and wellbeing**, addressing and mitigating the climate crisis and creating liveable neighbourhoods.	***Influencing decision making:*** Securing buy-in from decision makers is paramount to instigating transformative changes in the realm of the goal. This involves not only garnering their support but also allocating adequate resources to influence changes in policy and investment aligned to community priorities.	**Decision-making** – Investigate the understanding of social capital amongst strategic decision-makers and build their value of social capital in decision-making. Create an environment where all feel confident and comfortable to get involved in decision making processes. Decision making processes need to be built on the ability for people to participate
3	**Collaboration** - Community Wealth Building - Collaboration with Local Employers and Anchor Organisations. Utilise local employers and anchor organisations to take a collective approach to community wealth building.	**Employment and skills funding is mainly short-term, so we need to influence funding bodies**, including government, to provide long-term funding, rather than the current piecemeal approach.	**Preventing homelessness and ensuring choice in housing -** Deliver the homelessness recommendations of the Tackling Disadvantage assessment of the JSNA	**Promote a greater level of strategic coordination** to green and blue space provision across South Tees.	**Low Emission Corporate Fleets:** Explore the ability to implement zero-emission practices within fleet management systems. Specifically, we will investigate the viability of transitioning to a fleet composed entirely of electric with a longer range.	**Anchor institutions** - Better define and understand the role of anchor institutions of all sizes that are within our place and communities. Develop a more extensive relationships map within place against local needs
4	**Collaboration** - Links with mental health services. Services offering financial support are equipped in referring to mental health services	**Ensure all employment and skills programmes have a focus on empowering people** to address any underlying barriers to employment and skills development (mental ill health, transport, conviction etc)	**Preventing homelessness and ensuring choice in housing -** Promote the Tees Valley Home Finder scheme to deliver choice in affordable housing	**Increase local social capital and community power** in relation to the goal.	**Connection of Active Travel and Public Transport:** Bring together the work of Active Travel and Public transport together to explore how to connect the public transport and active travel options together to support joint travel opportunities.	**Training, employment, and progression** - Develop an understanding of the opportunities and design training around these opportunities and community needs. In particular, broaden the concept of training.
5	**Collaboration** - Listen to People with lived experience. Engage with people with lived experience to understand the issues; support system change where needed and improved collaboration.	**Embed a Making Every Contact Count (MECC) approach within all sectors** (local employers, anchor organisations and services such as DWP)	**Minimising the impact of welfare reform -** Use Discretionary Housing Payments to assist those households in the most severe financial need	**To maintain or improve on the current level of provision** by planning for future developments to increase the amount and diversity of green space available.	**Stakeholder and Business Connections:** Engage with organisations to implement flexible solutions around work times to enable active travel as well and work to implement suitable infrastructure to support sustainable travel opportunities.	**Data** – Better understand and use the data we have, to ensure that it informs decision-making. Commit to listen, collect, and share data worded to make more informed decisions. Be aware of the limits that data has.
6	**Collaboration** - Collective gathering of Data and Intelligence	**Consider options such as bursaries to support those wanting to leave paid employment to re-train** in new skill areas so they can manage living costs.	**Minimising the impact of welfare reform -** Support RP partners in developing income management and personal budgeting support for tenants	**Develop a holistic and inclusive goal that extends beyond the initial scope** to embrace the broader assets of South Tees, encompassing Grey, Blue, Green, and Open Spaces		**Networking** – Create more spaces for collaborative conversations and networking. Broaden networks and strengthen links with under-represented communities.
7	**Services** -Increase benefits take up : Providing easy, accessible support to residents to ensure that they are accessing all benefits that they are entitled to can help ensure that they do not enter into harmful debt.	**Increase engagement with communities affected by low pay and worklessness** to further develop recommendations and coproduce employability solutions with communities and partners.	**Enabling independent living -** Increase appropriate accommodation options for people requiring housing support			**Volunteering and community action** – Improve understanding of what volunteering is, who volunteers, why they volunteer and appreciate the value they create.
8	**Services** - Increase Debt Advice and Support : Continued support, signposting and advice for those in debt through mainstream Council and VCS partners who are trained in giving this advice	**Increase the number of those in the local workforce with a level 3 qualification**, improve the technical vocational skills of residents and improve the maths skills of adult residents without a Level 2 qualification through the new Multiply Shared Prosperity Fund.	**Enabling independent living -** Support the use of telecare and assistive technologies to help people remain independent in their own homes			**Voluntary sector** – Value, support and develop a strong and thriving voluntary sector, recognising the sector's role in both achieving and maintaining social cohesion.

9	**Services** - Encourage Best Practice within public sector debt teams : Evidence shows that debts in the public sector are an increasing source of problem debt, typically for those already in need of financial support.	**With a growing number of employers turning to skills-first hiring**, universities to support their graduates to meet the expectations of industry, embedding in-demand skills in curricula and focus on developing human skills	**Planning a strategic approach to supported housing** - Review the needs of different client groups for supported accommodation			**Systemic Change** - Ensure that public policy reflects community needs and address the barriers that stop local people from taking action and developing solutions for themselves.
10	**Services** - Energy Efficient Homes and Housing : Social Housing providers and private landlords should ensure they are meeting required guidelines to ensure homes are as energy efficient as possible	**Universities to promote short training/education programmes to aid young people who are not in education/employment** or training to build a CV and increase employability.	**Planning a strategic approach to supported housing -** Use assessments to work with partners to develop appropriate supported housing schemes			
11	**Prevention** - Provide Money Management and Debt Training: To reduce the risk of falling into harmful debt, education and training in money management and budgeting	**Address the digital divide across South Tees** so those who are digitally excluded have the same opportunities to access job and skills development opportunities.				
12	**Prevention** - MECC (Making Every Contact Count) approach for finances - upskilling frontline staff and community contacts who engage with our communities to be able to normalise conversations about money as part of a making every contact count approach	**Continue to develop digital skills of South Tees residents to keep up with the pace of change within the digital world** and to ensure South Tees residents have the skills for jobs now and in the future.				

Lifecourse	**Live Well** - *People live healthier and longer lives*				
Mission	**We will support people and communities to build better health**		**We will build an inclusive model of care for people suffering from multiple disadvantage across all partners**		
Goal	**We want to reduce the prevalence of the leading risk factors for ill health and premature mortality**	**We want to find more diseases and ill health earlier and promote clinical prevention interventions and pathways across the system**	**We want to reduce the prevalence and impact of violence in South Tees**	**We want to improve outcomes for inclusion health groups**	**We want to understand and reduce the impact of parental substance misuse and trauma on children**
1	Establish the governance for the Ill health prevention programme including wider partnership meetings, internal team meetings and a multi agency action plan that delivers the key actions in relation to each topic.	Establish the governance for the Ill health prevention programme including wider partnership meetings, internal team meetings and a multi agency action plan that delivers the key actions in relation to each topic.	The Cleveland Unit for the Reduction of Violence (CURV) currently provides a multi-agency partnership through which organisations work collaboratively to address serious violence. The scope of this work should extend, with the support of boths Council as key signatories of the partnership, to delivering workshops, learning sessions and other informative activities to educate children and young people on the consequences of violence.	To improve the outcomes of asylum seekers and refugees, local authority strategies should focus on improving the social determinants of health that affect health and wellbeing	The voices of the children should be heard and listened to. Work is required to develop means of enabling the children of problem drug users safely to express their thoughts and feelings about their circumstances.
2	Implement a Health Equity Audit process across all services to ensure that resources are fairly distributed and health inequalities are not being widened.	Implement a Health Equity Audit process across all screening and diagnostic services to ensure that resources are fairly distributed and health inequalities are not being widened particularly among our CORE20PLUS groups.	Further research and analysis should be undertaken to identify reasons for negative school engagement such as high exclusion rates and low educational attainment among individuals	Healthcare resources from local GP and other primary care centres should be made available in other languages as standard practice, to resolve language barriers to accessing healthcare for refugees and asylum seekers	Drug misuse services, maternity services and children's health and social care services should forge links that will enable them to respond in a co-ordinated way to the needs of the children.
3	Ensure the use of population health data to design and commission high quality joined up prevention services (tobacco, alcohol, substances(linked) physical inactivity and obesity) that meets the needs of service users, improves access, experience and outcomes, and reduces inequalities.	Ensure the use of population health data to review and recommission high quality joined up diagnostic / screening services (ie NHS Health checks, cancer screening) that meet the needs of service users, improve access, experience and outcomes, and reduces inequalities.	At present, CURV supports the delivery of training for professionals on how to identify those at risk of violent crime and on interventions and measures to prevent crime, in line with Government guidance on Serious Violence Duty, which stipulates that authorities should consult educational authorities	Local Authorities and Health and Wellbeing Boards should collaboratively address the negative impact accommodation insecurity has on Gypsies' and Travellers' physical and mental health	James Cook University Hospital maternity unit should ensure that it provides a service that is accessible to and non-judgemental of pregnant problem drug users and able to offer high quality care aimed at minimising the impact of the mother's drug use on the pregnancy and the baby
4	Development and delivery of a robust primary prevention offer which includes raising awareness of health issues through communications plan that utilised local, regional and national campaigns / resources.	Development and delivery of a robust primary prevention offer which includes raising awareness of health status and risk, through a communications plan that utilises local, regional and national campaigns / resources.	Ongoing investment into services offering support or working to positively impact psychosocial risk factors is essential	Services to be more flexible and trauma informed in their service provision, recognising that potentially vulnerable women may have specific needs to be considered regarding timings of appointments alongside the consideration of an increase in out of hours support	Primary care teams providing services for drug users should ensure that the health and well-being of their children are also being met, in partnership with the school health service, children and family teams and other services as appropriate
5	Workforce training for adult social care, children services, front line services, health care, education, in relation to MECC, brief intervention, and promotion of primary prevention campaigns and referrals to ill health prevention services.	Workforce training for adult social care, children services, front line services, health care, education, in relation to MECC, brief intervention, and promotion of diagnostic / screening services (like targeted lung health check) and referrals to appropriate services (like stop smoking service).	There should be a focus on ongoing monitoring and evaluation of all early intervention and educational activities to ensure approaches are effective and are inclusive for all at risk groups	Commissioners and policy makers to understand and consider the multiple needs of women who are involved in or exploited through the sex industry and/or involved in the criminal justice service, within a health and safety model of service provision.	General practitioners should take steps to ensure that drug users have access to appropriate contraceptive and family planning advice and management. Contraceptive services should be provided through specialist drug services including methadone clinics and needle exchanges
6	Consultation and codesign of all commissioned services and obtaining data from young people.	Consultation and community engagement to inform the codesign and quality improvement of how existing commissioned services can better meet the needs of local people.	Guidance and training for parents and carers of young people should be delivered by relevant organisations and local authority partners, to raise awareness of all forms of online abuse and enable them to better protect the children and young people in their care	Improved reporting routes to police with specific points of contact for women who experience multiple disadvantages such as the development of non-uniform, non-enforcing officers who are specifically trained to offer an enhanced response.	All early year's education services and schools should have critical incident plans and clear arrangements for liaison with their local social services team when concerns arise about the impact on a child of parental problem drug or alcohol use.
7	Joined up approach across primary care, secondary care and public health (data pathways referrals etc.) to promote and increase uptake of ill health prevention services and ensure seamless pathways.	Take an integrated approach to the delivery of diagnostic and screening services across primary care, secondary care, voluntary sector, public health and communities to promote and increase uptake of treatment and referral to ill health prevention services.	There should be an increase in investment in neighbourhood facilities such as youth clubs and community centres which will provide young people with comfortable spaces to form meaningful connections, whilst keeping them off the street	More effective collaboration to be developed amongst frontline services, both public and voluntary to ensure sustained appropriate services for women experiencing multiple disadvantages.	Children's Services departments should aim to achieve the following in their work with the children of drug users (see document)
8			There should be a continued commitment to collaborative commissioning through working closely and collaboratively with the Cleveland Unit for the Reduction of Violence (CURV), which provides an existing partnership to establish knowledge sharing procedures and decide on joint priorities for tackling serous crime in the area	Improvement of through the gate support from custody to community including the provision of suitable housing, particularly for women at this vulnerable stage	Drug and alcohol agencies should recognise that they have a responsibility towards the dependent children of their clients and aim to provide accessible and effective support for parents and their children, either directly or through good links with other relevant services.

9			CURVare committed to co-production and collaboration with grassroots organisations. However, there should be a commitment to ensure that the voices of those with lived experience are included and considered within all internal procedures throughout the council.	Early interventions to prevent a custodial sentence and therefore to prevent health and wellbeing needs escalating	The possible role of parental drug or alcohol misuse should be explored in all cases of suspected child neglect, sexual abuse, non-accidental injury or accidental drug overdose. Child and adolescent mental health services should routinely explore the possibility of parental drug or alcohol misuse.
10				To promote health literacy and reduce inequalities in health (sub recommendations within)	All non-statutory organisations dedicated to helping children or drug or alcohol users should carefully consider whether they could help meet the needs of the children of drug or alcohol users. Substance support services should explore the potential of involving non-statutory organisations, in conjunction with health and social services, in joint work aimed at collectively meeting the needs of the children of problem drug or alcohol users in their area.
11					Cleveland Police should seek to develop a multi-agency abuse prevention strategy which incorporates measures to safeguard the children of problem drug users.
12					All women's prisons should ensure they have facilities that enable pregnant female drug users to receive antenatal care and treatment of drug dependence of the same standard that would be expected in the community.
13					Review gaps in data and identify opportunities to improve data collection, analysis and dissemination.

Lifecourse	**Age Well** - *More people lead safe, independent lives*			
Mission	**We will promote independence for older people**			**We will ensure everone has the right to a dignified death**
Goal	**We want to reduce the levels of loneliness and isolation in our communities and ensure our places promote healthy ageing**	**We want to reduce the level of frailty to improve healthy ageing**	**We want to ensue our communities are dementia friendly**	**We want to improve the identification of people who are approaching end of life and enable choice - relating to personalised and coordinated care.**
1	Improve connections and collaboration between existing partnerships (including Age Well RCBC Partnership, Age Friendly Steering Group and Dementia Friendly Networks) ensuring a strategic/coordinated approach to addressing isolation and loneliness across the system with a clear reporting line to the Health and Wellbeing Board.	Review reablement care and identify areas of improvement which contribute to preventing unnecessary admissions to hospitals and residential care, as well as ensuring a timely transfer from hospital to community. (Will also support the NHS long term plan 2-hour crisis response, for people living in their own home)	Explore and reduce the variation between diagnosis and reviews by GP practice so everyone has the same experience	Improve the early identification of palliative patients to ensure they are supported on their end-of-life journey as soon as possible. Ensuring that patients, families, and carers are better informed, both from a health perspective in managing their advance care planning needs and also from a social welfare perspective.
2	To ensure there is a strategic and operational commitment to embedding Making Every Contact Count (MECC) at scale across organisations and communities, ensuring easy access to health and wellbeing self-care information, community activities and services, alongside increasing conversations around isolation and loneliness which in turn contributes to reducing stigma.	Raise awareness in communities re the need for patients to seek regular medication reviews, to help reduce adverse consequences of polypharmacy and improve medication reviews	Ensure information and advice is widely available so that people understand the risk factors for dementia and how their risk could be reduced. Include improved interventions around modifiable risk factors such as smoking and exercise (intervention having more focus on dementia risk reduction) NHS Screening	Ensure care is joined up across health and social care teams to identify patients on the palliative care register who also have other long-term conditions. This should Include Improved System Interoperability (i.e., shared access to system one)
3	Review the current community social activities offer, ensuring that consideration is given to needs led intelligence, the voices of residents and sustainability of this provision.	Review current processes in primary care for identifying and managing frailty to determine a model that enhances the care planning for people living with frailty. Need to standardise frailty screening tools and ensure consistent reviews.	Develop a dementia strategy, which includes direct input from people living with dementia and their carers, setting out how the Councils, wider Health and Social Care Partners and the Tees Valley Integrated Care System, will work with other organisations to support people with dementia, their families, and carers to obtain a diagnosis, maintain their independence and enjoy a good quality of life.	Introduce strategies to increase awareness with families, professionals, and wider communities on the variety of social welfare support for end-of-life patients. Addressing health inequalities in palliative and end of life care, to improve equity of access to services and reducing inequity of outcomes and experience. Need to utilise population health management approaches for identifying priority groups.
4	Use learning from You've Got this Warm Welcome approach and work with social activity providers to implement this within their group/organisation (this may include themes such as dementia friends training, learning disability awareness, sensory loss awareness, Making Every Contact Count and Poverty Proofing approaches).	Work with community partners to review current education programmes on how to prevent frailty such as the importance of staying physically active. Working with key partners to embed frailty awareness and education into the community.	Explore potential to improve Dementia Friendly Transport to increase access to support and improve connectivity. Increase dementia awareness training for bus operatives and taxi drivers. (Teeswide Dementia Network group leads are researching local transport issues and meeting with Stagecoach and Arriva directors)	ICB and South Tees Trust to work collaboratively to review current training programmes for staff (including cares home and GP practices) and agree consistent programmes that focus on provision of good quality palliative and end of life care.
5	To develop a clear understanding across South Tees of the different models of social prescribing including referral pathways and criteria to enable the promotion of these services to residents and professionals and ensuring that there is an equitable offer across all population groups.	Develop a process to ensure existing and future referrals to IAPT who are identified with low mood/depression on the eFIregister are also offered a referral to befriending services to address isolation.	Increasing the role of the housing sector in promoting independent living through exploring opportunities to increase joint planning and service delivery for availability of appropriate housing, equipment and adaptations between housing providers and key partners. Ensure that this includes Increased Dementia Training for Housing Providers	Look into costs and benefits of investing in Gold Standard Framework to Increase the number of accredited GP practices and Care Homes. Option to widen access to care homes and social care.
6	Review enhanced connector roles across South Tees to gain a greater understanding what's working well, gaps, areas for development and equity of access.	Integrated frailty service - Teams who work in a more integrated way to deliver frailty care across health, community, and social care services to optimise opportunities to provide effective person-centred care, to slow deterioration in people and avoid potential for admission to hospital.	Improve the dementia services offer in all Care Homes through implementation of Dementia Friendly Care Home guide/self-assessment tool)	Ensure that specialist palliative care services are available 7 days a week. This will require a review of community palliative care services commissioned from Trust providers and may require investment into these services.
7	Explore solutions to volunteer recruitment difficulties with organisations and communities. This may include testing 'new' approaches such as working with communities to develop Time Bank models, building mutual social and practical support networks in communities alongside alternative solutions such as anchor organisations	Explore potential for an Acute frailty unit within each hospital, which is accessed by the frailty coordination, the single point access and community frailty services, as well as the urgent care and accident and emergency services. Ensure the inclusion of a Dementia and Frailty protocol to encourage a more seamless pathway of care when people are admitted.	Explore strategies to improve support and outcomes for families, enabling people to stay longer in their own homes, including communication between Primary Care, Adult Social Care and the Voluntary Community Sector Organisations to identify people in the community.	Explore strategies with primary care to increase the number of care plan conversations and in turn, the number of plans that are developed and implemented.

8	Ensure a coordinated approach to Age Friendly Communities across South Tees, guided by the World Health Organisations Age Friendly Communities framework (including housing, transport, outdoor space etc).	Proactively work with health and social care services to ensure early identification and intervention to slow decline of frailty and avoid hospital admission.	Patients living with dementia identified on admission and bedside/personal identification applied from point of admission or contact. Carer's details to also be entered in healthcare records. (Include Launch and Promotion of Dementia Health Passport)	Develop a public health response to death, dying and loss, extending end-of-life care to community settings using a compassionate approach to end-of-life care, to encourage sustainable responses and networks of care that are adaptable and flexible, depending upon need and demand. This includes upholding the principle of a compassionate community approach and Compassionate Communities UK Accreditation.
9	Develop a health inequalities impact assessment approach to the development and implementation of all key policies and strategies that should include the consideration of loneliness and isolation utilising the Age Friendly Communities framework	Consider including participatory arts as an integral and necessary component of quality care for older people living in care homes (Influenced by policy makers and those working in the care sector)	Improved Identification of dementia patients' carers, through promoting the adoption of Carer Friendly Practices, which includes Social Prescribers signposting Carers to support services and community activities. Ensuring that the needs of carers for people with dementia are a priority to enhance both the carers wellbeing and maintain independence for the person with dementia.	
10	Continue to invest in and support existing digital programmes and embed referral to this support into community and service pathways (self/professional referral)			
11	Develop an online space for organisations and communities to share community engagement activities they are planning/have carried out to prevent duplication of efforts and to develop a 'live' picture of residents' experiences, views and ideas around addressing loneliness and isolation			
12	Review isolation and loneliness measures used across organisations/services across South Tees and explore opportunities to embed ONS 'gold standard' questions			

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Social Prescribing

20th March 2024

Louise Mason-Crowe, Service Manager - Public Health & Partnerships, PHST
Lucy Cushley, Service Manager - MIND

What is Social Prescribing?

Public Health England

Healthmatters

Social prescribing – addressing people's needs in a holistic way

GPs and other health care professionals can refer people to a range of local, non-clinical services, supported by a link worker or connector

NHS E: Long Term Plan states the best vehicle for SPLW is Primary Care

900,000 clients to be able to use the service by 23/24

Core Principles

- A holistic approach focussing on individual need
- Promotes health and wellbeing and reduces health inequalities in a community setting, using non-clinical methods
- Addresses barriers to engagement and enables people to play an active part in their care
- Utilises and builds on the local community assets in developing and delivering the service or activity
- Aims to increase people's control over their health and lives

(OHID)

Middlesbrough

- 3 PCNs engaged

1. Holgate PCN
2. Greater Middlesbrough PCN
3. Central Middlesbrough PCN

- 27 SPLW (including specialists in CYP and finance)
- 1 Service Manager
- Delivered by MIND

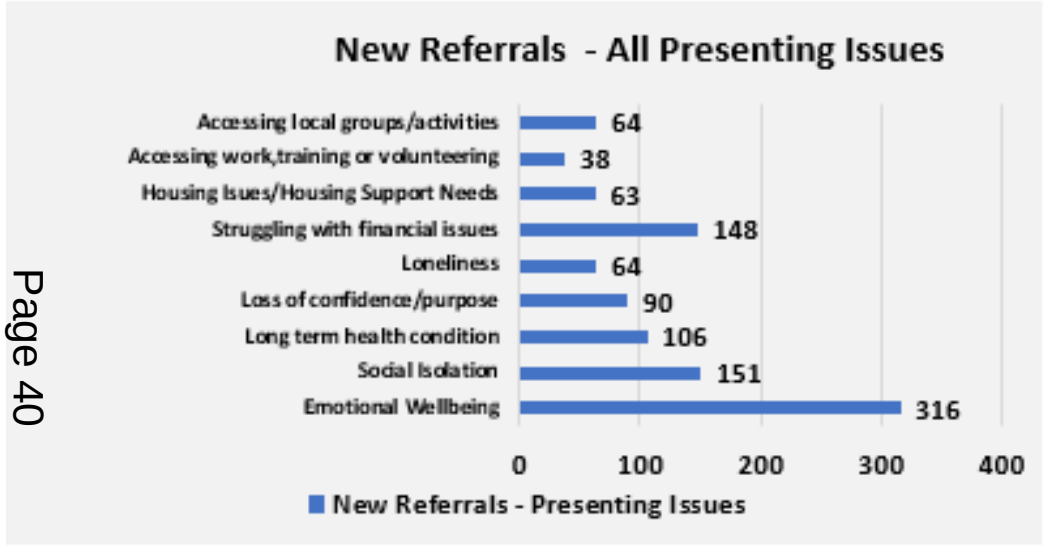
Redcar and Cleveland

- 3 PCNs engaged

1. East Cleveland PCN
2. Redcar Coastal PCN
3. Eston PCN

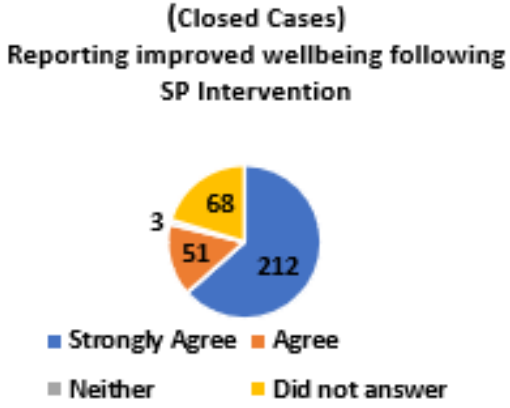
- 8 SPLW
- 1 Team Leader
- 1 Manager
- Delivered by RCBC

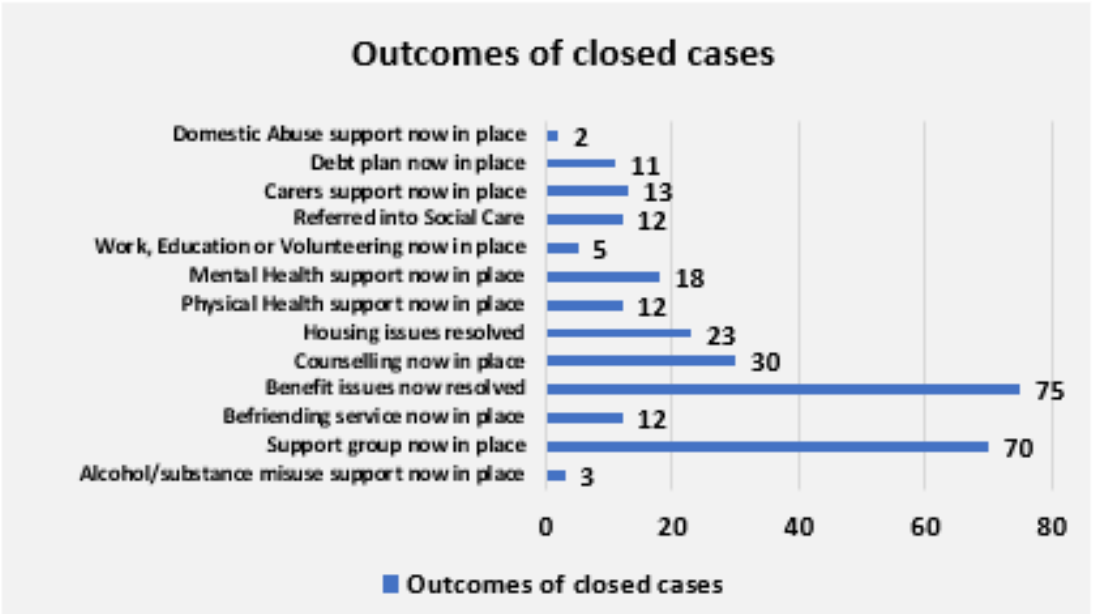
Redcar & Cleveland



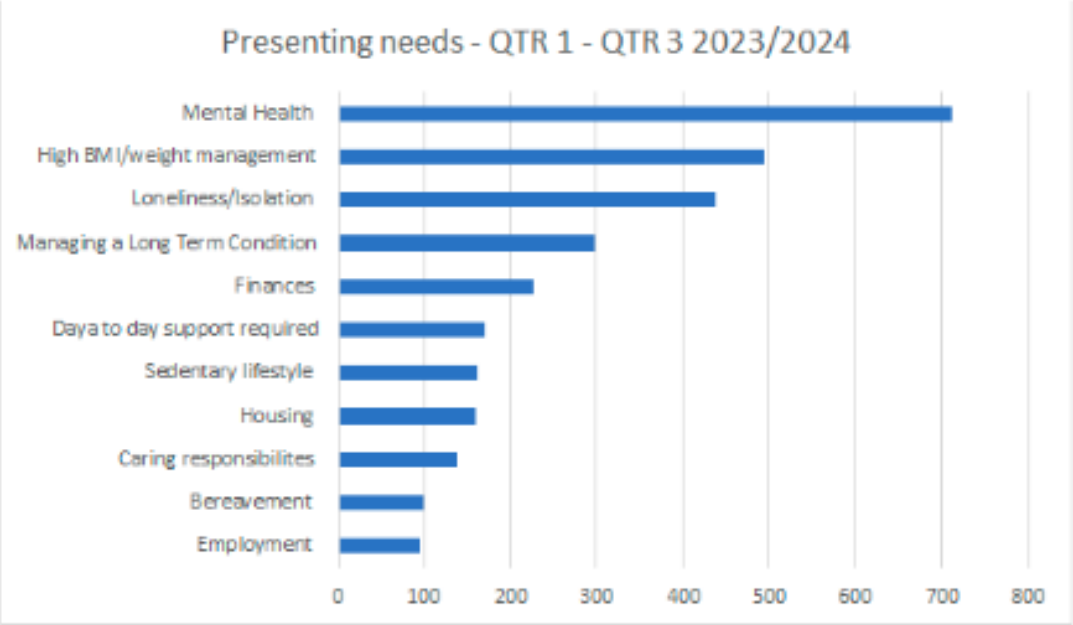
Social Prescribing

SP Data	22/23				23/24	Comparison to Q3 22/23
	Q1	Q2	Q3	Q4	Q3	
New Referrals	316	368	402	412	595	48% ↑
Closed Cases	198	279	286	339	334	17% ↑





Middlesbrough



- **32** Average days until discharge.
- **5** Average number of contacts per client.
- **89%** improvement in wellbeing with an average percentage change per person of **17.1%.**

	2022/2023					2023/2024				
SP Data (Middlesbrough)	Q1	Q2	Q3	Q4	Total 2022/23	Q1	Q2	Q3	Total year to date	Comparison to QTR 3 22/23
New referrals	522	521	763	770	2576	534	626	719	1879	-5.7%
Closed cases	419	679	669	386	2153	459	561	479	1499	-28.4%

RCBC Case Study

MIND Case Study

- **Jason*** – *themes of case study - mental health, physical health, finances and employment*
- Jason, aged 33 was referred to social prescribing. At first Jason was reluctant and hesitate to access support with the service – this was a symptom of his current challenging situation. The link worker adapted his approach to build trust and rapport with Jason over time to support him to access the support.
- Jason was referred after taking an overdose of painkillers and was having issues with benefits sanctions and debt, Jason has moved back in with mother due to losing tenancy and was living off a total of £3 a week. There were financial barriers and confidence barriers. Jason hoped to build structure to his week and to get on top of his debt issues.
- Time was taken to explore options and interests with Jason. He was put in contact with Citizens Advice and Welfare Rights in relation to his finances. Jason was referred to Rooted in Nature as he wanted structure and social contact, we also looked at options in relation to exercise. Jason engaged with both Rooted in Nature and Exercise on Referral and felt these services benefitted him as he had structure and was able to focus on his health. We also carried out walk and talks to discuss options instead of office base or telephone appointments, Jason felt he benefitted from the face-to-face element of support with this link worker.
- Over several sessions Jason informed his link worker that he had lost weight and was planning on reengaging with exercise on referral, now as a paid participant. Jason was looking at securing steady employment and was looking forward to the future. He was working with an employment support team to identify future suitable employment. Jason felt like his physical health was better and, he felt his mental health was in a much stabler place. Jason was motivated for the future and confident moving forward.