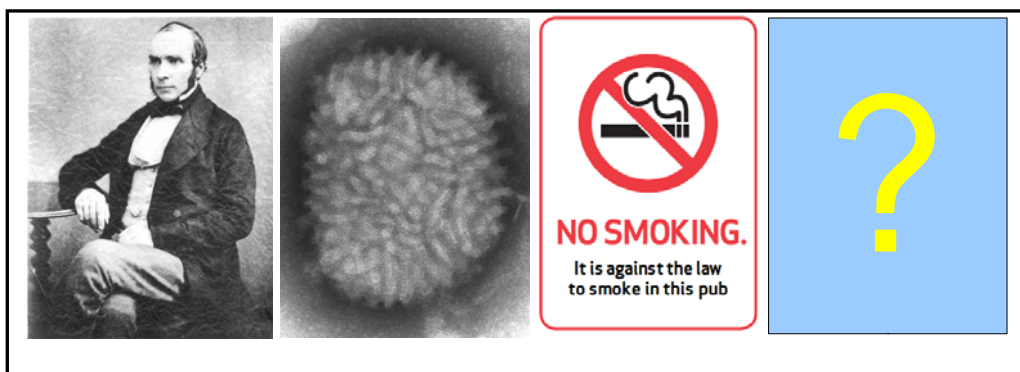


# Better Health, Fairer Health

## Consultation on a Strategy for 21st Century Health and Well-being in North East England

By the Regional Director of Public Health



## Summary Report on the Consultation

January 2008



# Summary Report of the *Better Health, Fairer Health* Consultation, October - December 2007

## 1. Launch of the consultation

The consultation document *Better Health, Fairer Health* was launched by the Regional Director of Public Health at a major stakeholder event on 4 October 2007. The event was attended by 180 delegates from a wide range of organisations representing the statutory, business, community and voluntary sectors in the North East. It included presentation sessions and facilitated workshops on the key areas for action set out in the consultation document.

All attendees of the launch event received a copy of the consultation document and it was issued by email to over 150 key stakeholders. It was also made available on the Public Health North East website, along with notes from the launch event workshop sessions.

Significant press interest and reporting of the launch event was used to publicise the consultation. In addition, launch delegates and key stakeholders used their own networks to ensure that the consultation document reached a wide audience.

The launch was the start of a three month consultation period which ran until 31 December 2007. The consultation was conducted in one stage and in accordance with the Better Regulation Executive Code of Practice on Consultation

A template for responding to the consultation was prepared and made available on the website. Respondents were encouraged to use this response template to submit answers to any of the 32 specific questions in the consultation document, or to make any additional comments.

## 2. Consultation opportunities

Following on from the launch event Public Health North East helped to organise and facilitate a series of 17 consultation opportunities as requested by organisations around the region. These included presenting to planned board and general meetings, speaking at dedicated consultation events and facilitating workshop discussions. A list of these consultation opportunities is given at **Appendix 1**.

Local consultation events were also held by a number of key stakeholder organisations around the region. A further 260 hard copies of the consultation document were made available during the consultation period to a variety of different organisations.

### **3. Submission of consultation responses**

Consultation responses were submitted by a broad range of public, private, voluntary and community organisations and groups, and from individuals. A full list of responses is included at **Appendix 2**.

In total of 104 responses were received in the period up to and including 8 January 2008. Of these, 93 responses were received by the consultation end date of 31 December. The remainder comprised some responses sent by post and some where respondents had specifically requested a short extension of time beyond the deadline. All responses were read in detail and taken into account in preparing this summary report and drafting the health and well-being strategy.

The response template was intended to help respondents to prepare their response and submit this electronically to a dedicated mailbox. The majority of respondents made use of the template, with most submitting this electronically. A few supplemented their template response with a covering letter or other supporting document, allowing additional scope for comment.

Some respondents felt that the template was not sufficiently flexible to accommodate the points that they wished to make, whilst a few felt that it was too complex or onerous to complete. These used email or letter to draw out their key points either in relation to specific questions or more generally.

In some cases the same person submitted responses both in an individual capacity - giving their personal view - and separately on behalf of an organisation. Some responses from different organisations were clearly coordinated and made the same points using exactly the same language. Some made direct reference to responses submitted by other organisations. Others presented a list of different views, which were sometimes conflicting and not representative of the views of any one individual or organisation.

### **4. Analysis of consultation responses**

The timetable for moving from the consultation phase to publication of the 1<sup>st</sup> edition of the strategy on 1 February 2008 was tight and ambitious. A structured process for recording and analysis of consultation responses was established at an early stage to ensure that all responses were read and analysed in time to influence the next stage of development of the strategy.

This included an initial processing phase where basic details about the respondent were recorded and a unique identifying code assigned to each response. A summary of which questions were answered in each response was prepared, followed by a detailed question by question analysis of answers to both the yes/no elements of each question and any additional qualitative comments provided.

The detailed analysis allowed for identification of common emerging themes and assessment of the extent to which particular issues were seen to be of importance. This was the most challenging part of the consultation exercise, as qualitative comments in different responses were often expressed differently but often shared a common thread.

The response template was intended to assist with analysis of consultation responses and ensure that this was carried out in a structured way. In preparing the analysis it was helpful to have responses broken down question by question but there were some limitations in using this approach, as set out below.

Several of the consultation questions were complex and multi-part, requiring both one or more yes/no answers as well as supporting qualitative comments. This affected the degree to which the different parts of individual questions were completed.

In general, many responses did not deal directly with the yes/no parts of the consultation questions but provided significant amounts of supporting commentary. In some instances it was possible to determine from the narrative whether the response meant yes or no, but often this was not sufficiently clear. To a large extent, this was not a major issue as the greatest value to be derived from the responses was often found in the commentaries rather than in simple positive or negative views.

Where respondents did not make use of the template different issues arose. In some cases the respondents answered specific questions in a structured way that was clear from the text of their letter or email. In other cases, where the respondent specifically wished to raise more general points about the whole of the consultation document or where the commentary seemed to deal with more than one question at a time, it was not always possible to assign the comments directly to any one of the specific questions.

The summary analysis included at **Section 6** below gives some flavour of the responses but does not attempt to represent their full range, richness and value.

## **5. Influencing the development of the strategy**

Respondents to the consultation will be keen to see how their views have influenced and can continue to influence the emerging strategy. The key message from the responses to the consultation document was a positive one, clearly welcoming the development of a strategy for health and well-being and placing it at the heart of an integrated strategy for the North East.

The consultation document identified priorities across eight key areas for action. Some of the proposed actions within these themes were endorsed, and will form the initial programme of action within the strategy. Others were more controversial and require further work.

The key areas have been expanded to ten and now include:

- Economy, culture and environment
- Mental health and happiness
- Tobacco
- Alcohol
- Obesity, diet & physical activity
- Prevention, fair and early treatment
- Early life
- Working life
- Later life
- A good death

Within the responses to the consultation were a great variety of views and possible changes or additions to the already significant list of actions that had been proposed. Some of these had a large body of support and have been incorporated into the first edition of the strategy.

Others are now included in the strategy as areas for potential further development. Amongst these are:

- pollution
- climate change
- green spaces and natural environment
- transport modal shift
- accident prevention
- business, economy and a healthier environment
- employability, employment and health
- social inclusion and community involvement
- malnutrition
- action to support carers
- sexual health
- lifelong education and learning
- physical and emotional health
- longer-term interventions for alcohol
- substance misuse
- targeting specific groups for action: young people; older people; asylum seekers and migrants

## 6. Summary analysis of responses

The response to individual questions in the consultation document was variable and reflected the different interests of respondents in the wide range of topics covered. The fundamental question of whether a strategy should exist was answered in 78 responses, whereas the two questions on branding (numbers 29 and 30) were answered in only 32 responses.

The number of questions answered in responses varied widely. 10 responses answered all of the questions as well as providing additional comments. 6 responses did not address any of the questions directly but provided commentary on the consultation document as a whole and on some of the detailed issues arising. Other responses concentrated on a few questions - or a single question - covering a specific area of interest and expertise, whereas others answered a range of different questions. In some instances responses included the same answer to several questions covering different subjects.

### ***Q1 Should a regional health and well being strategy for the North East exist and how can it add value?***

This question was the most answered question, with 78 responses providing an answer. Most agreed strongly that a regional health and well-being strategy should exist. None were entirely against the idea.

Most responses said that a strategy could add value - for example by providing a coordinated framework for action - whilst expressing some caveats and making suggestions on how a strategy could be taken forward.

However, some responses were less clear as to whether a strategy should exist, but said on balance that it could add value by drawing together a range of other strategies and policies. Some felt that a strategy should have a limited lifespan or cover a shorter timescale.

### ***Q2 Do you agree with the restrictions that have been placed around the development of this strategy, or is there a need to explore some of the pitfalls at greater length?***

60 responses answered this question. Of these, the majority seemed to agree with the restrictions, wholly or in part. Of the remainder, most felt that they could support some of the restrictions whilst suggesting further exploration of the pitfalls. A small number of responses appeared to disagree with the restrictions.

Some responses suggested that it was essential to set out the context for strategic action and provide additional detail - perhaps in supporting documents rather than the main narrative - especially for those who might be less familiar with the key issues.

**Q3 Are the principles outlined the correct ones upon which to base a health and well being strategy? Are some over-restrictive? Are there other principles that should be observed?**

65 responses answered this question. Of these, the majority seemed to agree with the restrictions, including the need for regionally focused evidence-based actions and the importance of adding value. Some responses also commented on whether the principles were over-restrictive and suggested additional principles that could be taken into account, for example encouraging innovation through work with community and voluntary organisations. A few appeared to disagree with the principles.

**Q4 Are there other life course events, periods, processes or qualities of the life-course that should be considered?**

63 responses answered this question. Of these, almost all seemed to agree that the life course model covered many key areas but most also offered additional suggestions. A majority said that more could be added to the life-course whilst a few felt that the model encapsulated all the main periods, processes and qualities. One response said that the life-course model was entirely unhelpful.

The wide range of suggestions fell into a variety of categories:

- key stages and different age ranges within the life course, including transitions such as childhood to adulthood and older age
- education, working age and employment issues
- life-course issues affecting specific groups such as those with learning disabilities and mental health problems
- quality of life and the role of the community

**Q5 What is missing from the 'menu' of areas in which we could act?**

53 responses answered this question, with a wide range of additional areas for action suggested. These included:

- sexual health and teenage pregnancy
- health in the workplace and occupational health
- issues for older people
- oral health
- childhood, including vulnerable and disabled children
- healthy living and emotional well-being
- community engagement and support for carers

**Q6 *Are these the most significant and alterable of areas that influence health and well being? What others would you advocate?***

60 responses answered this question. Of these, the majority seemed to agree with the significant alterable areas set out in the consultation document. A few responses suggested that there were more important issues to be considered. Some of the answers to this question were similar to those to question 5.

Several additional areas were advocated, including:

- sexual health and teenage pregnancy
- psychological health and emotional well-being
- issues for older people
- poverty, housing and personal economic circumstances
- substance misuse
- linking the strategy to key planning processes such as Local Area Agreements

**Q7 *What other regional action should be taken on smoking?***

41 responses answered this question. Several other actions on smoking were suggested:

- specific action to support children to stop smoking
- primary prevention and establishment of an evidence base
- focus on deprived communities, disadvantaged, vulnerable and 'hard to reach' groups
- reduction of demand for and supply of cheap tobacco
- dealing with smoking alongside other addictions

**Q8 *Is it appropriate to set a regional smoking prevalence target? Is this the right level and timescale? Should we also set a long term regional target for the reduction of lung cancer deaths as an indicator of overall smoking prevalence?***

This is a complex multi-part question which was answered in part by 43 responses. There was general support for a smoking prevalence target. Several responses commented further on the proposed target, with most agreeing that this was at the right level. Others suggested that a more challenging target should be set.

There were mixed views on whether a target for lung cancer deaths should also be set as an indicator of smoking prevalence. Some responses suggested that this might be less appropriate if other causes contributed significantly to lung cancer.

**Q9 Are the proposed initiatives the most appropriate regional actions to tackle diet and obesity? What other actions would you advocate?**

63 responses answered this question. Some suggested that the proposed initiatives were the most appropriate actions on diet and obesity, but a significant number of others appeared to suggest that they were not. Several advocated other areas for action, including:

- more explicit links between action to tackle obesity and increased physical activity
- malnourishment in older people and vulnerable groups
- workplace-based interventions
- management of obesity as well as treatment
- family-based interventions

**Q10 Is the division of physical activity current and future risk groups understandable and rational? What other conditions should be addressed specifically?**

52 responses answered this question. There were mixed views about the division into current and future risk groups. Some responses suggested that this was both understandable and rational. Others agreed that it was an understandable division but felt that it was not especially appropriate. A few had fundamental objections to the division or felt that it was generally unhelpful.

Suggestions for areas to be addressed included:

- emphasis on physical activity in schools
- addressing the needs of older people
- rehabilitation for chronic back pain and falls
- long term maintenance of physical activity
- community sports and extended schools activity

**Q11 Are these the best available actions to tackle alcohol? Are there others that should be evaluated? How far should we go in advocating and lobbying for increased restrictions through legislation and statutory regulation?**

This is a complex multi-part question which was answered in part by 51 responses. Many agreed that these were some of the best ways of tackling alcohol, whilst suggesting that the proposed interventions needed to go further as well as identifying additional areas for action. A few suggested that the actions proposed were not the best ones.

The proposal to establish an office for the safe consumption of alcohol was welcomed in several responses as a means of coordinating and bringing together actions to tackle alcohol. A few responses said that the OSCA proposal went further than necessary.

**Q12 Do you agree that health and well being should have this status within a regional integrated strategy? What other measures might be taken?**

57 responses answered this question, with the majority agreeing strongly that health and well-being should have a primary place in the context of an overall regional integrated strategy. Some responses suggested that - whilst this was desirable - achieving this status would be difficult and would require strong partnership working.

Some responses suggested that health and well-being should be seen as part of a broader strategic emphasis on social capital and quality of life, perhaps as part of a regional 'social strategy'. The importance of linking to education, employment, workplace health and the economy was raised in several responses.

**Q13 What do you think about the prioritisation for educational attainment? How would this work in practice for organisations other than schools?**

53 responses answered this question and gave a mixture of views about the prioritisation for educational attainment. There was significant support for the idea that educational attainment plays a key part in improving health and well-being.

Many responses said that it could be taken further to include life long learning and raising aspirations for all groups, including those for whom educational attainment might not be the most appropriate goal, for example those not in employment education or training, disabled groups and marginalised groups.

A few responses said that educational attainment did not contribute to or was not a priority for health and well-being, and should not be included in the strategy.

**Q14 Are these the most important measures for modifying physical activity through the environment? What other approaches might be used? How else might we go beyond the likely NICE recommendations?**

56 responses answered this question. There was generally positive support for the proposed measures for modifying physical activity through the environment and promotion of casual opportunities for physical activity. Proposals for walking, cycling and active travel plans were well supported, but these might not be appropriate for all. Suggestions for going further included:

- physical activity in the workplace
- active living for both younger and older people
- maximising opportunities for active design

**Q15 *Should a Winter Health Protection Plan be a priority for the region? What elements should it contain?***

47 responses answered this question. Most were in favour of the idea that a winter health protection plan should be a priority. Elimination of fuel poverty was seen by many as a key part of any such plan. This could be taken forward by measures such as improving the fuel efficiency of homes through the use of appropriate grants and subsidy of fuel bills.

Responses also raised the need to stimulate changing attitudes and to provide clear and consistent information on countering the effects of hypothermia. Equity of access to grants and helping the most vulnerable groups were also seen to be important.

A small minority of responses said that action on climate change and planning for higher temperatures in summer should take precedence over a plan for protecting health during the winter.

**Q16 *Is an aspirational target like energy independence appropriate? What other approaches might we adopt in terms of redesigning our environment to improve health?***

36 responses answered this question. Most were positive, although recognising that energy independence was an ambitious goal. Several responses suggested that practical action in the short term should concentrate on energy efficient new and existing buildings and measures to tackle fuel poverty.

A few responses suggested that energy independence was not practicable or questioned whether it would lead to improved health.

**Q17 *Considering section 3.5 as a whole, do you consider the selected areas to be the most important in which we might act? What others might we consider?***

33 responses answered this question. Whilst generally positive about the broader actions proposed in the consultation document many suggested that some of these needed further exploration and development. Some responses suggested that the section required a clearer focus on community engagement, quality of life and actions to help vulnerable groups.

**Q18 *The set of issues listed under ‘receiving early help’ is diverse and has a stronger health care focus than other parts of this strategy – do you agree that these should be specified? What would you add to or remove from this list?***

41 responses answered this question. Most seemed to agree that it was appropriate to specify areas for ‘receiving early help’ within the health and well-being strategy. Several noted that cultural change would be required in order to encourage people to seek help at the earliest opportunity. Self-management and difficulties of overcoming low expectations in some groups was raised. Access issues for those with learning difficulties and other vulnerable groups were also highlighted.

There was some support for the idea of health-improving encounters not only in healthcare but also in community settings.

Other opportunities for early intervention and help included:

- diabetes and cardio-vascular disease
- screening, including measures to increase uptake
- podiatry, dentistry and eye tests
- support for carers

**Q19 *Do these proposals capture the key actions in support of improving mental health at a regional level? Is the focus correct? What is missing?***

61 responses answered this question. Whilst action to address mental health was seen by most as a crucial part of any health and well-being strategy, many seemed to feel that, paradoxically, this section of the consultation document was rather weak.

There was a mixed response in terms of whether the key actions in support of improving mental health had been captured, with some support for this view but several other responses suggesting that significant areas had been missed out.

Several responses suggested that the focus of this section should be on eradicating the stigma and discrimination experienced by those with mental health problems. The strategy should also address issues covering both prevention and treatment of mental ill health.

Specific areas for action included:

- explicit support for children, young people and families
- involvement of service users in planning their own care
- physical health needs of people with mental illness
- social inclusion, education and employment opportunities
- supporting emotional well-being

**Q20 Do you agree that end of life care should be a focus of a regional strategy? Are these the right commitments? What others should be included?**

47 responses answered this question. A significant majority confirmed the need for a focus on end of life care within a regional strategy for health and well-being. Some responses suggested that, whilst this was a highly important area, it was a matter for local rather than regional action. A few others felt that “achieving a good death” was out of place in a strategy for health and well-being. A small minority felt that the terminology was offensive and disrespectful.

Several responses pointed out that end of life care was an issue for all ages and should not just be thought of in terms of terminal care for the elderly. Palliative care for children and young people was raised as a key issue.

It was also important to recognise the different settings for care of the dying, including not only hospices but care in hospitals and in the home. Responses also suggested that there was a need to provide carer and family support, including access to bereavement counselling.

**Q21 Do you agree that there should be an integrated North East approach to public health research? What specific areas of research are most urgently needed? Should there also be an integrated approach to all health care research in the region?**

This three part question was answered in part by 59 responses, almost all of which seemed to support the proposal for an integrated approach to public health research in the North East. Fewer responses answered explicitly the question of an integrated approach to all health care research, but those which did seemed largely to support this.

Several areas for research were proposed, including:

- obesogenic environments
- health needs of vulnerable young people and their families
- economic benefits to business of better health and well-being
- demographics and an ageing population
- voluntary and community sector impact on health and well-being

**Q22 *Are the Social Marketing and campaign issues listed the most important that should be pursued at a regional level? What is missing? What should not be priority?***

57 responses answered this question in a generally positive way that suggested a high level of support for the idea of using social marketing to promote health and well-being. There was a mixed response in terms of whether the proposals in the consultation document were the most important campaign issues. Suggestions for other priority areas included:

- smoking in children and young people
- changing sexual behaviour and improving sexual health
- alcohol and offending (not just violent crime)
- promotion of physical activity
- cultural and attitudinal shifts in relation to mental health, risk taking behaviour and death

**Q23 *Are the legislative objectives appropriate? What other changes to law and current practice might enhance health and well being in the North East?***

40 responses answered this question. A significant proportion of those answering this question seemed to suggest that the legislative objectives were appropriate, with only a few raising doubts about these. A wide selection of other potential areas for changes to law and practice was offered, including several related to further restrictions on the purchase, advertising and use of alcohol and tobacco.

**Q24 *Are the proposed NHS Service changes justified and necessary?***

35 responses answered this question, with the majority appearing to support the NHS service changes outlined in the consultation document.

**Q25 *Do you agree that there should be clear regional spending targets for health and well being? Should these apply across sectors?***

47 responses answered this question. The majority seemed to support the proposal for clear regional spending targets for health and well-being. Some said that further clarification was required on how these spending targets might take account of local needs and offer flexibility to fit specific local requirements. There was some support for spending targets for health and well-being to encompass the work of community and voluntary organisations, particularly if this might lead to fewer restrictions on using statutory funding to support the 3<sup>rd</sup> sector.

**Q26 *In order to be effective, a regional health and well being strategy must influence all other planning processes, do you think that this can be achieved?***

57 responses answered this question. There was strong support from most for the concept of a regional health and well-being strategy with influence over other planning processes. Whilst endorsing this, however, many responses recognised that achieving such a level of influence would be a difficult task. Suggestions for opportunities that might assist with this included: better partnership working by NHS bodies; influencing local area agreements and the work of local strategic partnerships; and involvement in the development of an integrated strategy for the region.

**Q27 *Do you agree with the set of targets and standards in section 4.8? What is missing? What should not be included?***

51 responses answered this question. There was a mixed response to the targets and standards set out in the consultation document, with strong support from some, more ambiguous answers from others and clear objections to specific targets in a few responses. One response said that the list of targets was too long and should be reduced to identify a few major priority areas.

Several additional areas for development of standards and targets were proposed, including:

- poverty
- depression and anxiety in older people
- diabetes
- mental well-being
- uptake of warm front grants
- domestic violence

**Q28 *Is this governance framework appropriate? Will there be sufficient and appropriate representation for concerned parties?***

53 responses answered this question. There was significant support for the proposed governance framework. Many of the positive responses raised issues about levels of engagement of different agencies, including the extent to which the views of local authorities, 3<sup>rd</sup> sector organisations, universities and service users would be represented. Some responses stressed the need for full engagement of all partners to develop common ownership.

A few responses said that the proposed governance framework was too heavily biased toward the health sector and needed to be broader based.

**Q29 What are your thoughts on the branding and public recognition of the office of the Regional Director of Public Health? Would it be useful in improving health and well being to build 'brand recognition' of its roles and functions?**

With just 32 responses providing an answer this was one of 2 questions with the lowest level of response. In general there was support for enhanced branding of, and a higher public profile for the office of the Regional Director of Public Health if this could lead to a stronger influence over regional policy and other key stakeholders. Some responses said that leadership could be strengthened if there was better recognition of the role of the RDPH and Directors of Public Health at local level. A few raised concerns about the potential for perceived 'waste' of resources and poor value for money.

**Q30 To enhance recognition of the role and identify of a regional office and programme to press for improvement of health and well being, should the title 'Regional Medical Officer' be used to signal the link with the role of the 'Chief Medical Officer'? Is there a better that could be used? Or is Regional Director of Public Health sufficient?**

This question was also answered in just 32 responses. Those which did answer gave a strong and unequivocal majority view that the title 'Regional Director of Public Health' was the most appropriate one to use. A minority of responses said that 'Regional Medical Officer' would be better and two suggested the alternative title of 'Regional Director for Health and Well-being'.

**Q31 Is a three yearly cycle of review for a health and well being strategy appropriate?**

53 responses answered this question, with the majority confirming that a three yearly cycle of review was the most appropriate. A few responses suggested that - in addition - an annual refresh or progress report would be appropriate.

**Q32 Are the provisional timeline targets right? What others should be included or used instead of these? Are the timings realistic or too ambitious?**

This complex multi-part question was answered in part by 42 responses. Some indicated clearly that these were the right targets but several other suggestions were put forward, including targets on: exercise participation; sexual and reproductive health; physical activity and early cancer care.

Some suggestions for retiming of targets were made. A few responses suggested that the existing targets could be more ambitious. A few others felt that setting targets beyond 2015 was not appropriate.

### ***Any other comments***

46 responses provided comments in addition to the points they had raised in relation to specific consultation questions. In several cases this section was used to reiterate or develop points already raised elsewhere. Others responses provided additional positive comments on the consultation document as a whole.

A further 6 responses did not specifically address any of the questions raised but provided detailed commentary on specific issues related to:

- alcohol, worklessness and community cohesion
- issues for people with learning disabilities
- perceived complexity and use of jargon and other terminology in the consultation document
- major recurrent themes and key issues for ageing and older people
- self-responsibility for health and well-being
- improving the built environment and active travel

Keith Aungiers  
Acting Head of Public Health Strategy and Intelligence  
25 January 2008

## **Appendix 1: Consultation Opportunities facilitated by Public Health North East**

<b>Date</b>	<b>Description</b>	<b>Details</b>
29/10/2007	Board report	Board meeting, Government Office for the North East
01/11/2007	Face to face meeting	Consultant in Palliative Care
12/11/2007	Face to face meeting	ONE North East
22/11/2007	Board report	Board meeting, NHS North East
23/11/2007	Briefing	REFIT, ONE North East
23/11/2007	Briefing	Tees Valley & Community Safety Team, Government Office for the North East
27/11/2007	Briefing	TUC Regional Policy Forum
28/11/2007	Consultation event	Association of North East Councils
29/11/2007	Consultation event	Gateshead Health Group (Learning Disabilities)
30/11/2007	Workshop sessions	VONNE Annual Meeting and Conference
03/12/2007	Briefing	Children and Learners Group Team Meeting, Government Office for the North East
04/12/2007	Consultation event	VONNE (3 <sup>rd</sup> sector organisations)
06/12/2007	Briefing	Natural England, Green Exercise Group
06/12/2007	Consultation event	Years Ahead and Age Concern
06/12/2007	Briefing	Chief Executives, Tees Valley Local Authorities
10/12/2007	Consultation event	Tees Primary Care Trusts (North)
14/12/2007	Board report	North East Health Forum

## Appendix 2

### Responses to Consultation

Ref	Position/Organisation	Individual Capacity
A01	Private Individual	✓
A02	Volunteer Care Service	✓
A03	Details Withheld	✓
A04	Consultant in Palliative Medicine	✓
A05	North East SHA (Dental Lead)	
A06	Consultant in Palliative Medicine	✓
A07	North East Community Forests	
A08	Private Individual	✓
A09	Care Services Improvement Partnership	✓
A10	Northern CFS/ME Clinical Network	
A11	Cycling England	
A12	Consultant Paediatrician	✓
A13	Occupational Health Service, Durham County Council	
A14	Strategic Housing Service, Newcastle City Council	
A15	Job Centre Plus	
A16	North East Public Health Observatory	✓
A17	Consultant Paediatrician	✓
A18	North East Public Health Observatory	
A19	Regional Health in the Workplace Group	
A20	Public Health Trainees Group	
A21	North Tyneside Primary Care Trust	
A22	Voluntary Sector Advisory Group, Gateshead Voluntary Organisations Council & Mental Health North East	
A23	Gateshead Health Group	
A24	Community Energy Solutions (CIC) Ltd.	
A25	Health Protection Agency	
A26	Northumberland Citizens Advice Bureaux	
A27	Northumberland, Tyne and Wear Public Health Network	
A28	Government Office for the North East Children and Learners Group	✓
A29	Job Centre Plus	
A30	Sport England	
A31	Gateshead Advocacy Information Network	
A32	North East Chief Environmental Health Officers Group	
A33	National Offender Management Service	
A34	Tees Public Health Directorate	
A35	Northern TUC	

<b>Ref</b>	<b>Position/Organisation</b>	<b>Individual Capacity</b>
A36	Natural England	
A37	Community Action on Health	
A38	Care Services Improvement Partnership	✓
A39	North East Domestic Energy Forum	
A40	Tees Valley Rural Community Council	
A41	Tees Public Health Directorate	✓
A42	NEA (National Energy Action)	
A43	Health & Well-Being Review Committee, Sunderland Council	
A44	School of Health, Northumbria University	
A45	Government Office for the North East, Community Safety & Tees Valley	✓
A46	West End Health Resource Centre	
A47	Newcastle Healthy City	
A48	Association of North East Councils	
A49	Age Concern (North East)	
A50	Health Improvement Solutions/THPN	✓
A51	North East Region, Cruse Bereavement Care	
A52	Northumberland Stop Smoking Service	
A53	Public Health Department, Northumberland Care Trust	✓
A54	Forestry Commission	
A55	Regional STI Action Group	
A56	Children's Services, Newcastle City Council	
A57	Northumberland Mental Health Promotion Steering Group	
A58	Newcastle Learning Disabilities Partnership Board	
A59	Living Streets	
A60	South Tyneside Strategic Partnership	
A61	County Durham and Darlington Primary Care Trusts	
A62	Wolfson Research Institute, Durham University	
A63	Public Health North East	✓
A64	Voluntary Organisations Network North East	
A65	Northgate Hospital Committee Group	
A66	Learning Disabilities Directorate, Northumberland Tyne and Wear NHS Trust	
A67	Legal and Democratic Services, North Tyneside Council	
A68	Attend Rights to Warmth	
A69	Gateshead Partnership Board	
A70	North of Tyne Professional Executive Committee	
A71	Middlesbrough Community Network	
A72	Elders Council of Newcastle	
A73	Northern Initiative on Women and Eating	

<b>Ref</b>	<b>Position/Organisation</b>	<b>Individual Capacity</b>
A74	North East Chamber of Commerce	
A75	Health Protection Agency, Consultants/ Specialists Group	
A76	St Cuthbert's Hospice	
A77	Institute of Health and Society, Newcastle University	
A78	Physical Activity Steering Group	
A79	Institute of Health and Society, Newcastle University	
A80	Partnership Board of Years Ahead	
A81	Seroptimist International Great Britain	
A82	Gateshead Public Health Partnership	
A83	Local Engagement Board	
A84	Adult and Children's Services	
A85	Sustain	
A86	The North East Teaching Public Health Network	
A87	Northumberland Care Trust & Northumberland Tyne and Wear NHS Trust	
A88	North Tyneside Older People's Forum	✓
A89	North Tyneside Council	
A90	Sunderland Teaching Primary Care Trust	✓
A91	North East Assembly	
A92	North East Public Protection Chief Officers Group	
A93	Living Streets Northumbria	✓
A94	Campaign to Protect Rural England	
A95	Sustrans	
A96	Gateshead Healthier Communities Group	
A97	Older People's Partnership Board Northumberland	✓
A98	Arts Council England, North East	
A99	South Tyneside Local Engagement Board	
A100	HealthNet	
B01	Fresh - Smoke Free North East	
B02	NHS South of Tyne and Wear	
B03	Newcastle PCT & Newcastle City Council	✓
B04	Food Quality and Health Research Group	