Stockton-on-Tees BOROUGH COUNCIL
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Health & Wellbeing Board
Agenda

Date: Wednesday 29 March 2023 at 2.00 pm

Venue: Jim Cooke Conference Suite, Stockton Central Libary, Church Road, Stockton on Tees, TS18 1TU

Cllr Robert Cook (Chair)
Cllr Lisa Evans (Vice-Chair)

Cllr Jacky Bright
Cllr Mrs Ann McCoy
Cllr Andrew Sherris
Fiona Adamson
Jon Carling
Dominic Gardner
Martin Gray
Peter Smith
Cllr Dan Fagan
Cllr Steve Nelson
Cllr Sylvia Walmsley
Sarah Bowman-Abouna
David Gallagher
Julie Gillon
Jonathan Slade
Ann Workman

AGENDA

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Health & Wellbeing Board
Agenda

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Persons wishing to obtain any further information on this meeting, including the opportunities available for any member of the public to speak at the meeting; or for details of access to the meeting for disabled people, please

Contact: Michael Henderson on e mail: michael.henderson@stockton.gov.uk on email Michael.henderson@stockton.gov.uk

Stockton-on-Tees BOROUGH COUNCIL

KEY - Declarable interests are:-

- Disclosable Pecuniary Interests (DPI's)
- Other Registerable Interests (ORI's)
- Non Registerable Interests (NRI's)

Members – Declaration of Interest Guidance

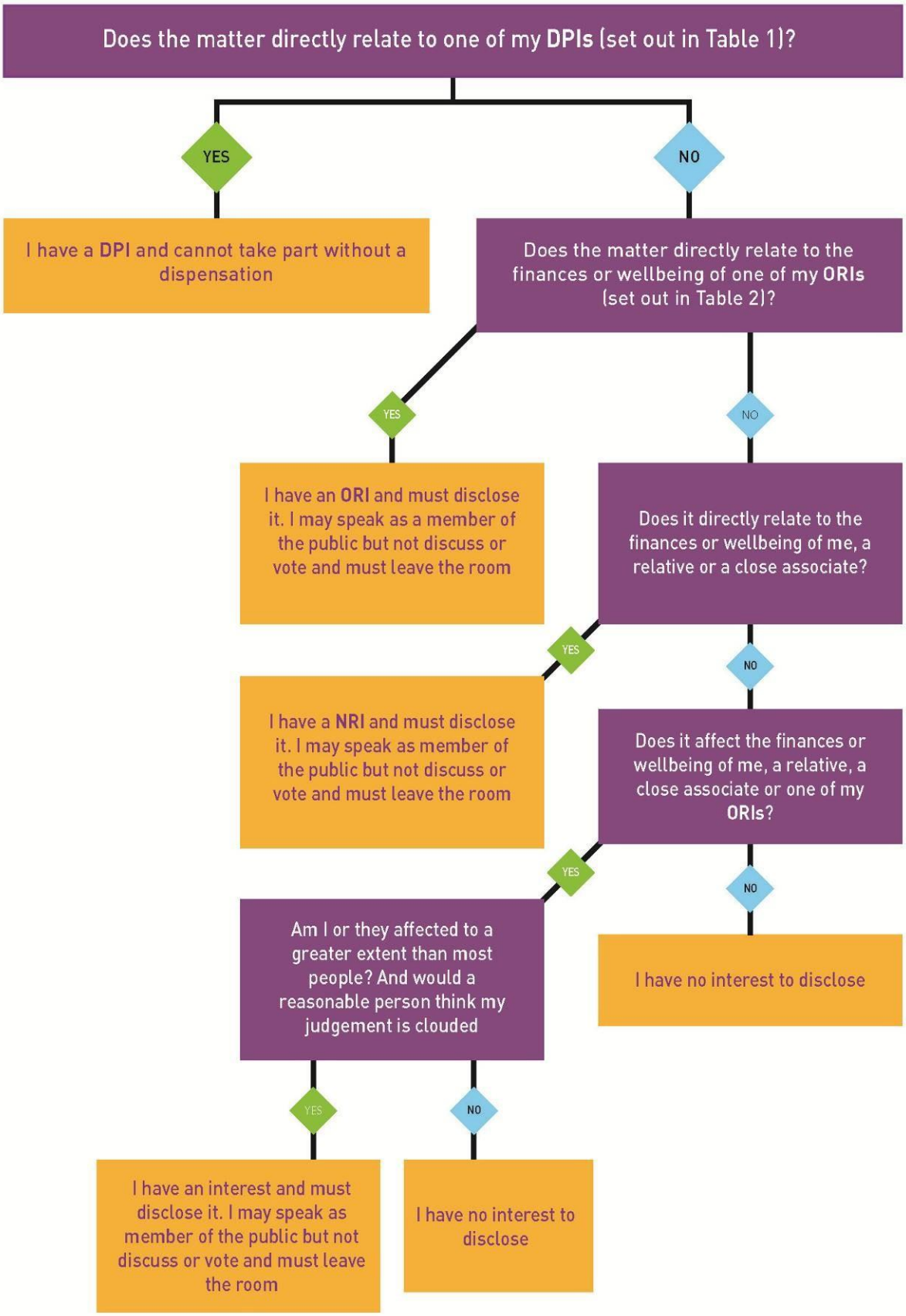

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Table 1 - Disclosable Pecuniary Interests

Subject	Description
Employment, office, trade, profession or vocation	Any employment, office, trade, profession or vocation carried on for profit or gain
Sponsorship	Any payment or provision of any other financial benefit (other than from the council) made to the councillor during the previous 12-month period for expenses incurred by him/her in carrying out his/her duties as a councillor, or towards his/her election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
Contracts	Any contract made between the councillor or his/her spouse or civil partner or the person with whom the councillor is living as if they were spouses/civil partners (or a firm in which such person is a partner, or an incorporated body of which such person is a director* or a body that such person has a beneficial interest in the securities of*) and the council — (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged.
Land and property	Any beneficial interest in land which is within the area of the council. 'Land' excludes an easement, servitude, interest or right in or over land which does not give the councillor or his/her spouse or civil partner or the person with whom the councillor is living as if they were spouses/ civil partners (alone or jointly with another) a right to occupy or to receive income.
Licences	Any licence (alone or jointly with others) to occupy land in the area of the council for a month or longer.
Corporate tenancies	Any tenancy where (to the councillor's knowledge)— (a) the landlord is the council; and (b) the tenant is a body that the councillor, or his/her spouse or civil partner or the person with whom the councillor is living as if they were spouses/ civil partners is a partner of or a director* of or has a beneficial interest in the securities* of.
Securities	Any beneficial interest in securities* of a body where— (a) that body (to the councillor's knowledge) has a place of business or land in the area of the council; and (b) either— (i) the total nominal value of the securities* exceeds £25,000 or one hundredth of the total issued share capital of that body; or (ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the councillor, or his/ her spouse or civil partner or the person with whom the councillor is living as if they were spouses/civil partners have a beneficial interest exceeds one hundredth of the total issued share capital of that class.

* 'director' includes a member of the committee of management of an industrial and provident society.

* 'securities' means shares, debentures, debenture stock, loan stock, bonds, units of a collective investment scheme within the meaning of the Financial Services and Markets Act 2000 and other securities of any description, other than money deposited with a building society.

Stockton-on-Tees BOROUGH COUNCIL

Table 2 – Other Registerable Interest

You must register as an Other Registrable Interest:

a) any unpaid directorships

b) any body of which you are a member or are in a position of general control or management and to which you are nominated or appointed by your authority

c) any body

(i) exercising functions of a public nature

(ii) directed to charitable purposes or

(iii) one of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union) of which you are a member or in a position of general control or management

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Health & Wellbeing Board

A meeting of Health & Wellbeing Board was held on Wednesday, 22nd February, 2023.

Present: Cllr Robert Cook (Chair), Cllr Ann McCoy, Cllr Steve Nelson, Cllr Sylvia Walmsley, Ann Workman, Fiona Adamson, Tanja Braun (Sub for Sarah Bowman - Abouna), Lucy Owens (sub for Jon Carling), Alex Sinclair (Sub for David Gallagher), Shaun Mayo (Sub for Dominic Gardner), Hilton Heslop (Sub for Julie Gillon)

Officers: Michael Henderson, Mandy Mackinnon

Also in attendance:

Apologies: Cllr Jacky Bright, Jon Carling, Cllr Lisa Evans, Cllr Dan Fagan, David Gallagher, Dominic Gardner, Julie Gillon, Cllr Andrew Sherris, Martin Gray, Sarah Bowman - Abouna, Jonathan Slade, Peter Smith

1 Declarations of Interest

There were no declarations of interest.

2 Minutes of the meeting held on 25 January, 2023

The minutes of the meeting held on 25 January 2023 were confirmed as a correct record.

3 Alcohol Update

Members received an overview presentation relating to alcohol services. The presentation covered the following:-

•Alcohol profiles and data for Stockton-on-Tees
• ICS Alcohol Health Care Needs Assessment & recommendations
• ICS approaches
• Alcohol awareness
• Alcohol licensing
• Community alcohol services
• Inpatient detox provision

Discussion:-

- Reference was made to the promotion of discounted alcohol at retail outlets and particularly supermarkets and how this might influence consumption. The Board noted the difficulties associated with engagement with outlets at a local level and a national approach/agreement was needed. The issue relating to alcohol pricing, promotion and placement was being pursued through a number of routes.

- The definition of alcohol dependence use by the Council was in line with NICE Guidance.

- Member supported the recommendations coming from the Integrated Care System's Alcohol Healthcare Needs Assessment. It was recognised that a focus of the recommendations was the identification of individuals who may benefit from treatment and there was work to improve access to treatment. Also

there had been an increase in funding of services, in Stockton, over the next 2 years, to enable the expansion of the treatment offer.

- The voluntary sector highlighted that it could assist with the delivery of some of the Needs Assessment's recommendations, particularly recommendation 12, relating to engagement with people with lived experience. Reference was also made to work it was involved in with assisting the private sector around its social responsibilities and this could be a route into discussions around reducing alcohol promotion.

RESOLVED that the update be noted.

4 Multiple Complex Needs - Peer Advocacy Pilot

The Board considered a report that provided an overview of the pilot work to support people in the borough with multiple complex needs, using a peer advocacy and support model and funded through the ICS health inequalities monies devolved to each local authority area.

It was explained that a steering group had been established to take the pilot work forward, comprising public health, adult safeguarding, the homelessness team and the A Fairer Stockton team, also liaising closely with A Way Out. The group was developing the pilot based on a range of public health background work and context including:

• A comprehensive health needs assessment for drugs was undertaken as part of the reprocurement of service in 2020.
•A comprehensive health needs assessment for domestic abuse was undertaken in preparation for reprocurement of service 2022/23
•Liaison with homelessness / supported accommodation service providers
•Contract monitoring and service improvement for people with substance misuse (drugs and alcohol)
•Learning from drug-related death reviews
•Learning from targeted work with hostels during the Covid pandemic
•Stakeholder engagement in planning activities and interventions funded through the national drug strategy monies
•Observation and learning from Team Around the Individual (TATI) meetings (adult safeguarding).

The group had established a referral route for the individuals and families who would be identified through the adult safeguarding process. There were several different potential ways of identifying a cohort of focus for the work. Due to the existing work to further develop the 'Team Around the Individual' (TATI) process as part of the borough's safeguarding work, the work was being commenced with those individuals being part of the TATI process. A 'test and learn' approach was being used, so that learning could be incorporated as the pilot developed. It was envisaged that, should the work be successful, the approach could be used for work with different cohorts and communities, being adapted as needed. Discussions were underway on building in evaluation from early in the work.

Next steps for the group were to develop eligibility criteria for the peer advocacy pilot; develop a job outline for the peer advocate; and seek expressions of

interest from the VCSE sector.

The pilot would run alongside other innovative approaches in development, with the opportunity for them to inform each other. This included the development of a change house which provided intensive individual and group-based support from substance misuse treatment services into existing housing provision to enable those with complex housing and substance misuse needs to stabilise their lives and engage with treatment.

Discussion:-

- The Board supported the proposals in the report.

- It would be important to try and identify the most difficult cases at an early stage, however, getting people to engage may be a challenge.

- It was suggested that the Pilot should link in with the Changing Futures work.

RESOLVED that

1. the approach set out in the report be supported.

2. an update be provided at a future meeting.

5 Place Based Committee

RESOLVED that the item be deferred to a future meeting.

6 Members' Updates

There were no members' updates.

7 Forward Plan

Members noted the Board's Forward Plan.

Domestic Abuse update, scheduled for March to be removed.

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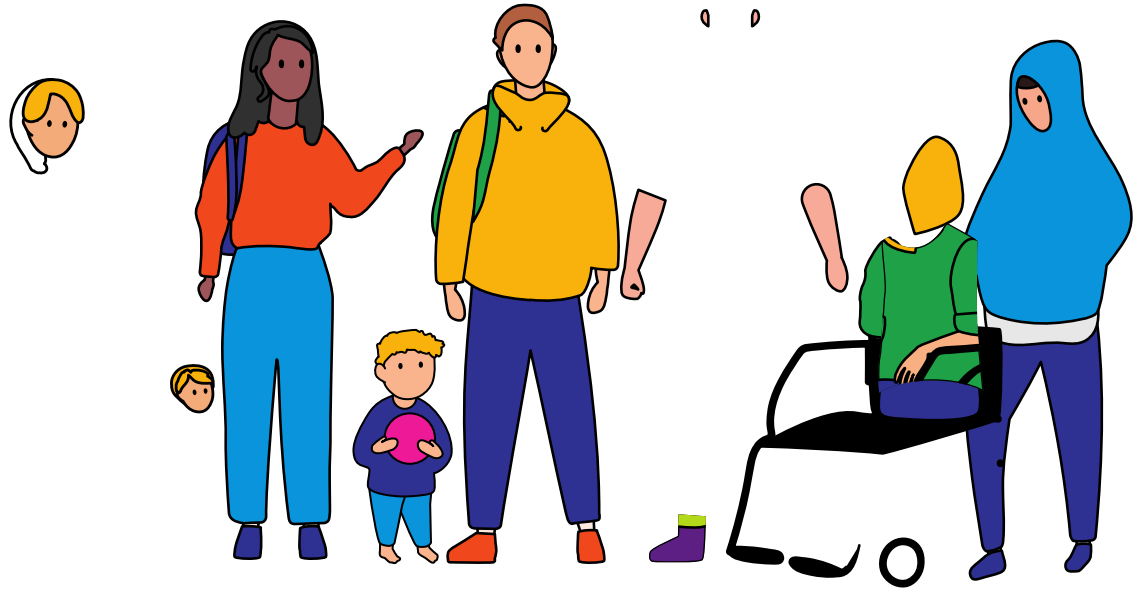
Post COVID Update

Stockton-on-Tees Health and Wellbeing Board

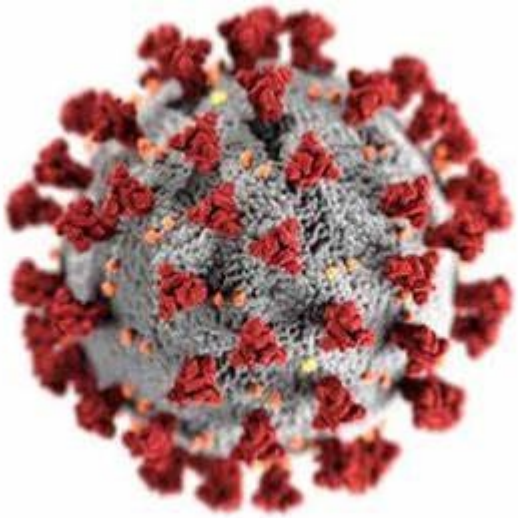
29th March 2023



Overview

Post COVID

- Definition
- Presentation
- Latest prevalence data
- New Research
- Post covid services



Post COVID Definition

NICE/WHO

NICE states that the term ‘long COVID’ is commonly used to describe signs and symptoms that continue or develop after acute COVID-19. It includes both ongoing symptomatic COVID-19 (from 4 to 12 weeks) and post-COVID-19 syndrome (12 weeks or more).

The WHO adds that the post COVID condition occurs usually 3 months from onset of the infections, lasts for at least 2 months, cannot be explained by an alternative diagnosis and impacts on everyday functioning. Symptoms may be new onset following initial recover or persist from the initial illness; symptoms may fluctuate or relapse over time.

Overview | COVID-19 rapid guideline: managing the long-term effects of COVID-19 | Guidance | NICE

Post COVID-19 condition (Long COVID) (who.int)

What is Post COVID?

Clinical Picture

- Common symptoms include fatigue, shortness of breath, cognitive dysfunction (brain fog) but also other symptoms that generally have an impact on everyday functioning
- Symptoms may be new onset following initial recovery from an acute COVID-19 episode or persist from the initial illness
- Symptoms may also fluctuate or relapse over time
- Recovery is different for everyone due the wide ranging symptoms, especially for those with organ damage, research is ongoing into treatment

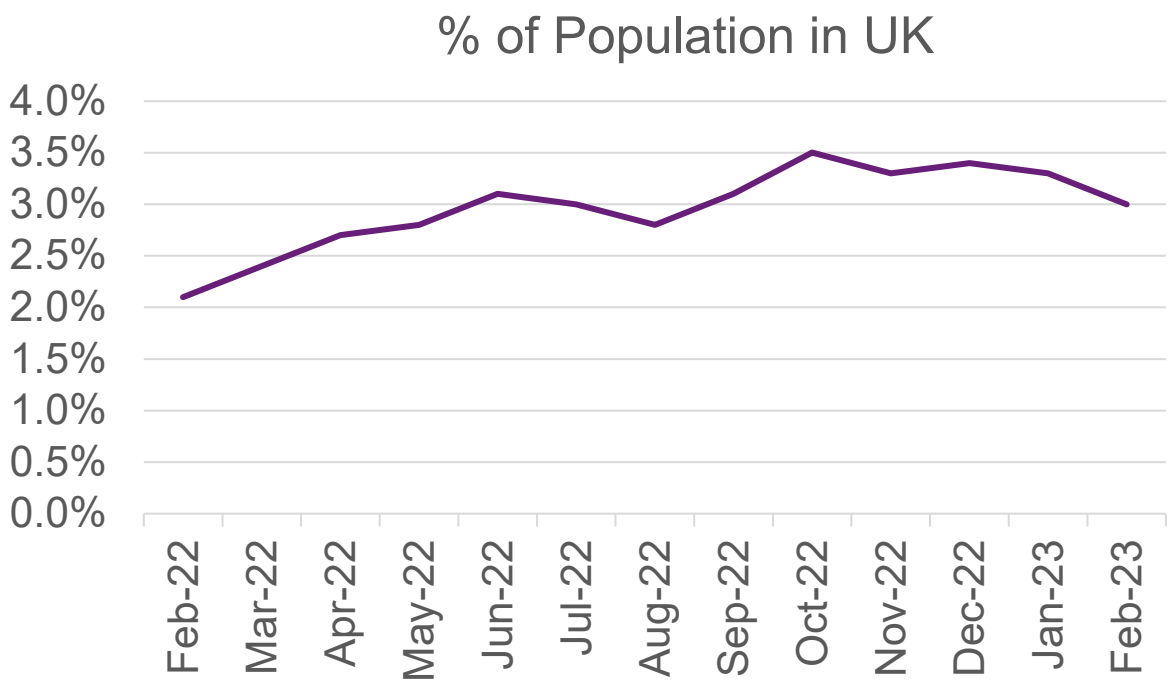
Post COVID Prevalence

Self reported, all ages, UK

Latest ONS release: 3% of population

Prevalence of self-reported Post COVID syndrome was greatest in people

- aged **35 to 49 years**,
- **females,**
- people living in more **deprived areas**,
- those working in **social care, teaching and education or health care**, and
- those with another activity-limiting **health condition or disability**.



Source: ONS Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK

New Vaccine Research

Does vaccination help prevent Post COVID Syndrome?

A review found that vaccination reduces chance of getting Post COVID syndrome if infected with COVID-19, protection increases with number of vaccination doses.

Vaccination significantly reduces the severity and duration of the symptoms of Post COVID syndrome and its impact on life

ONS research also highlights previous infection may reduce the risk upon reinfection.

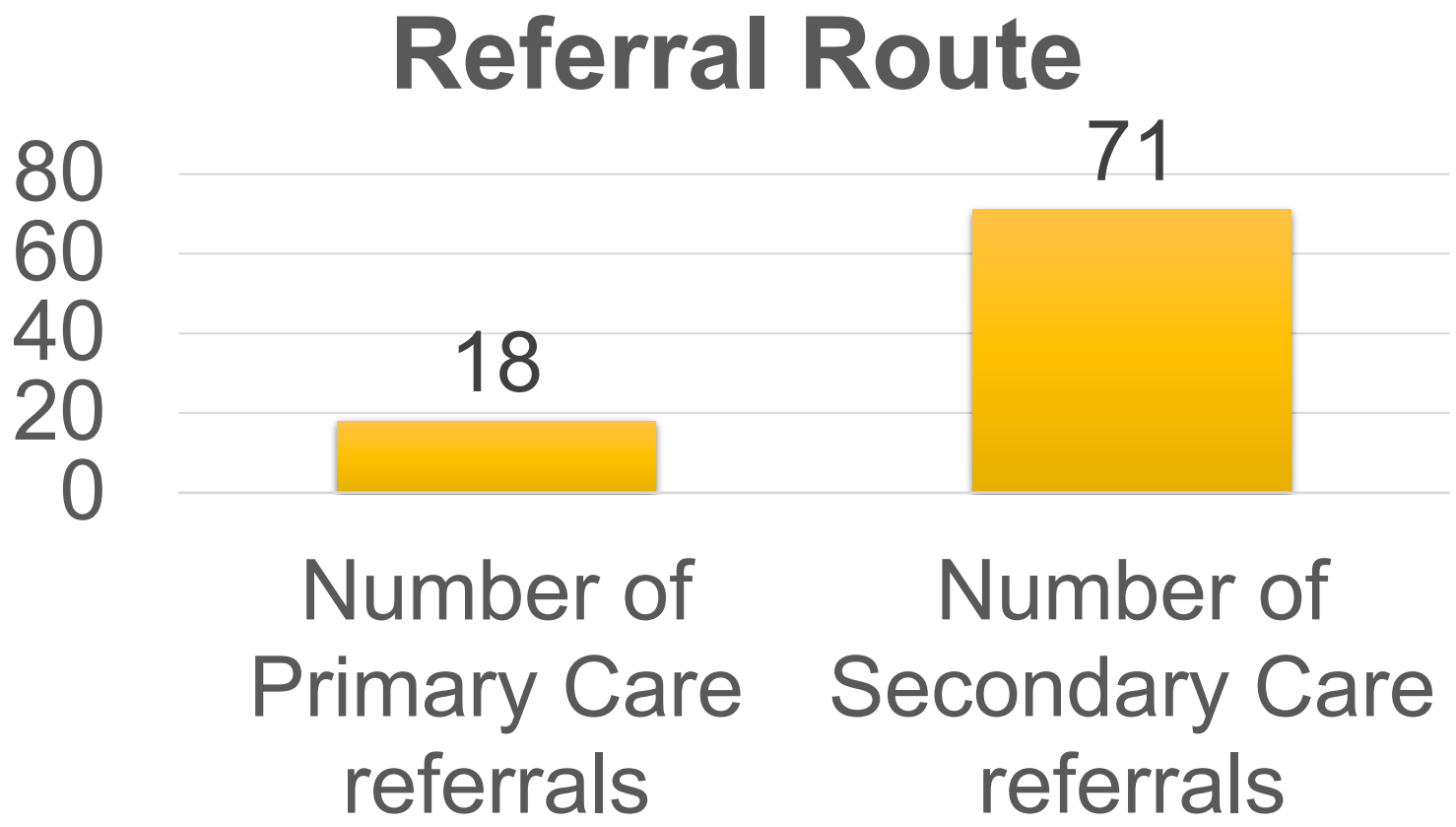
Tees Active Post COVID Pilot

Physical Activity to Support Recovery

- Started in January 2022 with a total of 89 referrals to date
- Referral into the pilot stops 31st March 2023
- Adapted the Active Health programme to create 1 programme accessible to those suffering from on going COVID-19 symptoms
- More work planned to gain feedback and evaluate the pilot

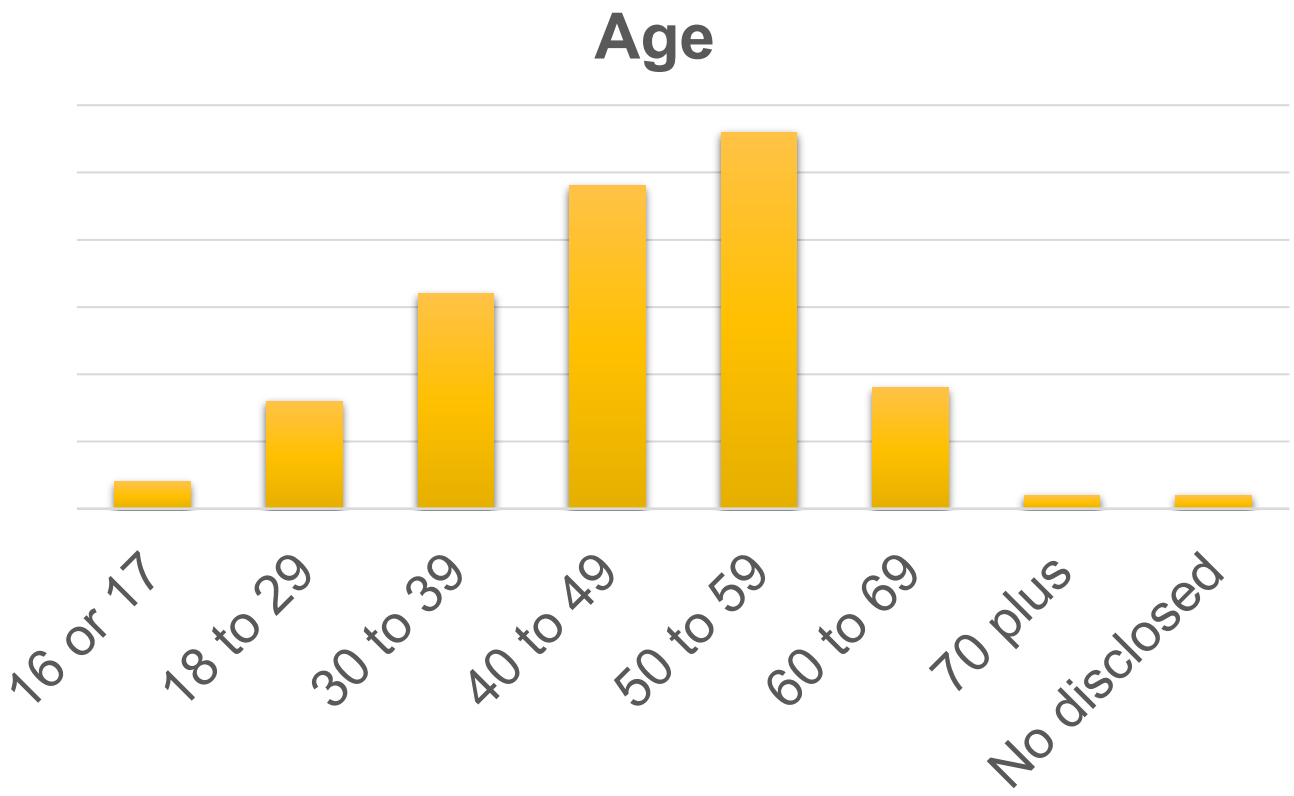
Referrals to Service

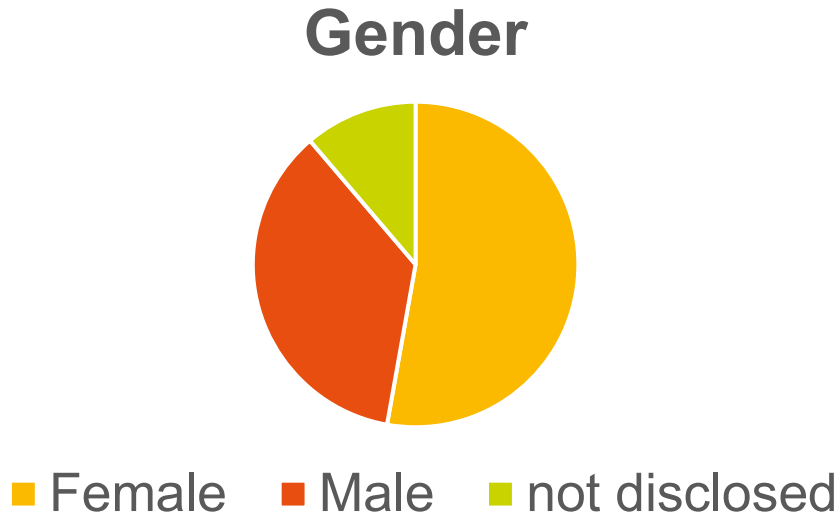
89 In total

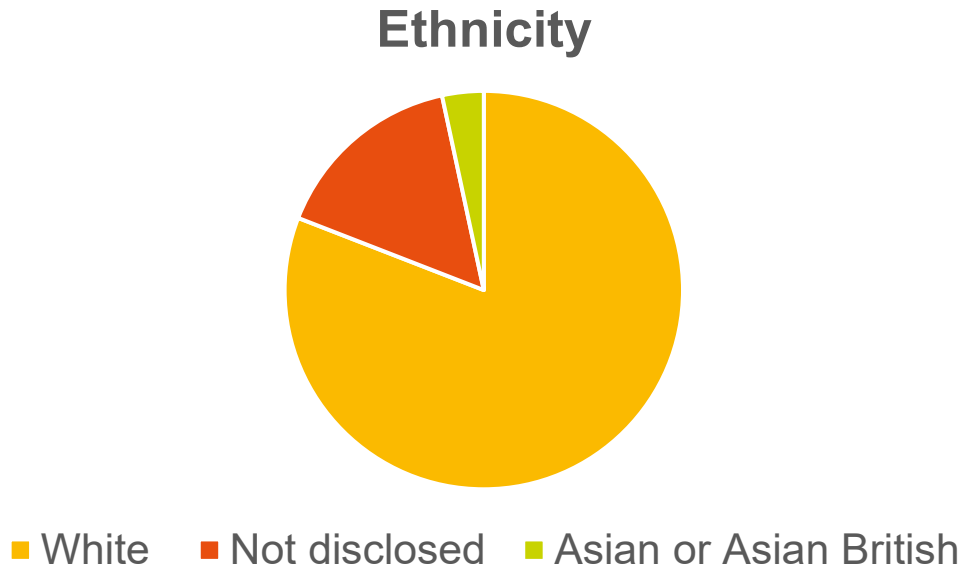


Post COVID Pilot

Demographic







Feedback

Initial early feedback

‘Really good’

‘more information on the content of the scheme before coming to tees active‘

‘I’ve only joined the gym a couple of weeks ago however I can already feel the difference in my general health’

Further follow up planned…

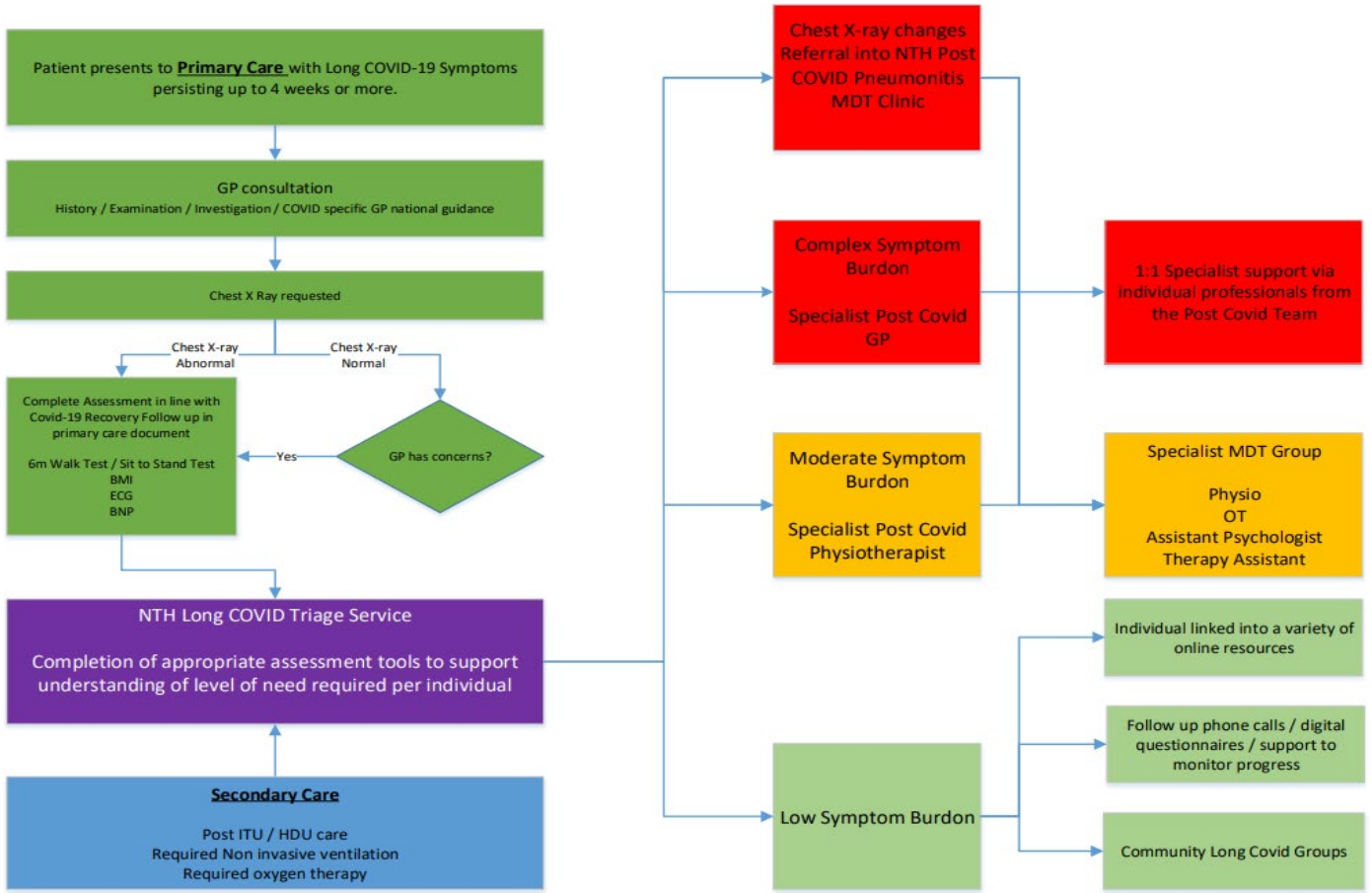
Summary

Post COVID

- New research show vaccines reduces risk of Post COVID syndrome, more research needed
- Tees Active Pilot has ended, alternative programme developed and adapted to enable those suffering to access a Tees Active service

Thank you

NTHFT Post COVID Assessment Service



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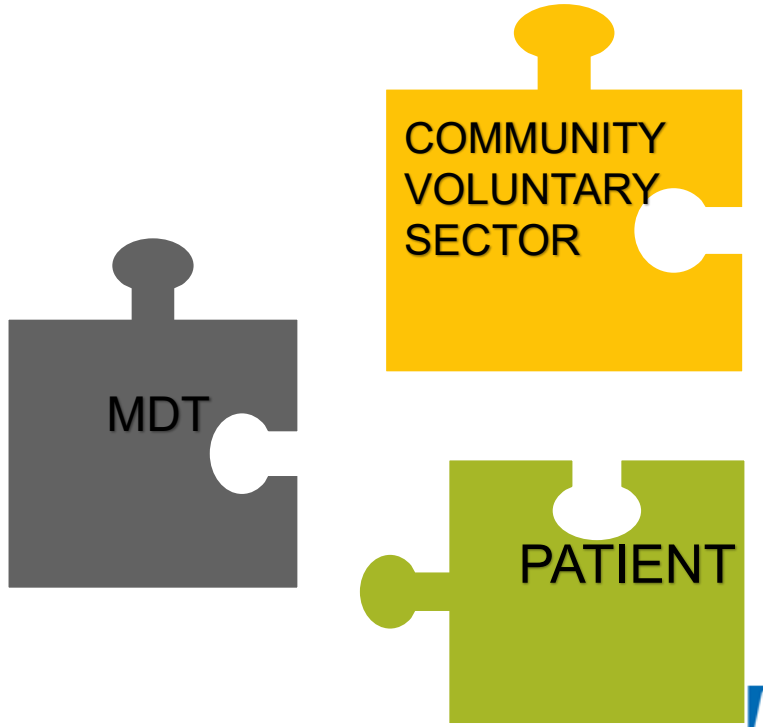
Post COVID Clinic Staffing

- Respiratory Consultant
- GP with Specialist Interest in Post Covid
- Respiratory Physiotherapist
- Senior Occupational therapist
- Clinical Psychologist
- Assistant Psychologist
- Specialist Therapy Assistant



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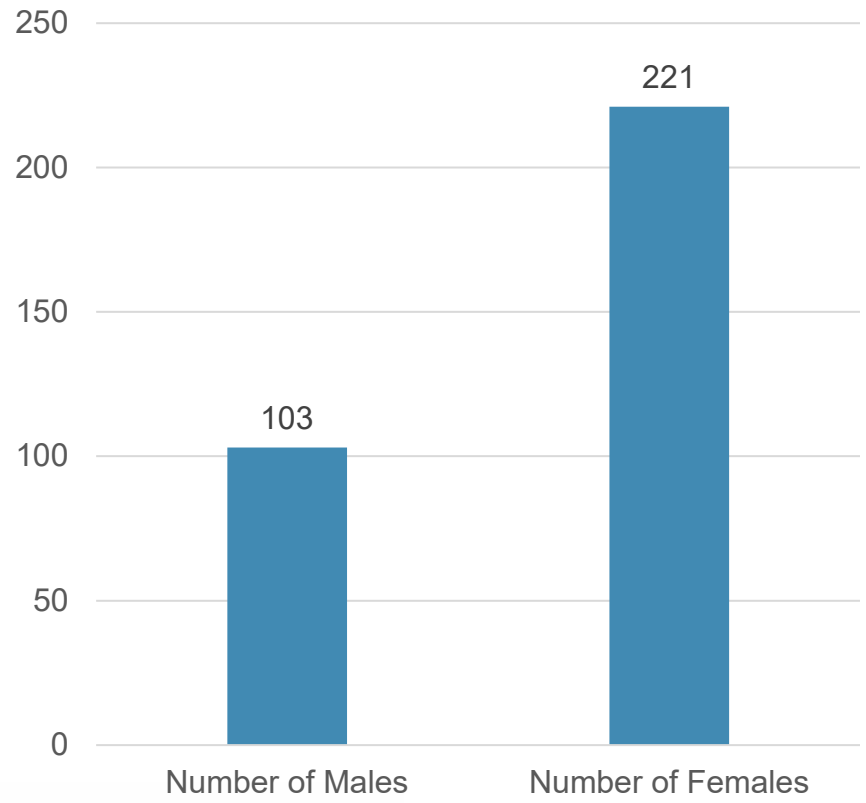
Referrals by Gender and Age 1/5/22-31/10/22



Age Groups	Numbers	%
19-24	8	3
25-34	21	6
35-44	64	19
45-54	105	32
55-64	78	25
65-74	39	12
75-84	8	2
85+	1	1

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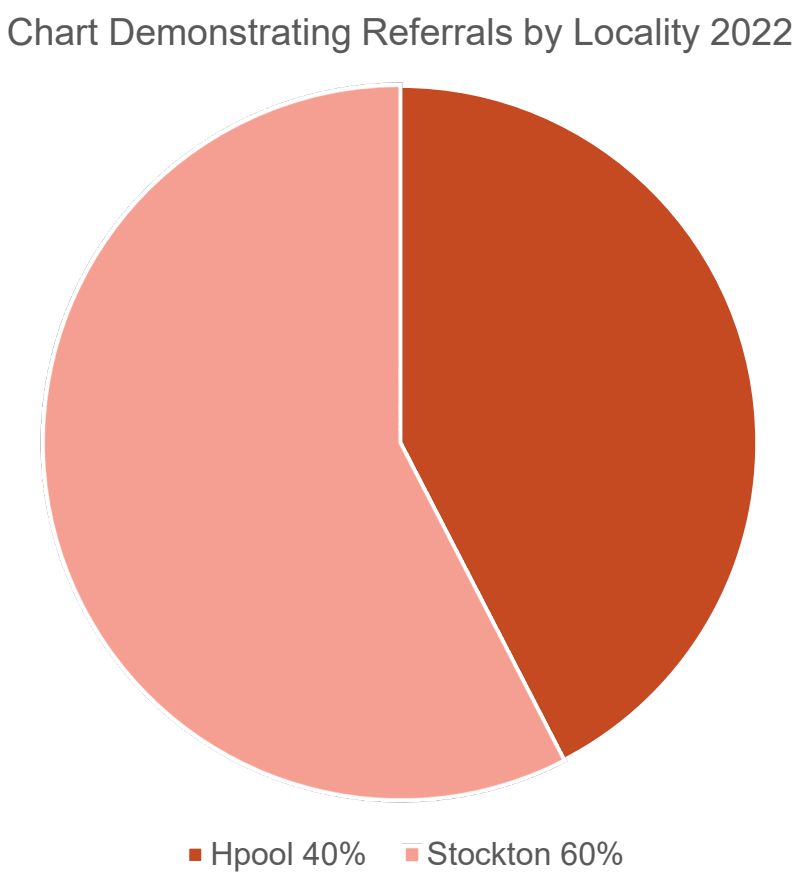
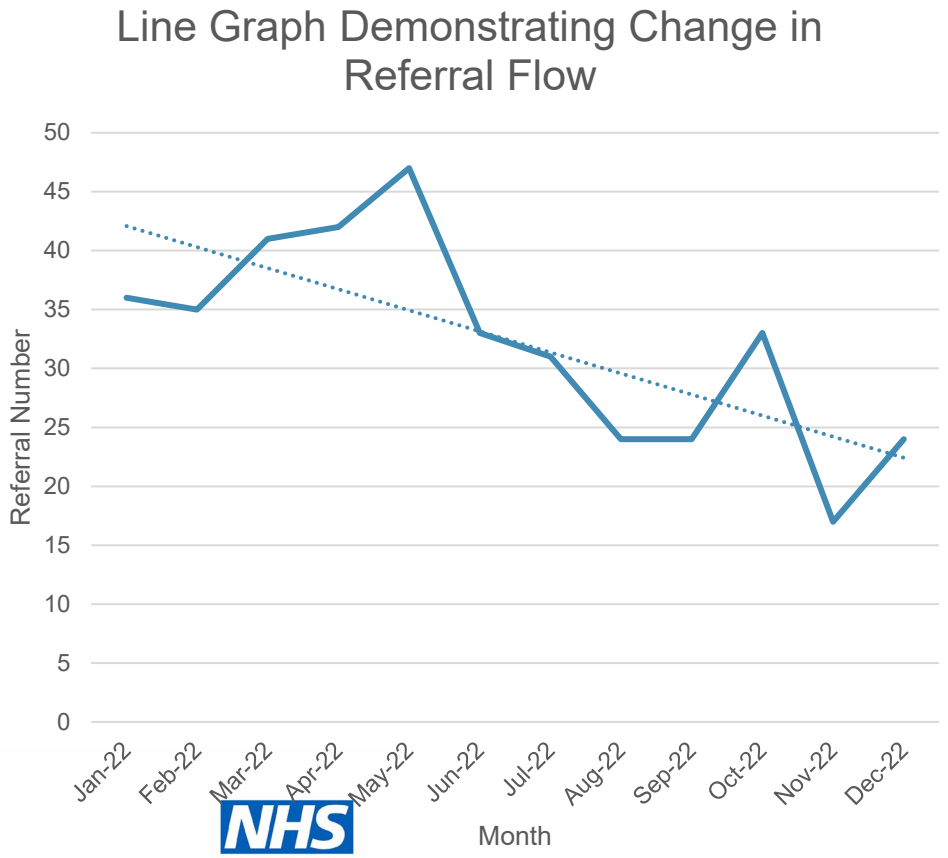
Referral Demographics

Referral Source	Total	%Total
GP	314	91
Consultant	32	9
Total	346	



Referrals Continued…



ONS Data 2022
Estimated Number of Patients living with Post Covid

Hartlepool – 723
Stockton – 1584

38% of estimated numbers referred to service. This represents those experiencing large symptom burden as per PHE presentation

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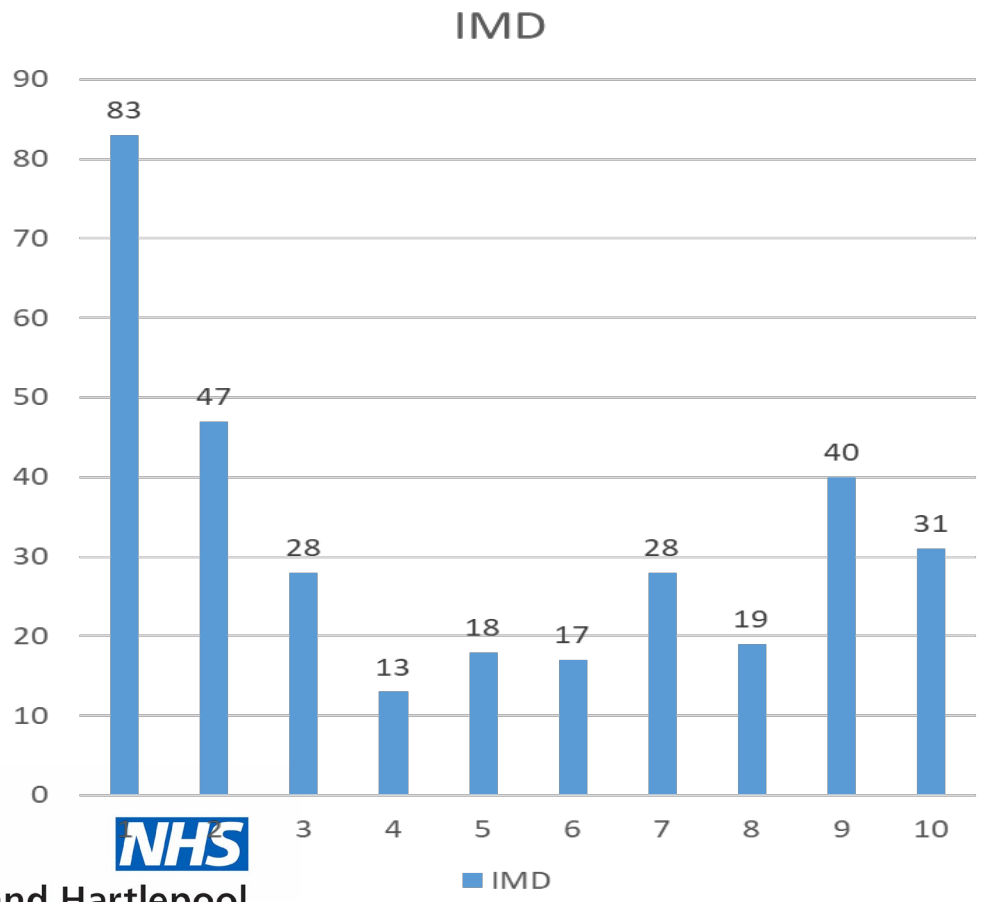
Referrals by IMD 1/5/22 – 31/10/22



This demonstrates a breakdown of referrals by IMD.
More referrals from areas of higher deprivation.
1 - 5 = 189
6 -10 = 135

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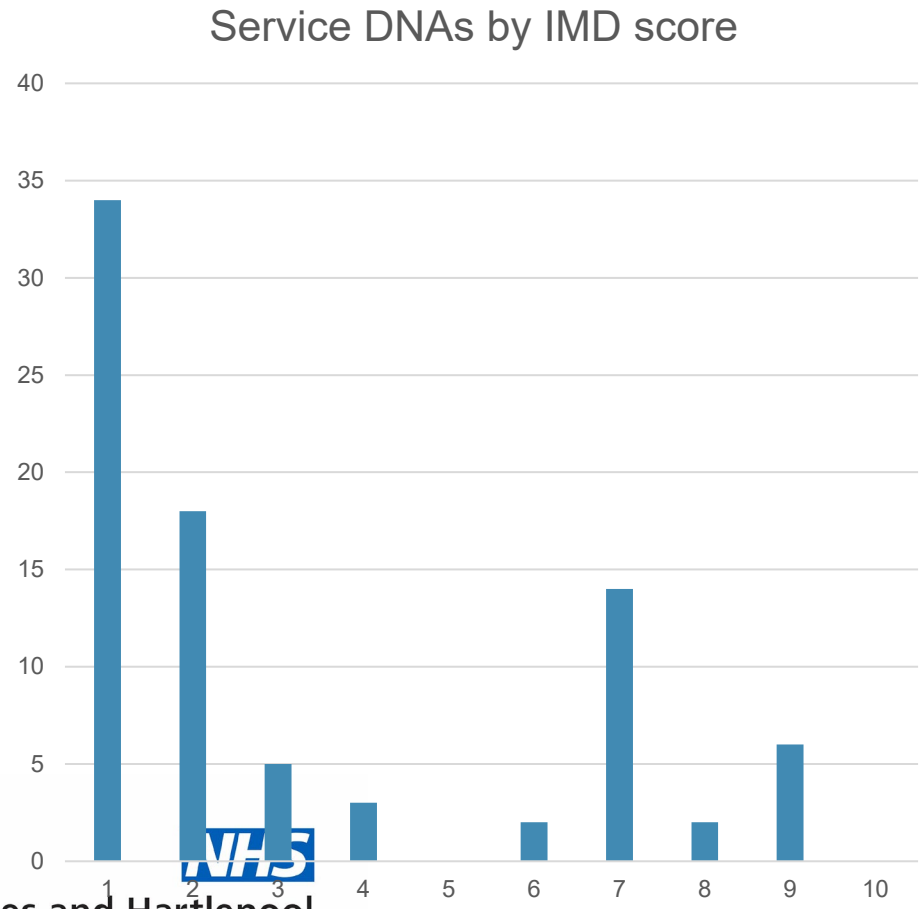
DNA's



72 appointments missed throughout the whole service.

Represents 3.9% of all appointments.

Most are forgotten appointments.

Actions to achieve reduction in DNA numbers:
- Appointment reminder via SMS for clinics and groups.
- Phone call reminder for home visits.
- Option of telephone appointment

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Post Covid Recovery Groups

The next 7 slides provide further information about the groups.

Cover both Stockton and Hartlepool sites

6 week course

- Education sessions including GP introduction
- Introduction to exercise / activity
- Peer support

Outcome measures

Referral on to Community / Voluntary sector

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Group demographics

Looked at first 75 patients

- 52 Females (69%)
- 23 Males (31%)

Locality

- Hartlepool 35
- Stockton 40

Age range

- 30 - 75 (youngest and oldest)

This reflects the referral demographics to our service shown in a previous slide Gender, locality and age range.

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Group Outcome Measures

Bench marking against regional and national services.

- Evaluation completed on Post Covid Groups

- PHQ9 / GAD7 – anxiety and depression scale
- MFIS – modified fatigue impact scale
- 6MWT – 6 minute walk test
- Patient feedback forms

PHQ9 / GAD7 /MFIS / 6MWT are carried out Week 1 and repeated Week 6

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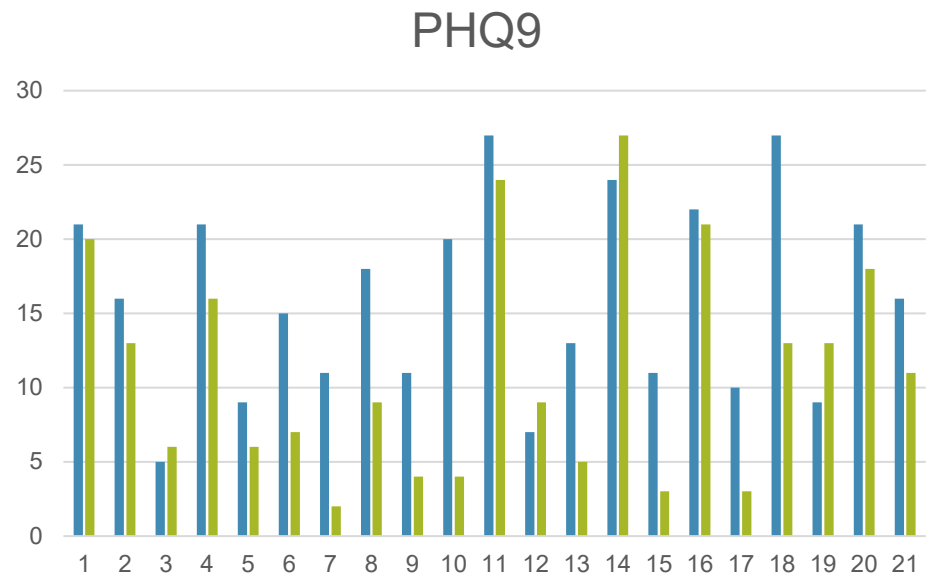
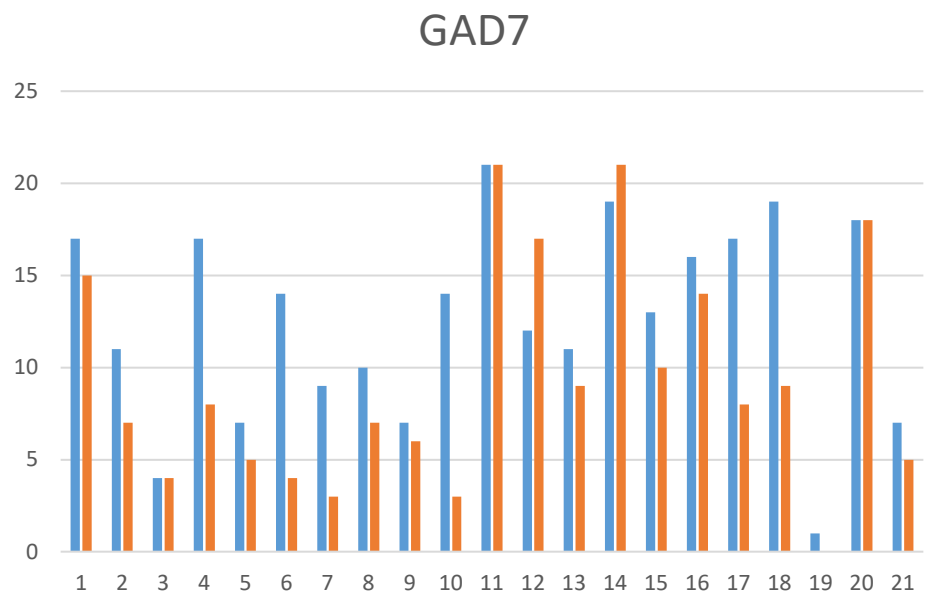
Outcome Measures



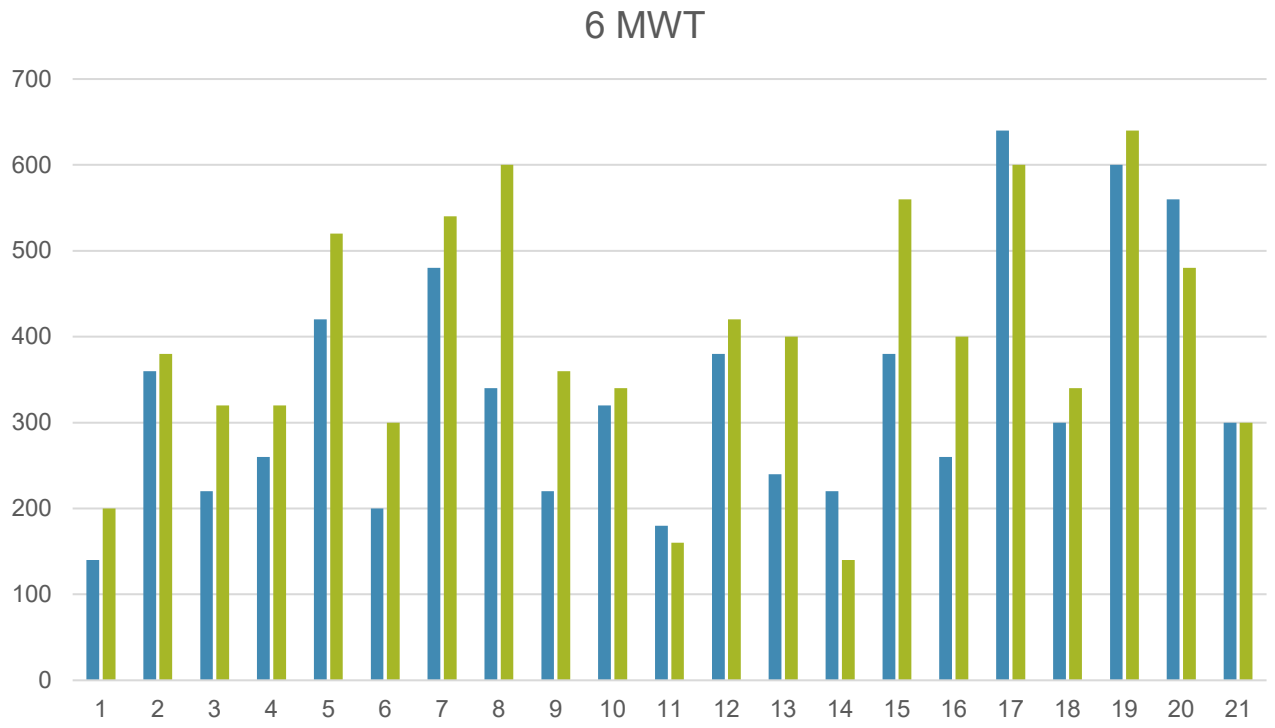
17 patients had a reduction in score (improved anxiety symptoms)
4 patient demonstrated an increase in their score at Week 6 and were offered 1-1 session with Psychology team.

Outcome Measures



17 patients demonstrated a reduction in score (improved depression symptoms)
2 patients showed an increase in score and were offered 1-1 session with the Psychology team as were the 2 patients reporting no change.

Outcome Measures



16 patients increased their walking distance.

14 achieved the MCID target.

4 patients scores reduced.

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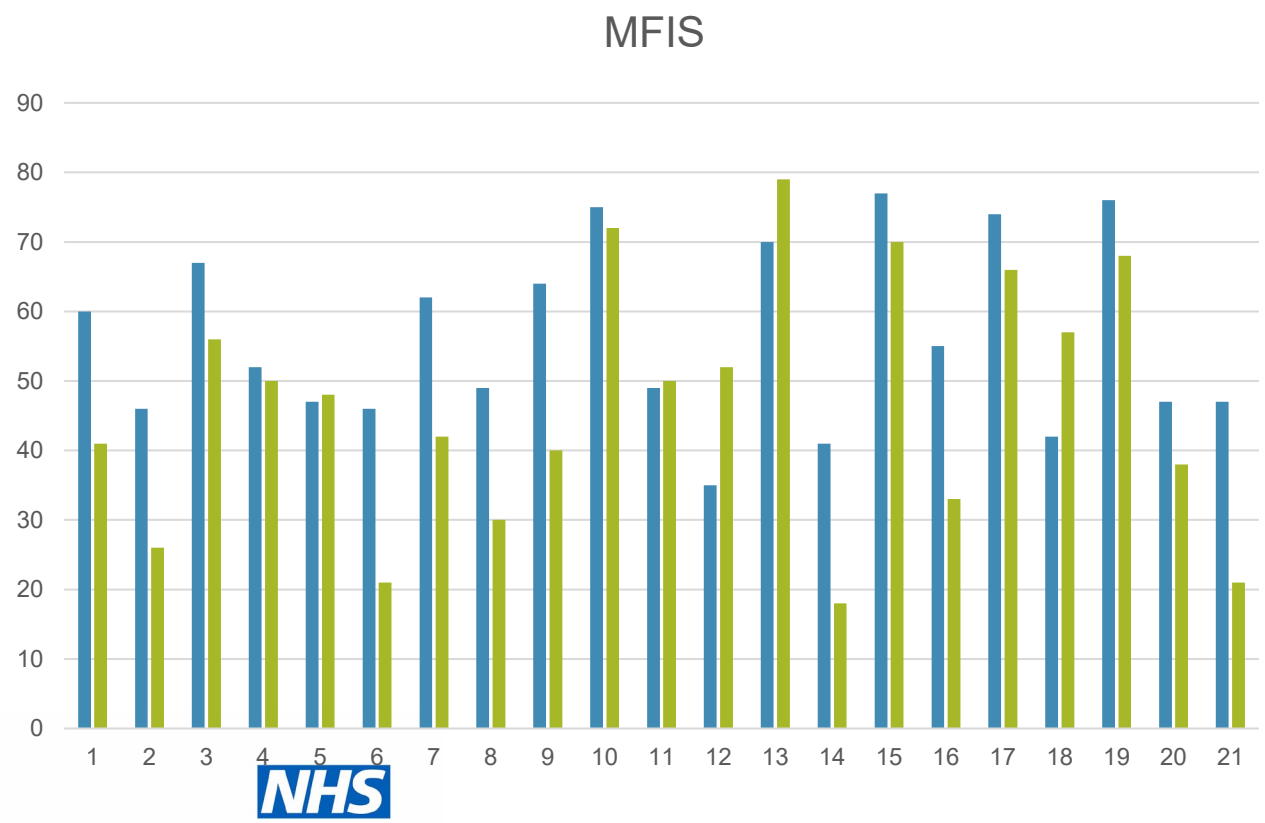
Outcome Measures



The overall outcome is one of improvement.
16 patients scores decreased (indicating improvement of fatigue symptoms)
5 patients scores increased
15 patients attended all 6 sessions.

Where scores have increased patients will continue with an element of 1:1 support from one of the team.

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Group Feedback

- Hearing the advice and information provided
- Learning coping strategies
- Meeting other people with Long Covid
- Extremely informative, learned a lot
- Really enjoyed today very, very helpful
- Looking forward to next week
- Knowing that you are not on your own
- Sad that it is finishing

Onward Referrals

- Referral onto
  - Tees Active Post Covid Programme – project ends 31/3/23
  - Hartlepool Health and Wellbeing Team
  -
  - Voluntary Sector - Catalyst / Resilience Team / Community Connect
  -
  - Community Hubs / Navigators
  - Social Prescribers

Service Developments

- Reviewing the service, we recognized a need for more support with mental health wellbeing and as such are expanding psychology input to our service.
- A lot of the patients being referred into the service are increasingly more complex and as such most of the referrals are triaged to the GP led MDT clinic pathway.
- As the number of referrals continue to decrease, we are looking at other services that we can possibly integrate with to provide individuals with the appropriate education and management. One such service is Pulmonary Rehab. We need to learn more about the Pulmonary Rehab groups as the outcome measures that we have from our groups has demonstrated far better / higher results than we would have expected in a relatively short period of time.
- Work is ongoing with the Survey Lead from our Trust looking at capturing qualitative and quantitative feedback post groups.
- Friends and family test are handed to patients post MDT clinic appointment as online return rates were poor.

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Post COVID Services
Evaluation & Next Steps

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Relevant National Guidance

- The NHS plan for improving long covid services – July 2022
- Long COVID Toolkit; advice and resources for healthcare professionals – July 2022
- National Commissioning Guidance for Post COVID services – July 2022
- Long COVID Multi-agency Support Framework – January 2023

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Patient Experience Survey & Learning

Post COVID-19 Syndrome Survey – 2023

- January-February 2023
- 77 respondents with symptoms ongoing for:
  - 4-12 weeks: 13%
  - 12+ weeks: 74%
- Most commonly experienced symptoms after 12 weeks similar to previous survey: fatigue and reduced ability to be physically active. However two additional symptoms reported: muscle aches and weakness, and poor sleep.
- Tees Active service was commissioned to support with being physically active. 72% of respondents advised that physical activity levels have affected their day-to-day lives.
- To assist with management of fatigue, the Post COVID Assessment Service offer education sessions within the groups and appropriate patients are signposted to the CRESTA clinic fatigue webinars, which have been specifically designed for Post C-19 patients.
- To assist patients with reduced/poor sleep the group sessions also provide information on sleep hygiene by the Psychologist and handouts given to patients at clinic. The FT team are also exploring the use of the Sleepstation digital platform.

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Patient Experience Survey & Learning

- 80% of respondents to this survey were aged between 35-65.
- Similarly to the previous survey, 79% of respondents noted that their mental wellbeing had been affected by their ongoing symptoms.
- Access to self-help resources significantly improved – 73% of respondents advised that they had accessed some form of self-help support. This can be improved via Health Champions and VCSE organisations.
- 74% of respondents are not aware of the Your COVID Recovery website. Similarly 79% of respondents were not aware of the NENC ICB website.
- 62% of respondents accessed the main NHS website for information.
- 30% of respondents have been formally diagnosed with Long COVID/Post COVID Syndrome.
- 96% of respondents have been vaccinated against COVID-19.

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Patient Experience Survey & Learning

- 30% of people reported accessing social media pages/groups to gather information and 65% of these found this information very helpful.
- When asked whether people sought out alternative self help information the following were noted:
  - Private chronic fatigue specialist
  - Google forums
  - Private meditation and body and mind courses.
- Overall 62% of respondents feel that there are not enough self-help resources available, so it is clear that this needs further development and reach across local communities.
- Alternative suggestions were sought and feedback included:
  - Access to helplines to reduce isolation.
  - Greater employer awareness of Post COVID Syndrome.
  - Exploration of advertisement opportunities on TV or social media.
- It is encouraging that when asked for preferred methods of receiving information the most common response (65%) was dedicated webpages, as this is already in place but needs refining.

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Patient Experience Survey & Learning

- 52% of people did not access their GP for support.
- 20% of people who accessed their GP were referred to the Post COVID Assessment Service, but 21% felt that they were provided with no information. Despite GP engagement around self-help resources, only 5% of people were directed to this.
- Majority of people felt that the help from their GP was helpful: 61%.
- 94% of respondents did not access any community services e.g. Tees Active.
- In total 23% of respondents were referred to the NTHFT Post COVID Assessment Service, and 100% of these have already had initial contact.
- 82% of people found organising their appointment easy or very easy.
- 59% reported that support from the Post COVID Assessment Service was very helpful or helpful.
- For those who did not think that the intervention was helpful some of the key reasons were a lack of onward referral to appropriate service and lengthy waits between appointments.

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Health Inequalities

The Long COVID Multi-Agency Support Framework for ICS's equips commissioners with tools and resources to better support Post COVID Syndrome patients with a view to reducing health inequalities. The resources/tools that are provided can be utilised locally.

Some of the key HI's outlined within this are:

- **Health:** People from ethnic minority groups are more likely to report being in poorer health and to report poorer experiences of using health services than their white counterparts. The COVID-19 pandemic has had a disproportionate impact on ethnic minority communities, who have experienced higher infection and mortality rates than the white population.
- **Employment:** Unemployment has risen exponentially during the COVID-19 pandemic, and has consistently been found to have a negative impact on a range of health outcomes. This has had a disproportionate impact on black and minority ethnicities.
- **Income:** Income influences health directly through the goods and services that people buy which can support, or damage, their health. The effects of Long-COVID may leave a patient without a reliable source of income. Those living in the most deprived deciles have between a 50- 65% greater prevalence of conditions such as learning disabilities, chronic lung diseases, serious mental illness and obesity when compared to the least deprived decile.
- **Peer support:** Individuals may feel more comfortable asking for and receiving support when it comes from a culturally sensitive service that is tailored more to their background.

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Post COVID Assessment Clinic Activity v Expected Prevalence

Prevalence:

ONS estimates 3%; this is self-reported for symptoms ongoing past 4 weeks.

BMJ estimates 1%; for symptoms ongoing past 12 weeks.

BMJ (Greenhalgh)		COVID no long term symptoms				79-89%
		Unwell after 3 weeks				10-20%
		Unwell after 12 weeks				1%

Applying this to the Tees Valley anticipates that there will be:

Hartlepool: 723 patients

Stockton: 1,583 patients

Activity between April 2021 and January 2023 has been collated and NTHFT data has been pulled from this.

- 888 referrals have been made and 749 accepted; an acceptance rate of 84%. This is 38% of BMJ estimated prevalence for Hartlepool and Stockton.

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Next Steps

The patient engagement survey has provided us with detailed information and recommendations related to the provision of self-help resources, which will be explored. This will include:

- Inclusion of further information regarding anosmia, fatigue and sleep.
- Consideration of alternative ways of advertising self-help support in local pharmacies and online.
- Further awareness raising with VCSE colleagues to share self-help resources.
- Building on the survey work continue to link with VCSE colleagues to ensure that information is shared with as many people as possible across the local community, to reduce Health Inequalities.

This is not only related to self-help resources but ensuring that people are aware of the Post COVID Assessment Service and how they can access this.

All of the above will be fed into a Tees Valley Post COVID Evaluation Report.

The Tees Valley Post COVID Steering Group will develop and undertake actions identified within the evaluation.

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Next Steps (continued)

Recognising the national guidance for Post COVID Syndrome and NHS England commitments to addressing health inequalities, the ICB will take guidance from NHSE and support local services to reduce HI with various interventions including:

- improving service-level data to help identify inequalities in access, experience and outcomes
- all services having a robust inequalities plan in place which are reviewed as required in the national commissioning guidance for post COVID services
- making every contact count by using opportunities in other healthcare settings to signpost people to post COVID services
- using social prescribers to support people with the socio-economic impacts of COVID, as set out in the national commissioning guidance for post COVID services

<u>NHSE Commitments:</u>

• NHS England and Health Education England will roll out a long COVID training programme for healthcare professionals from autumn 2022.

• Post COVID services should enrol at least one clinician in the long COVID training programme by March 2023.

• NHS England will review the future model for long COVID services, informed by latest evidence.

- Further funding for 23/24 has been committed to; local areas are awaiting information on locality splits.

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End of presentation, thank you for listening

Agenda Item 5

AGENDA ITEM

REPORT TO HEALTH AND WELLBEING BOARD

29 MARCH 2023

REPORT OF STOCKTON ON TEES BOROUGH COUNCIL AND INTEGRATED CARE BOARED

THRIVE STOCKTON ON TEES: TRANSFORMING SERVICES AND SUPPORT FOR CHILDREN AND YOUNG PEOPLE WITH EMOTIONAL HEALTH AND WELLBEING NEEDS

SUMMARY

This report provides an updates on work to transform support for children and young people with emotional health and wellbeing needs in the Borough. It updates on previous reports, and outlines the way this work is being taken forward, some key highlights and actions, and next steps

RECOMMENDATIONS

Board is asked to:

1. Note the update in this report
2. Agree to receive a further update in September 2023.

CONTEXT AND PURPOSE

1. What this work is seeking to is to lead on the development of a local model of emotional health and wellbeing support for children and young people, first for Stockton-on-Tees but which can be replicated and adapted in the other LAs in the Tees Valley.In other words, this is the transformation of services as promised in the Future in Mind work, and in the whole pathway transformation work.
2. The current NHS Children and Young People's Mental Health Transformation Programme reflects a rapid expansion of projects aimed at achieving better mental health and wellbeing for Children and Young People and their families and carers, which began with the Children and Young People psychological therapies services (IAPT) programme in 2011.The key underpinning documents for the current programme are Future in Mind (FiM), the Five Year Forward View for Mental Health (FYFVMH), Transforming Children and Young People's Mental Health Provision: a green paper, and the NHS Long Term Plan
3. It is also one of the key priorities in the Integrated care Strategy for the North East and Cumbria, and one of the key priority pillars for the Tees Valley.
4. We recognise that much good work is underway already, so our approach is to bring this work together, coordinate it, develop it further where necessary, to link things together and to get better at communicating what is happening, as well as giving some visibility to this work in the wider system.
5. In short, our objective is to make a reality of change, to turn the many words into action, and to deliver better outcomes for children and young people.

CURRENT POSITION

Our emerging model and approach

6. We have developed some basic building blocks for a new system which provide the foundations for what we are seeking to achieve. We believe these are the fundamental elements of a new system

Building a Thriving Stockton-on-Tees: the things we need to have in place and which we will oversee

Changing the conversation – Thriving system; good to talk;	***Rigorous planning, oversight, data and evaluation***	***High quality services and support across the Thrive framework***
Integrated systems / front door (SPOC and links to local systems)	***Mental Health Support Teams in all schools***	***Support for parents and carers***
A skilled and available workforce	***Attachment aware, trauma informed***	***Information, advice, guidance in many forms – digital, Kooth etc***

7. We are seeking to raise the profile of this work by developing it as a blueprint for change across the system, starting with the implementation of the model in Stockton-on-Tees.
8. The work is being led through a working group which has developed these principles and is leading this work. The group has recently been expanded to include more health professionals and will shortly be further expanded to include schools.

So what has been achieved?

9. An update on progress to date includes:
    a. The approach to changing the language away from CAMHS reform / change into building a system of support; which is based on the implementation of I-Thrive http://implementingthrive.org/about-us/the-thrive-framework/
    b. The rollout of Mental Health Support Teams in Schools – Wave 1 2019/20 targeted all Billingham Schools; this team is now established and fully operational and has the core role of the Education Mental Health Practitioner. In Autumn 2022 a further MHST mobilised within education settings across North locality and as part of Wave 7/8 of the national roll-out. This team is expected to be fully operational by Autumn 2023 and means that 51% of all schools in the Borough now have this support in place;
    c. Getting Help Teams provide additional capacity for mild-moderate MH support through the core role of the Children's Wellbeing Practitioner (CWP) and a range of psychological interventions through a multi-provider approach. Access through CAMHS 'front-door' (single point of access) is helping to streamline this offer, providing timely advice, triage and through a 'consultative' multi-agency huddle

timely access to appropriate interventions much earlier. Schools without access to an MHST have benefited from this additional resource locally and as part of a Tees Valley wide approach to improve equity.

d. Integration of CYP MH through primary care networks continues with the addition of a dedicated mental health practitioner based across all GP practices as part of BYTES PCN supported through the Additional Roles Reimbursement Scheme. This role is working alongside the existing system of support including the Footsteps Youth Wellbeing Service, with the aim of providing early advice, signposting and brief interventions for children, young people and families presenting at their GP practice. Early impact is showing evidence of early intervention provided for mild to mental health including anxiety, low mood and neurodiverse support

e. Continuation of investment for children and young people from a Getting Help (early perspective) continues and has been agreed across Tees Valley have been extended for a further 12 months and will be reviewed and considered for 2024;

f. Online support is available through the ICB commissioned Kooth and Quell system – Kooth for young people, Qwell for adults (including those working with young people

Existing waiting times and performance

10. As a snapshot at the beginning of March, 11 young people awaiting assessment for mental health support from the Stockton CAMHS team
    a. Average days waiting is 28 days
    b. Only 4 YP in Stockton have been waiting for more than 1 month
11. For the specialist eating disorder service, across Durham and Tees Valley there are:
    c. 0 YP currently waiting following an urgent referral
    d. 3 YP waiting between 4-12 weeks following routine referral

Specific provision for children in our care

12. Stockton-LAC CAMHS provision currently undergoing review, new model due to roll out early 23/24:
    a. Integrated team of therapeutic social workers and CAMHS practitioners
    b. Consultations to social workers and other professionals to ensure that the needs of children/young people are understood within the context of their lived experience
    c. Assessments: these include carers, emotional wellbeing assessments and Initial Mental Health assessments.
    d. Delivery of therapeutic interventions with the child/young person and their family/carers following an assessment where a targeted or specialist response is required.
    e. Consultation and training for residential staff that draws on attachment theory.
    f. Nurturing Attachment Training for foster carers.
    g. Foster carer drop-in sessions to support placement stability.
    h. Telephone advice and guidance for carers and professionals.
    i. Support to social workers or other local authority staff when they are working therapeutically with young people.

13. As part of Tees Valley level work on complex commissioning, it is anticipated that new models of care and new provision will be designed which can provide the basis for supporting young people with the most complex needs where effective high quality provision is currently not available.

WHERE NEXT?

14. We will be systematically working through the building blocks as a work programme to explore how they contribute to an integrated systemic response and approach.
15. We are currently reviewing how this model fits with the 0-19 health and wellbeing model and the opportunities for greater alignment and collaboration, especially around school age children.
16. We have identified a number of opportunities for close working with the Council's help and Support Teams, specifically the SMART Team (the early help hub) and how this can be integrated in the Mental Health Support Teams model.
17. We need to be exploring funding opportunities and making sure we are working as part of ICS structures to ensure the visibility and primacy of this work. This will take place through the emerging Tees Valley structures and the priorities which have been identified for children and young people.

SUMMARY

18. Work to change the support available for children and young people is well advanced and is leading to a significant change in the way services are experienced by children and young people.
19. The focus for future work is to embed and integrate further as this model outlined continues to be worked through.

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Background Papers:

Ward(s) and Ward Councillors:

Property Implications:

AGENDA ITEM

REPORT TO HEALTH AND WELLBEING BOARD

29th March 2023

REPORT OF DIRECTOR OF PUBLIC HEALTH

Substance Misuse in Stockton-on-Tees

SUMMARY

- Substance misuse and drug related deaths remain a significant problem in Stockton-on-Tees.
- The local implementation of the national drug strategy 'From Harm to Hope' is supported by additional national funding for the expansion of local drug treatment services and introduction of combatting drug partnerships.
- A Tees Combatting Drug Partnership has been launched to oversee the implementation of the national drug strategy, in support of local action.
- Local drug treatment services are expanding their offer to improve access to treatment and recovery.

RECOMMENDATION

The Health and Wellbeing Board is asked to:

- Note the content of the report
- Note ongoing work to expand local treatment services and to consider substance misuse within the context of reducing health inequalities and the development of a local peer advocacy programme

DETAIL

Context

1. Substance misuse in Stockton-on-Tees remains an issue with an estimated 1800 opiate and crack cocaine users of which almost 1000 were in treatment in 2020/21. Drug related deaths (drug misuse deaths) in 2021 were highest in the North East and have seen a step increase over the last 10 years. The rate in Stockton in 2019-21 was similar to the North East average with 87 drug misuse deaths during the period.

2. Drug markets are shifting away from opioid (heroin) to an increased use and availability of cocaine, crack cocaine, prescription drugs, including benzodiazepines and pregabalin and counterfeit prescription drugs.

3. The national drug strategy by Dame Carol Black **'***From Harm to Hope'*, sets out the Government's aims to cut crime and save lives by reducing the supply and demand for drugs and delivering high-quality treatment and recovery services over the next 10 years. The implementation of the strategy is supported by additional funding to increase capacity for treatment services, strengthen links to criminal justice and prevent drug-related deaths. Further funding is provided to develop local capacity for medically managed drug and alcohol detoxification and to provide employability and work placement support.

Regional action

4. At regional level local authorities represented through their public health drug leads are working together in the regional Substance Misuse Leads Network which works closely with the regional Office for Health Improvement and Disparities (OHID) and reports to the regional Directors of Public Health.

5. The network monitors and reviews data, works on joint approaches to drug related deaths, links with the wider system including NHS and prisons and shares best practice. Over the past year the network has worked very closely with providers to ensure a robust response of treatment services during the pandemic, keeping service-users safe and connected with treatment. This included ensuring access through the introduction of telephone and virtual appointments and to respond to emerging challenges such as how to provide opioid substitution treatment with minimal contact with pharmacies during lockdown.

6. Following the pandemic, the group has focused on working with OHID on the local allocation of drug strategy related grants based on national guidance. The group also links with the ICS in relation to the impact of drug misuse on health inequalities and health and social care services.

Tees action

7. A key component of the strategy was to introduce Combatting Drug Partnerships to identify local need and oversee progress. The Cleveland Combatting Drug Partnership (CCDP) was established in October 2022 and is chaired by the Police & Crime Commissioner. The CCDP has just completed a needs assessment and, working with system partners including local authorities, has begun to develop a plan of action, which will align with the aims of the Health and Wellbeing Board, the Safer Stockton Partnership and Fairer Stockton-on-Tees.

8. Problem Solving Courts focussing on substance misuse are being introduced in three pilot sites across the country. Teesside Crown Court will target those with substance misuse issues linked to their offending and aim to address their substance misuse and consequently their offending through additional support from the judge and community services.

9. Preventing drug related deaths: In recognition of the high rate of drug related deaths in Teesside, local authorities have come together to prevent drug related deaths. This

includes a local network and a jointly funded post to liaise with the Coroner, Police, the NHS and treatment providers to understand and address causes for drug related deaths, develop pathways to respond to overdoses and prevent deaths. A multi- agency case review process for each suspected drug related death has been implemented to understand gaps, share learning, and facilitate improvement in services and pathways.

Local action

10. Stockton Borough Council has received additional grant funding since 2021 to fund additional capacity in drug and alcohol treatment services and provision of inpatient detoxification wto support service users back into work.

11. At local level public health at Stockton-on-Tees Borough council is leading on prevention, harm reduction and recovery approaches in line with the evidence base, through awareness raising, training and the commissioning of an integrated drug and alcohol recovery service, delivered by CGL.

12. Prevention starts from an early age with the development of personal resilience to protect those at risk of or vulnerable to substance misuse. This includes input to school communities on substance misuse by Education Improvement (Healthy Schools) and Stockton's Recovery Service (CGL) as well as individual and group-based work by the 5-19 (school nursing) service to support those at risk. Stockton Borough Council and CGL also raise awareness to the risks of misuse of prescription and illegal drugs through campaigns for example during the international recovery month in September.

13. Harm reduction approaches offered through the recovery service, pharmacies and others include the provision of clean syringes to prevent infections or the transmission of blood borne viruses such as HIV and Hepatitis B and C. Pharmacies also provide supervision of the consumption of medication used in the treatment of drug misuse (substitution therapy) to ensure compliance with treatment and to prevent overdoses. In addition, programmes to prevent further harm and death from drug overdoses is being rolled out by distributing overdose medication (naloxone) to service users, their families, and carers, in A&E, the ambulance service, police and prison.

14. A specialist carer service for families affected by substance misuse is provided through Bridges. Bridges supports through individual and group-based support and works with the recovery service.

15. The treatment and recovery service is provided by Change Grow Live (CGL) located in the centre of Stockton, which offers a broad range of services for adults and young people addicted to alcohol or drugs. The treatment journey includes community detoxification, substitution therapy, drinking/dosing down, wound care, psychological support, diversionary activities, employability, peer support and much more. CGL also works with Recovery Connections, the NHS, and other partners to ensure joined up pathways and communication e.g., for prison leavers, the development of pathways into independent living and into work.

16. Despite the increased investment into services the number of people in drug treatment in

Stockton-on-Tees has decreased over the past year from 1594 in 2021 to 1518 in 2020. This seems surprising but is seen as a result of more discharges from treatment for opioid addictions after a period during which discharges were consciously delayed. During the pandemic treatment services tried to provide additional support and keep service users engaged in treatment. However overall treatment numbers reduced only slightly with the number of patients in treatment for alcohol having increased threefold from 121 in 2021 to 362 in 2022. It is important to recognise that a 'good outcome' for the substance misuse population can often be defined as keeping individuals and those around them safe, and does not always mean discharge from treatment.

17. The number of young people in treatment was low with only 41 accessing drug or alcohol treatment in the past year. Further work to better understand the needs children and young people and develop in order to improve access to services is in progress. The expansion of treatment capacity also increases capacity to support children and young people.

Number of people in treatment, November 2022	
All adults in structured treatment	**1518**
Opiates	889
Non opiates (combined non-opiate only and non-opiates and alcohol)	267
Alcohol	362
All young people in structured treatment	**41**

18. The work on substance misuse takes an evidence-based approach across partners in the health and wellbeing system. Inherent to this approach is addressing inequalities. Work is underway on the potential for different ways of working e.g. through the multiple complex needs pilot (using local peer advocates) - working alongside communities who have substance misuse issues alongside other needs, to take an assets-based approach and empower and enable them to access support. We are also looking to work alongside the community further to shape our future models of support.

Next Steps

19. Work will be progressed to:
    - Further develop systems, work at regional, Teeswide and local level to prevent additional substance misuse, improve access to treatment and reduce drug related deaths.
    - Continue the local implementation of the national drug strategy through the additional treatment grant to ensure improved access to high quality treatment services.
    - Strengthen our prevention and harm reduction approach and specifically through improved access to naloxone, working with pharmacies and police.
    - Support the development and implementation of the Cleveland Combating Drugs Partnership plan.
    - Work together to improve our understanding and response to the needs of children and young people at risk of or engaging in substance misuse
    - Further develop our community asset-based approach to addressing substance misuse, with further updates on this back to the Board

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Agenda Item 8

HEALTH AND WELLBEING BOARD - FORWARD PLAN

31 May 2023	• SEND Strategic Action Plan **(Martin Gray)** • Integrated Mental Health Strategy Group **(Sarah Bowman Abouna/Tanja Braun)** • Physical Activity Steering Group Update **(Sarah Bowman Abouna/Tanja Braun)** • Better Care Plan **(Ann Workman/Emma Champley)** • Annual Review of Health Protection Collaborative and Terms of Reference **(Sarah Bowman- Abouna)** • Members' Updates • Forward Plan
28 June 2023	• Alcohol Strategic Group Update **(Sarah Bowman-Abouna/ Mandy Mackinnon)** • Members' Updates • Forward Plan
26 July 2023	• Tobacco Alliance Update **(Sarah Bowman Abouna/Mandy McKinnon)** • Health Protection Collaborative **(Sarah Bowman)** • Members' Updates • Forward Plan
30 August 2023	• Members' Updates • Forward Plan
27 September 2023	• Domestic Abuse Steering Group Update **(Sarah Bowman Abouna/Mandy McKinnon)** • Better Care Plan **(Ann Workman/Emma Champley)** • SEND Strategic Action Plan **(Martin Gray)**

	• Health and Wellbeing Partnerships' Update **(Partnership Chairs)** • Members' Updates • Forward Plan
25 October 2023	• Integrated Mental Health Strategy Group **(Sarah Bowman Abouna/Tanja Braun)** • Health Protection Collaborative **(Sarah Bowman)** • Members' Updates • Forward Plan
29 November 2023	• Physical Activity Steering Group Update **(Sarah Bowman Abouna/Tanja Braun)** • Members' Updates • Forward Plan
20 December 2023	• Alcohol Strategic Group Update **(Sarah Bowman-Abouna/ Mandy Mackinnon)** • Members' Updates • Forward Plan

To be scheduled:

- Scope and define key strategic system outcomes against the new priorities and monitoring approach **(Sarah Bowman-Abouna)**
- Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and future monitoring **(Sarah Bowman-Abouna)**
- Adults Social Care Strategy Action Plan **(Ann Workman)**
- Place Based Committee **(Ann Workman)**
- Protection of the most vulnerable (**Sarah Bowman-Abouna)**

- Linking community assets and primary care **(Ann Workman/Sarah Bowman Abouna)**

- Fairer Stockton Framework – Cost of Living Crisis Support Update **(Jane Edmends)**

- Adult Social Care Reforms/White Papers **(Emma Champley/ Ann Workman)**

- Multiple Complex Needs – Peer Advocacy Pilot **(Sarah Bowman Abouna/Mandy Mackinnon)**

Scheduled items Frequency:

- Domestic Abuse Steering Group Update (Usually March and September) **(Sarah Bowman Abouna/Mandy McKinnon)**

- Alcohol Strategic Group Update (Usually June and December) **(Sarah Bowman Abouna/Mandy McKinnon)**

- Integrated Mental Health Strategy Group (Usually April and October) **(Sarah Bowman Abouna/Tanja Braun)**

- Physical Activity Steering Group Update (Usually May and November) **(Sarah Bowman Abouna/Tanja Braun)**

- Tobacco Alliance Update (Usually January and July) **(Sarah Bowman Abouna/Mandy McKinnon)**

- Better Care Plan (Usually April and September) **(Ann Workman/Emma Champley)**

- SEND Strategic Action Plan (Usually March and September) **(Martin Gray)**

- Health Protection Collaborative (Usually January, April, July and October) **(Sarah Bowman)**

- Health and Wellbeing Partnerships' Update (Usually March and September) **(Partnership Chairs)**

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