

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

**Full Text of Responses
to the Consultation**

Questions 17 to 24

February 2008

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Q17	<p>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?</p>
	<p>[Louise Wilson A08 - Individual] Town planning and the structure of local communities – consider these impacts on health and well being.</p> <p>[Mike Lauerman A09 - CSIP - individual] Yes; should include Child and Adolescent Mental Health Services</p> <p>[David Chappel A16 - NEPHO - individual] We need to engage with transport and energy over the longer term.</p> <p>[David Chappel A18 - NEPHO response] We need to engage with transport and energy over the longer term.</p> <p>[Bharat Sibal A20 - Public Health Trainees Group] There are well rehearsed arguments and enough evidence on the relationship between these factors and health and wellbeing exists. What is perhaps more important is how the regeneration agenda and strategy support individuals and communities in maximising health gain. For example:</p> <ul style="list-style-type: none"> • Making healthier choices easier by improving access to healthier diets in communities with poor access to fresh foods because of availability of and distance to shops; • Providing additional financial and other support (additional to national funds and benefits) to help older people and poorer families keep warm in the winter. • Increasing access to good quality and affordable social housing for families with young children and young adults entering into employment. • Providing and improving access to community based facilities for sports and physical activities. <p>[Vivien Hollyoak A21 - North Tyneside PCT] Because the strategic aims are unclear, the selected areas lack coherence. They should be based upon a strategic assessment of need and evidence of impact to achieve greater equality of health outcome.</p> <p>[David Lacey A24 – Community Energy Solutions Ltd] The selected areas give grave concern as they fail to prioritise the simple, straight forward and cost-effective measures that existing agencies champion and instead focus far too heavily upon those that offer minimal hope to the vulnerable. It must be stated that the report is SERIOUSLY flawed in this regard. In 3.5.2.42 (page 34) reference is made to the poor state of the Region’s housing stock. In respect of thermal efficiency. Having made this point – which is certainly true – it then fails to propose a solution and instead drifts off into an aimless discussion about solar thermal and photovoltaic technologies, neither of which can provide cost-effective home heating for the fuel poor. In 3.5.43 the suggestion that the Government funded Warm Front scheme should be more actively promoted. However many of the fuel poor/vulnerable are not Warm Front eligible as they are not on qualifying benefits, so pinning too much hope upon this route to improved health will exclude many of the most deserving cases. A campaign aimed at the fuel poor / vulnerable needs a wider focus.</p> <p>3.5.46 proposes regional targets for photovoltaics. It should have come to the notice of the authors of this section that the North East is not blessed with much sunlight in the short winter days and in any case the payback on such devices is ridiculously long. Sadly no reference is made to a regional target on home insulation – a clear winner when it comes to reducing heat loss, running costs, carbon emissions and excess winter deaths. NEHIP (the North East Home Insulation Partnership) has been formed to promote the idea that all homes in the region should be insulated. The report should give a massive boost to this existing campaign and ditch the existing far-fetched references to solar technologies.</p> <p>[Rachel Turnbull A26 - Northumberland CAB] Quality of housing</p> <p>[Martin Shaw A36 - Natural England] The strategy needs to address the issue of climate change. In particular, we can use ‘green infrastructure’ and the design of our urban environments to mitigate the effects of climate change, delivering health and wellbeing gains for the region.</p> <p>[Neil Johnson A38 - CSIP - Individual] I think that reference should be made to the impact that arts and culture can have on general health and wellbeing</p> <p>[Janice McColm A40 - Tees Valley Rural Community Council] The selected areas are important but it would be a mistake to miss the opportunity of joint working with the voluntary sector who have built an expertise and have closer links to the community than most GP and health services before people become ill.</p> <p>[Ann-Marie Gibson A42 - National Energy Action] Consideration should be given to any regional promotion of Warm Front and other grant assistance as experience suggests that pressure on these services is always highest during the colder months (October – March), which results in lengthy waiting times for householders</p>

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	<p>before any measures are installed in their homes. A promotional campaign in the Spring may be effective since it is likely that waiting times during Spring and Summer will be shorter. This issue should be discussed further with eaga plc and other partners, who will be able to enter into more detailed dialogue on this issue. It is likely that the same considerations will apply to Warm Zones and other energy efficiency programmes. The NEHIP may be able to offer an overall summary of this issue and provide guidance on an appropriate schedule for any promotional campaign. NEA is concerned that the promotion of Warm Front should not be seen as the only response in dealing with cold homes because Warm Front does not meet the immediate needs of those at risk of winter health problems. A more comprehensive approach is needed for fast-track provision that can deal with housing repairs, under-occupancy issues, income maximisation, aids and adaptations, etc. as part of a care package. It may be more appropriate for the health sector to respond to winter pressures in a more co-ordinated and independent way over and above existing provision, NEA recommends that a discussion should take place with current partners involved in delivering fuel poverty/energy efficiency schemes to agree the best way forward for the region.</p> <p>As outlined above in the response to question 15, consideration should be given to targets on income maximisation as a means to tackling fuel poverty. A programme combining action to improve thermal insulation and the efficiency of heating systems and to ensure that the most 'vulnerable' householders in the region are claiming all of the welfare benefits to which they are entitled represents an effective affordable warmth package. NEA's experience is that householders considered to be 'vulnerable' are those most at risk of fuel poverty, that is, households containing babies, young children, older people, people with a chronic illness and/or disability, and the long-term unemployed (who often have a higher heat demand because they spend a great deal of time at home).</p> <p>[Chris Drinkwater A46 - West End Health Resource Centre] Think this is an area where the public sector could lead the way in ensuring that all public sector buildings were as energy efficient as possible. They should also be reporting the savings made.</p> <p>[Karen Evans A49 - Age Concern and Years Ahead] Yes, we consider the selected areas to be very important in which we might act.</p> <p>Our recent consultation event highlighted that the title of this section was thought to be confusing and too long. Most discussion groups broke it down into its constituent sections and in addition to previous comments on education, environment and physical activity, and excess winter deaths, the following comments were made</p> <p>Environmental Factors – many older people live in older accommodation which is poorly insulated. Warm Zone was welcomed.</p> <p>Proposal - for Warm Zone to cover the whole of the North East.</p> <p>One discussion table at our consultation event suggested that Environmental and Social factors should be amongst the key focuses of the strategy. The role of carers should be recognised and organisational cultural change should figure highly.</p> <p>Other areas that we might consider in this section are:-</p> <ul style="list-style-type: none"> • Local authorities need to be explicit about their contribution towards prevention. • Income – has a big impact on lifestyle and therefore health – It is important to make people aware of what is available and what their entitlements are. • 'Supported Living' needs promoting, particularly for very elderly and vulnerable people who don't want to go into residential care. Supported living is seen as an essential service. There needs to be an Increase in flexibility in how we deliver services – e.g. not enough places / resources on luncheon clubs – it shouldn't be a lottery. Need to meet low level needs <p>For further suggestions see Appendix 1</p> <p>[Richard Briggs A51 - Cruse Bereavement Care] We would support the selected areas.</p> <p>[Richard Pow A54 - Forestry Commission] Climate change is an area that the strategy needs to give recognition to. It is likely that winters in NE England will become milder and summers warmer with more frequent and severe heat waves and droughts. The key action at this stage is to begin to prepare for these changes in terms of the likely impact on human health and well-being. Greater green infrastructure provision and forward thinking urban design (planting of more shade giving urban trees for example) should be</p>

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	<p>encouraged as adaptation measures.</p> <p>[Cynthia Games A59 – Living Streets] Promotion of health support for an ageing population could be better highlighted. Living Streets is already taking the lead in promoting walking as an everyday lifestyle choice. Among other campaigns, Living Streets co-ordinates:</p> <ul style="list-style-type: none"> • the national Walk to School campaign (which is already successfully used by 82% of Local Authorities in England at primary school level and will expand into secondary schools in 2008) • Walking Works • Fitter for Walking (which launches in 2008) <p>These campaigns are having a demonstrable impact on hearts and minds across the country and it is hoped to sustain this success, subject to funding and partnership working arrangements</p> <p>[Tricia Cresswell A61 - Durham & Darlington PCTs] Yes.</p> <p>Leading a region wide social marketing campaign, particularly focused on the links between mild hypothermia and fuel poverty.</p> <p>Risk taking behaviour particularly among young people's use of alcohol.</p> <p>[Tim Blackman A62 - Wolfson Research Unit] Designing physical activity into the environment</p> <p>[VONNE A64] It is noted that section 3.5 has a broad remit, and potentially a separate strategy could be produced for each selected area with regard to the health & well-being agenda.</p> <p>We would welcome a greater focus on the provision of affordable and lifetime homes, particularly with regard to new build standards and house size, and the issues of supported and independent living. VONNE recommend that lobbying is undertaken to ensure new homes are not only designed with today's regional population in mind but with also a view to future populations. It is predicted that the North East will have an ageing population profile over the next 25 years.</p> <p>An area which we consider is missing is around well-being, and more importantly people's enjoyment. We would therefore seek inclusion of actions around people's access to leisure and recreational opportunities.</p> <p>Actions could include research into the availability of leisure and recreational opportunities, appropriate lobbying to ensure affordability and access for all, and targets around increasing people's enjoyment. VONNE would welcome further regional discussion and debate on this area.</p> <p>[Dave Parkin A67 - Wallsend Town Hall] Agree</p> <p>[Angus Anderson / Arthur Probert A68 - Attend Rights to Warmth] With the proviso that the Winter Health Protection Plan is extended to cover the broader impacts of cold, we would accept the selected areas as the most important in which there might be action.</p> <p>[Craig Duerden A71 – Middlesbrough Community Network] The role of assistive and other technology may be a factor to consider both now and in the future. This could potentially have an impact on reducing the causes of death and ill-health (mental health) in a number of ways ranging from early alarm rising for certain conditions to ensuring people with certain illnesses and impairments can be socially include and not isolated.</p> <p>[Joanne Lavender A74 – North East Chamber of Commerce] There is little mention of addressing the link between health and employments or health in the workplace. Employment is a large part of an individuals life cycle and so it is important that this is part of the strategy.</p> <p>[Martin White A77 - Institute of Health & Society] Economic development, greater education attainment, increased sustainability and reduced obesogenicity should be our headline targets.</p> <p>Preventing 1100 excess winter deaths may not seem like a high priority in terms of disease burden, but it may be a potential 'easy win', and there may be significant additional benefits in terms of reduced morbidity (i.e. the deaths represent the tip of the iceberg). There are also human rights issues. However, see 'further comments' below on other priorities.</p> <p>Emphasis of the intervention needs to be on energy efficiency, since burning more fossil fuel would be less sustainable.</p> <p>Think this is an area where the public sector could lead the way in ensuring that all public sector buildings were</p>

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	<p>as energy efficient as possible. They should also be reporting the savings made.</p> <p>[Ruth Stevens A78 – Physical Activity Steering Group] Think this is an area where the public sector could lead the way in ensuring that all public sector buildings were as energy efficient as possible. They should also be reporting the savings made.</p> <p>[Alma Laing A83 - Local Engagement Board Gateshead PCT]</p> <ul style="list-style-type: none"> • Clarity on broader action • Partnership working (health and social care) • Governance Process needs further work <p>[Steve Brooker A91 - NE Sustainability Officers] Only if you act within the existing processes that exist in the region. This will include working with Energy Savings Trust, National Energy Action, Community Energy Solutions and Domestic Energy Solutions.</p> <p>It would also be beneficial to work through the Local Strategic Partnerships, influencing Local Authorities to include energy efficiency targets in their Local Area Agreements.</p> <p>Think this is an area where the public sector could lead the way in ensuring that all public sector buildings were as energy efficient as possible. They should also be reporting the savings made.</p> <p>[Joyce Leeson A93 – Individual] See Q16. ‘Quality of life’ components need more research as does how to make components available to all including old, frail, disabled people, carers, isolated people, those with chronic health problems esp mental health etc.</p> <p>[Joanne Lavender A95 - NE Chamber of Commerce] There is little mention of addressing the link between health and employment or health in the workplace. Employment is a large part of an individual’s ‘life cycle’ and so it is important that this is part of the strategy.</p> <p>[Gateshead Healthier Communities Overview and Scrutiny Committee on Health Inequalities Core Group A96] Community engagement needs to be considered as well as social marketing. If there are not locally accessible activities and ways for people to get involved any form of marketing is less effective. The large scale cultural change envisaged will require front line work with people in deprived communities as well as deft political leadership.</p>

Q18	<p>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?</p>
	<p>[Janine A Ogilvie A07 – North East Community Forests] I would add culture, and reword catching cancer early, to detecting cancer early.</p> <p>[Louise Wilson A10 – Northern CFS/ME Clinical Network] Yes. CFS/ME is a condition of strategic social importance, impacting across the age continuum from children and young people to adults. Evidence suggests that early intervention leads to improved prognosis and outcomes, often at a huge cost impact to the individual and local services. It is also the single most significant reason for prolonged absence from schools amongst the under 16s (reference, Dr Esther Crawley) which has a prolonged ongoing social, financial, community, family and individual cost attached. This condition should be included explicitly, given its cross cutting nature of this strategy’s headings – early intervention, education, activity, family/networks, mental health, health and wellbeing and so on.</p> <p>[Jan Welbury A12 – consultant paediatrician – individual] I would add early and timely access to specialist care for children, because it can make a difference</p> <p>[Brian Hedley A14 – Newcastle CC Strategic Housing Service] Yes. Mental Illness should be added as an ‘early intervention’ issue.</p> <p>[David Chappel A16 – NEPHO – individual] Yes. It is important that these are in the strategy. I think immunisation should be prominent (childhood and ‘flu).</p> <p>[Karen Horridge A17 – consultant paediatrician – individual] I would add early and timely access to specialist care for disabled children, because it can make a difference.</p> <p>[David Chappel A18 – NEPHO response] Query regional input/role delivered at local level, evidence base and regional role not clear.</p> <p>[Bharat Sibal A20 – Public Health Trainees Group] In terms of raising awareness of seeking help early it is appropriate to concentrate efforts on areas of significant morbidity and mortality such as cancer and stroke, both of which are conditions that impact on all our lives at some time and to which the population can relate. As a starting point cancer and stroke provide a significant challenge. It follows that once encouraged to seek timely care that treatment and rehabilitation services are of the highest standard.</p> <p>[Vivien Hollyoak A21 – North Tyneside PCT] While health improving opportunities should be incorporated into every health care role, the implementation and promotion of this principle should be extended to partners in social care, and third sector providers.</p> <p>[Elaine Richardson A29 – Jobcentre Plus NE Region] Agree</p> <p>[Caroline Airs A31 – Gateshead Advocacy Information Network]</p> <ol style="list-style-type: none"> 1. Any “social marketing” campaign must ensure that it reaches and is specifically directed at the so-called “hard to reach” groups. Indicators should include indicators for specific groups, so as to address health inequalities as between different groups. (For example, indicators to ensure early diagnosis of cancer amongst people with learning disabilities) 2. Screening facilities must be made accessible – e.g. disabled women sometimes have difficulty accessing cervical screening; and breast screening facilities are not always wheelchair-accessible 3. Staff must be trained to ensure that members of all minority groups are made to feel welcome and comfortable in all health settings, and that their needs are identified and met 4. Advocacy can play a significant role in ensuring that vulnerable individuals are able to access health services at an early stage, and in helping to make more health service encounters health promoting encounters. Any action plan should include supporting the development of advocacy services in the North East. <p>[Barbara Harrison A33 – National Offender Management Service] NOMS NE supports the principle of early intervention and agrees that it is sensible to prioritise key issues.</p> <p>[Hartlepool & North Tees Workshop A34 annex] Stroke</p> <ul style="list-style-type: none"> • More awareness is required of the symptoms as well as the risk factors involved. • Social marketing to inform people of signs, and importance of recognising symptoms early and getting earliest specialist intervention. In particular, residents’ in disadvantaged areas self esteem and “Loss of Control” to empower the person to value health and not just accept illness etc

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	<ul style="list-style-type: none"> • stroke had not been seen as ‘sexy’ unlike cancer and heart attacks for instance, both of which have had massive awareness raising campaigns and are now thought to be well ingrained in the public consciousness. • Stroke has also not received the same amounts of funding including charitable funding and this needs to be rectified. • Good opportunity for social marketing to be able to aim appropriate messages at everyone tailored to specific groups when required but without scaring people which sends them into denial and panic. • 3.6.6 is absolutely fundamental if we are to reduce morbidity and mortality connected with stroke. • Need to be able to get message to males or the “macho male” will not “hear “the message. • Some people are fearful of dealing with professionals, or of troubling a busy doctor “in case it’s nothing”. • Training of more first line responders is important • Using existing population data especially from GP practices to inform action was highlighted • Workforce development/training so that staff see people holistically. <p>Cancer</p> <ul style="list-style-type: none"> • More active dissemination of information is required as currently this is felt to be patchy depending upon the services available in different areas. • Promotion/education re screening programmes and benefits of early intervention needs to be a social marketing exercise. • Identify which areas of community need to take up screening – ensure understanding, how to access etc • Body awareness and check in men especially need to be promoted. • Peer support e.g. for young girls and cervical screening • Identify which areas of community need to take up screening –ensure understanding, how to access etc • The use of leaflets is frowned upon by some organisations and more active information dissemination is required. However, leaflets should not be disregarded e.g. while waiting for appointments at schools or in GP practices. • Access to services can be difficult e.g. opening hours for Well Man clinics which are only available during office hours. This might prevent someone getting a ‘niggling’ issue checked out and waiting until it becomes more serious or important with perhaps poorer outcomes. • Health promotion messages should be introduced at urinals for men to follow up the success of the back of the toilet door health promotion messages for women. • Promote “life check” – go to GP • Extend out-of-hours services • Promote Life Check age 40+ <p>Bowel screening</p> <ul style="list-style-type: none"> • Screening may result in only the worried well or those who are serious about or interested in their health taking up this service. The Regional Office could examine the results of this screening service and use social marketing to target those who are not taking up screening. • Promoting cancer awareness to more male/lifestyle links i.e. alcohol/tobacco substance misuse/hard to reach groups “BME – Homeless” • Cancer register – does not indicate average stage of diagnosis – this would help measure progress of an early intervention in the future. • Awareness via big employers’ workplaces <p>[Leah Blacklock A37 – Community Action on Health] In terms of catching cancer early, in Newcastle CAO is involved in the Healthy Communities Collaborative project – Promoting Earlier Presentation of Cancer Symptoms and this project is also running in North Tyneside, South Tyneside, Gateshead and Sunderland. The work in this area will certainly involve social marketing and the regional strategy could look to continue and extend the work the project has begun as it is only funded for two years.</p> <p>Statistics to chart the progress of this project have been problematic so we would certainly agree with the proposal around the indicator.</p> <p>CAOH agrees with the other proposals suggested and we again would highlight the importance of education and awareness in a community setting.</p>

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	<p>[Janice McColm A40 – Tees Valley Rural Community Council] Education is the key, many people have a stoic don't want to bother anyone attitude.</p> <p>Getting the information and help into the community especially to the hard to reach groups and not just the groups that ask for the advice/information will help to change cultural attitudes to all aspects of health and the ageing process.</p> <p>There needs to be more ‘joined up’ working across agencies/voluntary sector working with communities to make sure that all areas are being addressed and accessed and to avoid duplication.</p> <p>[Peter Heywood A41 – Middlesbrough PCT – Individual] May be included elsewhere but was CVD missing? Primary prevention registers for CVD in all General Practices</p> <p>Social marketing research to get the public and patients to drive the system as well as the clinicians. E.g. a patient turns up to the GP saying, ‘I’ve turned 40 and realise that I need a CVD risk assessment’ (for example) Demand will change delivery.</p> <p>[Chris Drinkwater A46 – West End Health Resource Centre] Much of this section is about cultural change in patients and the public and professionals. Crude incentives like rapid access do not always work – there is evidence that rapid access for breast lumps has increased numbers coming forward with benign disease without impacting on delays in breast cancer presentations. Social marketing should help to address this.</p> <p>Equally before rushing to an action plan for delivering health improving encounters we should stand back and explore in greater depth the barriers and enablers to health improving encounters.</p> <p>[Heidi Jobling A47 – Newcastle Healthy City Project] Yes – the most significant area is getting people to a) recognise health issues and b) to change the culture of consulting GP's/Health professionals.</p> <p>[Karen Evans A49 – Age Concern and Years Ahead] Yes, Age Concerns in the North East and the Regional Forum on Ageing ‘years ahead’ agree that our main health concerns for the region should be specified.</p> <p>We would recommend the following services are vital when considering ‘receiving early help and should be included in the strategy or an action plan that is produced when the strategy is agreed:-</p> <p>The Strategy omits mention of key health services that provide help to older people at the earlier opportunity by preventing them becoming ill or in discomfort. Three examples of this are:</p> <p>Podiatry – it feels as if the NHS has abrogated its responsibility for providing podiatry by providing so little that older people use private podiatrists. This is a disincentive to access podiatry, which is a significant factor in maintaining older people's mobility. It is acknowledged that the NHS offers podiatry where there is clinical need. It does not offer a “cosmetic” chiropody service. In between these extremes there is an area of need e.g. for older people who cannot cut their toenails which can be addressed by training footcare assistants and staff in care homes, those providing care at home etc. However, as the experience of Age Concerns in the region show, often for the lack of small amounts of funding, volunteers and care staff are unable to provide basic foot care to older people.</p> <p>Dentistry – there have been significant changes in NHS dentistry with fewer NHS dentists and a system which does not incentivise dentists to see people regularly for checkups. However, having problems with oral health affects eating and nutrition as well as being painful. Should older people get free annual check-ups?</p> <p>Eye tests – it is good that older people receive free eye tests. However, there is an anomaly. If you want an eye test that will lead to you having glasses, it is free. If your eye test leads you to buying contact lenses, it is not free because it is deemed that you have chosen contact lenses over glasses. Although this is correct, it should not be that older people who prefer to wear contact lenses are penalised in terms of their eye tests. These tests are also about glaucoma.</p> <p>Cancer – we welcomed the extension of breast screening to over 60s a few years ago. However, why stop at 69? Although women can request a screen after that, it should be that they are invited for screening too. The same goes for prostate cancer, where the screening stops at 69.</p> <p>Medical checks for over 70s – this is supposed to be a national programme whereby GPs conduct medical checks for over 70s. However, it is being implemented patchily across the region.</p>

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	<p>Self Management – Getting the responsibility of the individual back onto the agenda and considering individual responsibility versus community responsibility. ‘Helping people to help themselves’: these would be useful at a regional level and include the statutory and services.</p> <p>Further, people need to know when to ask for help. Older old people tend to have lower expectations; “don’t want to be a nuisance”; fear victimisation if they bother the doctor too often. Is co-morbidity tackled effectively? Are arrangements for Very High Intensity Users effective throughout the region?]</p> <p>The role of Carers – The role of carers and the support they need is particularly important, perhaps especially at end of life. Health and social care could not cope without the huge input of carers and there is a huge need to recognise this.</p> <p>For further suggestions see Appendix 1</p> <p>[Ceri Mather A50 – Health Improvement Solutions / TPHN] Delayed conceptions</p> <p>Counselling and CBT</p> <p>3.6.9 requires a major training programme. ALL NHS staff should be trained in brief interventions and motivational interviewing this should happen in all undergrad studies and be appraised and topped up throughout career, but we should also be training LA H&SC staff, school staff, vol sector etc</p> <p>[Richard Briggs A51 – Cruse Bereavement Care] We agree the basis of this section. However with reference to Figure 6 we would make the point that matters relating to death occur very early in life and is not covered only by “End of life care”. Our work in bereavement care has shown very clearly that bereavement support to people of all ages encountering death is important to enable them to return to normal productive life as soon as possible and, in cases of traumatic death, can help to reduce cases of suicide.</p> <p>[Tricia Cresswell A61 – Durham & Darlington PCTs] Useful to have a clear indicator as to where this area sits within the bigger picture, for example, will there be a suggested spend set against these issues, and if so, what is this likely to be?</p> <p>[Tim Blackman A62 – Wolfson Research Unit] Yes, improving clinical practice to deliver health improvement and narrow health inequalities should be an important part of the strategy. There should be stronger monitoring of clinical effectiveness in this respect and a more extensive discussion of the role to be played by primary care services in proactive case finding and assessment for the major causes of premature death and morbidity. This should also include an expansion in the public health role of pharmacies where appropriate</p> <p>There is increasing evidence that early intervention in psychosis reduces long term disability (good Scandinavian evidence on public awareness campaign). A public health approach to early detection of psychosis, including a media campaign and social marketing techniques, could have direct preventive effects and help to reduce stigma and discrimination (there are small scale initiatives of this kind in the region, but it needs joining up and resourcing).</p> <p>[Madeleine Johnson A63 – PHNE – Individual] Reducing uptake for national screening programmes is a significant issue across the North East. For cervical screening, we are currently carrying out some market research to understand the reasons why younger women do not attend for screening. Early data from the bowel screening programme suggests that uptake amongst men is low, and this is also likely to be an issue with the forthcoming national aortic aneurysm screening programme. I would like to see a proposal included that we carry out a social marketing project across the North East, aimed at increasing uptake for national screening programmes.</p> <p>In section 3.6.9, the emphasis should be on “health” encounters, rather than “health service” encounters. This would recognise the role of people such as health trainers. The role of the workplace as an environment for delivering health promoting encounters should also be emphasised.</p> <p>[VONNE A64] Although we recognise the inclusion of a social marketing campaign which promotes cancer awareness, we are conscious of a number of campaigns being undertaken nationally which impact on this area. We propose that a more beneficial action would be to undertake region wide research into why people fail to seek help for serious problems sufficiently early. This research could then form the basis of a social marketing campaign to address the key issues.</p> <p>Receiving early help should be broadened to include appropriate help and for as long as required. We would</p>

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	<p>also welcome the inclusion of the recognition of the differences between genders in this area.</p> <p>We welcome the proposal for an action plan that every health service encounter should be a health promoting encounter. This needs to be combined with an education programme for health professionals around issues such as mental health and obesity, etc. It is important that health professionals understand the complex issues that surround these areas. For example, Dentists and optometrists may benefit in an understanding of some of the common issues and symptoms surrounding depression, and may be able to make an appropriate health intervention.</p> <p>VONNE would also wish to see specific inclusion and reference to carers both in terms of the support they require and the support they provide. Greater education and information provided to health and care professionals on the issues faced by carers may help support their role and maintain the carer’s health and well-being.</p> <p>[Dave Parkin A67 – Wallsend Town Hall] Agree. Additional publicity on benefits of early presentation and survival rates to minimise impact of cancers etc</p> <p>[Angus Anderson / Arthur Probert A68 – Attend Rights to Warmth] The stronger health care focus seems to be a consequence of the examples given. However, we note that both catching cancer and surviving stroke are looking for changes in public perceptions. We would advocate that staying warm and managing the cold need to be considered in the same way, so that people will take action to gain the assistance available and no longer live in conditions that induce mild hypothermia.</p> <p>[Craig Duerden A71 – Middlesbrough Community Network] In terms of stroke under the terms of the National Service Frameworks for Long Term Neurological Conditions (NSF), there is a growing tendency to ‘shift’ care provision for Stroke to the terms of the Older Persons NSF.</p> <p>This is inappropriate to service design and provision.</p> <ul style="list-style-type: none"> • After coronary disease, stroke is the 2nd leading cause of death and lead disability in the UK. • 25% of those who have a stroke are under 65 yrs of age • 25% of all stroke patients also develop epilepsy (Source – National Society for Epilepsy). • Patients report a pronounced lack of awareness amongst GP’s when a patient has dual conditions, such as stroke and epilepsy or about contra-indicative drug reactions prescribed for 2 or more conditions. • Concern has been raised over the frequency of prescribing ‘front lone’ drugs for the epilepsy that exacerbates the effects of the stroke • Increase utilisation of stroke units for care of patient’s leads to better service outcomes, yet, stroke units are chronically under skilled and staffed, heavily reliant of the voluntary sector. • As life span increases there will be a significant rise in the incidence of Stroke and Epilepsy with professional education, skill and information being vital for future service delivery. <p>In terms of other areas men’s health is not addressed and is an issue that is becoming more important in a number of areas/</p> <p>The health improvement element is far too small in comparison to the other proposals when this may be the greatest opportunity to ‘receive early help’. There is also less focus on the wider determinants of health, maybe because they are not always easy to measure.</p> <p>[Martin White A77 – Institute of Health & Society] Yes, the target conditions are appropriate.</p> <p>Each intervention must be based on strong evidence.</p> <p>There was some disappointment that cardiovascular disease prevention was not included: screening all those over the age of 40 using JSB2 would have a major impact on deaths.</p> <p>This area of work should also include a focus on inequality, since there is evidence that screening uptake and outcomes are socio-economically patterned.</p>

Q18	<p>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?</p>
	<p>[Ruth Stevens A78 – NE Physical Activity Group] Much of this section is about cultural change in patients and the public and professionals. Crude incentives like rapid access do not always work – there is evidence that rapid access for breast lumps has increased numbers coming forward with benign disease without impacting on delays in breast cancer presentations. Social marketing should help to address this.</p> <p>Equally before rushing to an action plan for delivering health improving encounters we should stand back and explore in greater depth the barriers and enablers to health improving encounters.</p> <p>[J Chexal A81 – Soroptomist Society] Yes, these should be specified. They should include public awareness of the early symptoms of certain cancers; rapid access to brain scans to diagnose the exact nature of a stroke; public awareness of the early symptoms of stroke; greater awareness of the prevention of arthritis and osteoporosis; greater awareness of the early symptoms of meningitis.</p> <p>Some of this work should specifically focus on men as they are more likely than women to delay in presenting symptoms.</p> <p>For some of these issues, professional education is needed as well as public awareness.</p> <p>[Gateshead Public Health Partnership A82] Add increasing uptake of cancer screening programmes to the list.</p> <p>[Alma Laing A83 – Local Engagement Board Gateshead PCT] Agree that these issues are important and should be specified.</p> <ul style="list-style-type: none"> • Barriers at GP practices – GP’s Receptionist. Getting appointment and having to ring at certain times. • Impact third sector have on health • Need more support services • Often need medical input in an informal way – e.g. Street Doctor. • More holistic approach <p>Aspirations for the next 25 years:</p> <ul style="list-style-type: none"> • Looking at whole person – not just medical needs • Lifestyle changes can improve health • Moving towards a more holistic service • Changing mindset of medics • Social impact – more people are being isolated in homes <p>[Paul Hanson A89 – North Tyneside Council] There is a role of specific awareness raising campaigns which would benefit from a regionally approach</p> <p>[Nonnie Crawford A90 – Individual] I agree should be specified....if we have healthy baby books...for discussion between health visitor and parents. Should we be designing something similar for men and women and pilot...?</p> <p>[Joyce Leeson A93 – Individual] Good. Need to resist demands for inappropriate screening e.g. for prostate cancer and pharmaceutical only solutions e.g. drugs for early hypertension.</p> <p>[Gateshead Healthier Communities Overview and Scrutiny Committee on Health Inequalities Core Group A96] Yes. We would add circulatory disease generally not just stroke. This would allow for diabetes and heart disease including heart failure. Recent anecdotal evidence from a health trainer concerned someone with high blood pressure on being advised to see their GP.....’that is the last thing I am worried about’. So the issue about not seeking help rings true. Healthy Communities Collaborative work in Gateshead is establishing some of the issues in relation to cancer early detection.</p> <p>Health Improving contacts can be made by all agencies including LA employees, police, voluntary sector, etc. Currently this is framed as NHS orientated.</p>

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	<p>[Alisa Rutter B01 – Fresh – Smoke Free North East] Don’t recommend the use of the word ‘catching’ cancer early- implies it is contagious. Would prefer ‘detecting’.</p> <p>Would recommend an expansion on this section, and in particular further focus on skin cancer- simple legislative action could be taken in relation to solariums. Perhaps also a need for more skin awareness.</p> <p>Agree strongly with the role of health improving encounters- this has great potential and is currently hugely under exploited. There should be much greater synergy between the acute and primary care health sectors, wider public service sectors and the voluntary sector. Help to quit smoking should not rest solely with the local NHS SSS- many other partners could play a role in this.</p>

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	<p>[Janine A Ogilvie A07 - North East Community Forests] Access to counselling services is missing. GP s advocating non drug treatments for stress, anxiety and depression is also missing.</p> <p>[Mike Lauerman A09 - CSIP - individual] Yes and strengthen work with families building on various projects eg Respect and Family Nurse lead work</p> <p>[Louise Wilson A10 - Northern CFS/ME Clinical Network] Explicit support for children and young people’s mental health interventions and support.</p> <p>[Jan Welbury A12 - consultant paediatrician - individual] Mental health needs of children and young people are not addressed. If the mental health of children and young people in the region could be improved, this would impact significantly on the future adult population. The present position is that we do have enough mental health workers and limited therapeutic services.</p> <p>[Philip Wynn A13 - Durham CC Occupational health service] The significant individual and broader economic impact of the mild to moderate mental health disorders (including ‘stress’) in the workplace should be a specific priority. Employers should be encouraged to develop robust policies to promote the recruitment and retention of affected adults.</p> <p>Existing support mechanisms within NE workplaces warrant evaluation.</p> <p>[Brian Hedley A14 - Newcastle CC Strategic Housing Service] Other measures /actions could be more work-based support, more self-help/voluntary sector support, more focus on reducing mental illness stigma, better provision of ‘signposting’ accessible support for residents/carers with mental illness.</p> <p>[Patricia Coombes A15 - Jobcentre Plus] This section makes no mention of employment, or in-work support, to individuals or employers to help address mental health and well-being issues. This affects a large percentage of people with health problems in the region, and work is recognised as a contribution to well-being, yet employers often have a poor perception of those with mental health issues. We therefore consider that this is a gap in the strategy, which can be addressed by partners including Jobcentre Plus.</p> <p>[David Chappel A16 - NEPHO - individual] No, this section needs most work. It confuses happiness with mental health and lack of mental illness. There is clear evidence that deprivation is strongly linked to serious mental illness so rates are higher in the North East (although services seem to be better too). Mental health should be seen as a different dimension - related to psychological resilience (various definitions exist e.g. A state of psychological and emotional well-being that enables an individual to work, love, relate to others effectively, and resolve conflicts). You need to engage a range of mental health service professionals and users to work through this section. You might consider:</p> <ul style="list-style-type: none"> - Drugs, alcohol, gambling and other addictions as a key part of this agenda - Service issues such as early intervention in psychosis and crisis assessment teams - Social marketing and other health promotion aimed at reducing stigma <p>Cross-cutting with physical activity, diet, education, environment, etc.</p> <p>[Karen Horridge A17 - consultant paediatrician - individual] Mental health needs of children and young people are not addressed. If the mental health of children and young people in the region could be improved, this would impact significantly on the future adult population.</p> <p>[David Chappel A18 - NEPHO response] This is the most disappointing section: need rewriting by mental health professionals. Link between social deprivation and mental health is not addressed. Is link strong enough between measure of social capital and MH on a population basis? 3.7.5 Seems to be hotchpotch</p> <p>[Bharat Sibal A20 - Public Health Trainees Group] Yes they are appropriate, but there is no mention of:</p> <ul style="list-style-type: none"> ▪ Stigma ▪ Older people ▪ Children & young people ▪ Lobbying and campaigning <p>It is important to ensure there are “blanket” campaigns, but also targeted ones, for groups with particular needs. The region’s role in lobbying / campaigning and marketing is critical in adding value</p> <p>Also, there is no reference to Child and Adolescent Mental Health. Access and multi-agency working are two</p>

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	<p>important considerations to consider in addressing the issues around service delivery in this vulnerable group.</p> <p>Additional comments (Section 3.7):</p> <p>3.7.2 Can we promote this positive fact as part of promoting social capital and pride and tackling stigma?</p> <p>3.7.3 Can the regional work on social marketing (e.g. previous social marketing conferences) and any national work be used as a starting point for this to ensure learning / knowledge is used? Can a consistent framework be developed regionally, for use by LSPs who can then populate with local info and use this to use local resources / address local priorities, but in a systematic way, consistent with other areas across the region. Information and advice about how specifically social capital can be used and what sources / forms it has would be useful to start with also.</p> <p>3.7.4 Focus on quality of life through economic regeneration is good and could be appropriately measured. Sophisticated marketing techniques will be needed to engage businesses with this idea. However, how do we measure “happiness”? Danger is resources become directed at trying to measure something intangible, rather than actually tackling it. Will happiness not manifest itself in things we can already measure? E.g. levels of violent crime, levels of drug and alcohol misuse, usage of varying levels of mental health services.</p> <p>Focus on improving individual mental health is good and important. A focus on the mental health of children and young people and the use of social marketing to tackle stigma and raise awareness re: the early signs of mental health problems may support this.</p> <p>Presumably these are all evidence based. A regional strategy could add value on this by providing coordination / guidance where needed on levels of support / possible providers. A major benefit to regional support would be coordinated, large scale campaigns which are properly funded and sophisticated enough to engage with their audience. Also e.g. using input into soap operas etc. to get the message – requiring coordination with national bodies, which local organisations are not able to do</p> <p>[Vivien Hollyoak A21 - North Tyneside PCT] Workplace mental health should be a priority, and employers should be urged to sign up to the ‘Mindful Employer Charter’. NICE guidance for workplace mental health is due in 2008 and this will need needs structures in place for its implementation.</p> <p>Workplace health is a major omission and a missed opportunity to develop a NE approach.</p> <p>[Brendan Hill A22 - VOLSAG, GVOC, MHNE] The proposals do not capture the key actions or focus on appropriate issues involved in improving mental health. Where the document refers to the “many signs of happiness.....in the North East “(3.7.2), the reality is that all indications are that the region has more mental health problems than other regions of England. Whilst it is important for the strategy to have a positive focus and be aspirational in nature, it is of crucial importance that our current position is highlighted. If there is to be a regional health strategy, it should make mental health a priority area. Para 3.7.1 hits the right note..</p> <p>“The importance of improving mental health is often understated in policies, yet it is probably the single most essential element of well-being, and an enormous influence more broadly on health”</p> <p>The “Life Course” diagrams in the document do not refer to positive mental health or mental ill health and yet mental health problems are said to affect 1 in 4 of the population.</p> <p>The strategy needs to address both the preventative aspects of mental health and also service delivery issues for those who already have developed mental health problems.</p> <p>In terms of those with developed mental health problems, the strategy should stress the key importance of all working towards Social Inclusion, across, health, social, leisure, educational and vocational/employment fields. There is a need for Commissioners to support service developments which aim for positive outcomes in all of these areas for service users throughout statutory and voluntary sector services and the Strategy should highlight this. The Strategy should emphasise the importance of how all services should focus on the key components needed to maintain positive mental health, - relationships, purpose and feeling safe and secure . Such an emphasis needs to include the aim that service users are involved, not only in planning, but also running and evaluation of services</p> <p>There is a need to ensure that there is appropriate accommodation with support for people with mental health problems. Poor housing exacerbates mental health problems and lack of appropriate housing and support can lead to many delayed discharges from inpatient services, increased re-admissions and in some cases</p>

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	<p>homelessness.</p> <p>The emphasis on domestic violence within this section is misplaced – a much clearer link is with issues of alcohol and substance misuse.</p> <p>A further general media campaign on depression and suicide risk is not thought to be particularly helpful, or a good use of expenditure. However there is a continuing need to press for recognition and treatment of mental distress across the age range at the earliest point, particularly in Primary Care.</p> <p>Anti stigma work and education packages which focus on promoting emotional resilience, and recognition of mental health issues, should be targeted at children and young people. This approach should support positive change in the long term.</p> <p>The reference to funded support for physical activity (under 3.7.5) is relevant to positive mental health, not simply for people with developed problems but as a preventative measure in avoiding depression/anxiety.</p> <p>Similarly there is a need to focus on the availability of access to counselling and a range of Psychological therapies including but not exclusively CBT. Further support should also be encouraged for self-help and self-management</p> <p>There is an issue of poor diet and poor physical health generally for people with mental health problems which is not addressed.</p> <p>[Rachel Turnbull A26 - Northumberland CAB] 3.7.1 states that the importance of mental health is often understated, but then section 3.7 is possibly the shortest section of them all!</p> <p>No, the proposals do not capture the key actions in support of improving mental health. Need to differentiate between maintaining good mental health and assisting those with mental illness.</p> <p>For good mental health, the importance of good, independent, free and impartial information, advice and guidance can never be underestimated. For example, if a person is in several thousand pounds worth of debt, without help to get their debts under control, guidance of how to budget, responding to creditors, then their mental health will suffer. If their mental health suffers, so does their physical health – they may smoke more, drink more, become reclusive, not take part in any social or cultural aspects of life, relationships will suffer, children will suffer. Likewise with any other life problem that somebody may be experiencing. If people play a fulfilling part in their community, society, family, then they are more likely to have good mental health and vice versa.</p> <p>People with mental illness also need good, impartial information, advice and guidance – particularly at the point of entry to the health system – it is here particularly that they will encounter problems with benefits, debts, relationships, etc.</p> <p>Also the support mechanisms when they leave the health system – need to ensure people aren't just left to cope on their own, as invariably without any assistance e.g. with coping with debt or benefit problems, they will end up back in the system.</p> <p>Also need to look at what medical help these people are actually getting. Is it enough and of a high enough quality? Is it right that people have to wait 18 months before they can have an appointment with a psychologist?</p> <p>Need more help in place for people re-entering the work place, particularly with more and more people with mental health problems being taken off their benefits and especially with the implementation of the new Employment Support Allowance next year. Again this is more of a problem for people in rural areas, where many probably already feel isolated and alone and where there is less access to support.</p> <p>[Angela Ellins A28 - C&L GONE] What about mental health of immigrants / asylum seekers / refugees – often see high levels of mental health issues in these population groups</p> <p>[Elaine Richardson A29 - Jobcentre Plus NE Region] Yes, proposals capture key actions. Jobcentre Plus can also support via Pathways to Work and Condition Management Programme, and range of other provision specifically aimed at Mental Health</p> <p>[Louise Wilson A30 - Sport England] We welcome the link made between mental health and physical activity, though as previously noted, the interventions that are recommended are not appropriate for all.</p>

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	<p>[Caroline Airs A31 - Gateshead Advocacy Information Network] 1. It is important that any measures used to indicate quality of life should specifically address issues of quality of life for minority groups; and where systems are put in place to measure improvements in quality of life, separate measures are needed to ensure that disadvantaged groups progress further and faster</p> <p>2. Carers of people who have mental health issues are particularly vulnerable to mental ill-health themselves, and measures are needed to protect the mental health and quality of life of all carers, particularly carers of people in the mental health system</p> <p>3. As mentioned earlier, and as acknowledged in the draft strategy, mental and emotional health and wellbeing underpin all areas of health. Many vulnerable people who use health and social care services find the experience of accessing those services stressful in itself. Advocacy can support vulnerable people to access services, and can support them through the assessment process, helping to ensure that they are treated with respect and dignity, that they are enabled to make informed choices, and that they obtain the services they need to maximise their independence and control over their own lives.</p> <p>Many recent government strategies have acknowledged the importance of advocacy in securing the independence, choice and control which is so important to wellbeing – for example, Valuing People; Improving the Life Chances of Disabled People; A Sure Start to Later Life. There are a number of advocacy projects throughout the region, but there are still many gaps in advocacy provision; and where there is provision it is usually under-funded, and funding is insecure. A regional strategy for health needs to address the need for advocacy provision for all service user groups throughout the region. The North East Regional Advocacy Network is beginning to look at drawing up an advocacy plan for the region, and there is scope for joint working with commissioners in this respect.</p> <p>[Barbara Harrison A33 - National Offender Management Service] NOMS NE supports the assertion that steps must be taken to improve the mental health of individuals in the North East and concurs with the key actions outlined in the consultation document. However, the organisation believes that it would also be beneficial to acknowledge the links between mental ill-health and offending. Research has shown that 5% of all men in Britain and 2% of women exhibit 2 or more mental disorders. The equivalent figures for the prison population stand at 72% and 70% respectively. Mental ill-health is clearly a key focus of our work and we believe that it would be helpful to ensure that services are available and mainstreamed for everyone, including offenders.</p> <p>[Hartlepool & North Tees Workshop A34 annex] Social marketing opportunities</p> <ul style="list-style-type: none"> • Removing stigma is of vital importance • Lack of understanding / empathy to mental health. Needs to be de-stigmatised • Mental health social marketing not a taboo subject • Earlier identification and intervention through promotion/advertising of signs and symptoms • Non-clinical end of MH needs more exploration and promotion within the workplace i.e. stress (does not mean instant dismissal or label) • Low grade depression is rarely accounted for. • Physical and mental health are inherently inter-related particularly the relationship between increasing physical activity and improvements in mental health. Improving access to “talking” services. • Nothing mentioned about a lot of different talking therapies • One table supports 3.7.4 to develop a clear focus on valuing and improving individual mental health. • Early intervention – intervention at the right time. <p>Services</p> <ul style="list-style-type: none"> • Is a lack of services generally but also specifically to deal with the issues around post-natal depression and depression seen in general practice e.g. sick notes issued without proper psychological assessment. • It's also about recognising the stages that people are at (see earlier comments about the life course) and identifying when they might be vulnerable e.g. at specific life events and having the support, contact or pathways available to refer people at these times. • Services for under 16's are problematic. • Gaps in services e.g. for young people, building emotional resilience – promotion needed in good mental health. • Children and Young people missing from document (LAA target)

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	<ul style="list-style-type: none"> • We also need to ensure that individuals don't fall through the cracks e.g. alcohol misusers who are also alcoholics but have difficulty in being accepted by either service. Bringing services together into single assessment centres would help to facilitate this process. • Need to separate the 'worried well' from those who have identified mental health illness • Develop "tailor made" interventions for individuals <p>Well being</p> <ul style="list-style-type: none"> • Promote good mental wellbeing and support in accessing services/coping strategies <ul style="list-style-type: none"> ○ Ensure services are of adequate standard • What other services are available for mental wellbeing <ul style="list-style-type: none"> ○ Accessibility? <p>Mental health and alcohol</p> <ul style="list-style-type: none"> • A range of activities is required to be available e.g. options to provide alternatives to the pub such as referral or subsidised access to the gym. • Leisure activities are often excluded to those who need them on the basis of cost regardless of the other barriers e.g. lack of mobility. • Health services should focus on activity, leisure and sporting activities being made available. • There is a whole preventative agenda that requires addressing and perhaps a move away from the medical model is required. <p>Domestic Violence</p> <p>The signs associated with mental health and domestic violence need to be picked up early and the relationship between domestic violence and alcohol need to be acknowledged.</p> <p>Possible Regional role</p> <ul style="list-style-type: none"> • Ensure equal standards/accessibility of services across Region • Consider link between mental health and other health issues. Regional research and data available at local level • Measurements – lobby for meaningful targets – mental health has no quick fixes – takes longer to help. System for measuring mental wellbeing? • Capacity issues. Need to identify sufficient capacity. There seems to be a lack of trained workforce in this field • There is a need to learn and disseminate good practice and the Regional Office would be useful in order to facilitate the mapping of good practice throughout the region and its subsequent sharing and dissemination. • Review funding of mental health services <p>Delivering Health Improvement Encounters</p> <ul style="list-style-type: none"> • Are there appropriate training programmes in place for workforces? • Is the right advice being given? • Introduce appointment system – admin support, appointment times etc <p>Regional framework</p> <ul style="list-style-type: none"> • Link services and support holistic approach • Regional menu of services available at local level and standards • Broaden skills of workforce 'on the ground' to recognise symptoms/needs <p>[Martin Shaw A36 - Natural England] The beneficial effects of connecting people to 'nature' are well recognised and there are opportunities to deliver significant mental health benefits by doing more to promote green infrastructure and green exercise.</p> <p>[Leah Blacklock A37 - Community Action on Health] CAOHA agrees with the proposals around mental health but would stress the need for peer support groups and community based support services which reduce social exclusion as a target here.</p> <p>[Neil Johnson A38 - CSIP - Individual] I would be wary of cross-referencing Domestic Violence with Mental Illness as this would reaffirm public perceptions of 'dangerousness' and potentially undermine the proposed</p>

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	<p>media campaign</p> <p>The Foreword (viii c) asks for views on where, as a region, we should be in 25 years time. Taking this as a guide, the focus of the mental health section should be to: eradicate the stigma and discrimination experienced by those with mental health difficulties; ensure that, as a matter of course, end-users are involved from the outset in planning services; ensure that mental health and wellbeing is mainstreamed within all public health policy documents; and, ensure that the NE boasts a mentally healthy and aware population (with specific reference to schools, the workplace and the media)</p> <p>We should aim to be the first region in the country to actively provide people with the tools they need to look after their own mental wellbeing and that of their families, friends and communities. This process could be led by PCTs in partnership with the 3rd sector</p> <p>[Janice McColm A40 - Tees Valley Rural Community Council] Education to challenge discrimination and break down barriers</p> <p>The views, needs and ambitions of people with mental health problems need to be taken into account</p> <p>Develop quality services which reflect expressed need and diversity. More needs to be done to combat stress in the workplace and education on stress control and helping people avoid mental health problems.</p> <p>[Peter Heywood A41 - Middlesbrough PCT - Individual] Mental health section very weak unfortunately. Middlesbrough H&SC partnership has commented on this in detail and little further to add.</p> <p>[Ann-Marie Gibson A42 - National Energy Action] NEA would like to see the relationship between poor housing and poor mental health strengthened, particularly with reference to improving people's quality of life by improving their living conditions. Action to tackle fuel poverty can have direct benefits to mental health, for example, people have more disposable income so they are able to socialise more or may feel more comfortable having visitors, which reduces feelings of social isolation. Fuel poverty can be a source of considerable stress for householders who often face painful decisions about paying for 'heating' or 'eating', or who have to 'juggle' energy expenditure with other household costs, often including debt, which can lead to worsening mental health often manifest as chronic anxiety and/or depression.</p> <p>[Charlotte Clarke A44 - University of Northumbria] Recognition of the changing structure of the region, :</p> <ul style="list-style-type: none"> -such as populations of asylum seekers, - The lack of traditional community networks which probably cannot be re-established, but for which alternatives need to be developed. Loneliness as a social condition experienced by many age groups and which can have significant health consequences - needs of increasing elderly population to have easy access service and a promotion of mental health as opposed to ill health management <p>[Chris Drinkwater A46 - West End Health Resource Centre] An annual progress report on social capital is an excellent idea but as well as looking at social context we need to look at how we foster greater emotional literacy so that individuals are more resilient and able to deal with the problems that lead to mental ill health.</p> <p>One of the areas missing from this section is any specific mention of mental health in older people. Older people as a group have higher than average levels of depression and anxiety and high levels of suicide, particularly in men. Preventive interventions to reduce social isolation and to keep older people active and involved could produce an excellent return on investment by reducing demand for expensive statutory services.</p> <p>[Heidi Jobling A47 - Newcastle Healthy City Project] Cross Referencing is missing – the national Delivering Race Equality in Mental Health initiative, and the regional programme.</p> <p>[Karen Evans A49 - Age Concern and Years Ahead] Age Concerns in the North East and the Regional Forum on Ageing 'years ahead' felt this section should have been longer and more detailed. Considering point 3.7.1 states 'The importance of improving mental health is often understated in policies, yet it is probably the single most essential element of well-being' the length of this section should reflect that comment.</p> <p>The strategy would benefit from including information on depression and illnesses such as schizophrenia, along with dementia which is expected to increase over the next 20 years.</p> <p>It might be useful to mention support for carers in relation to their health and wellbeing whether they are</p>

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	<p>younger or older people in this section.</p> <p>Age Concern England considers that direct and indirect age discrimination remain at the heart of the organisation and funding of mental health services. The principle of age equality needs to be translated across all government health policies and into the practice and culture of NHS organisations and health professionals.</p> <p>It is also worth noting that Age Concern England is monitoring suicide statistics. The numbers of suicides amongst older men are around twice those for older women. This is a negative indicator for older people. The National Service Framework for Mental Health and the National Suicide Prevention Strategy has focused on action to prevent suicide by people under 65. Depression in older people is under-diagnosed and, even in diagnosed cases, under treated. More could be done to improve matters in these areas.</p> <p>Comments suggested by attendees at our consultation event on this subject included:-</p> <p>Services – services for older people concentrate on dementia as oppose to functional mental health problems, and older people with mental health problems often fall between two stools of mental health services designed for “working age adults” and older age psychiatry. There is a lack of activities for older people with mental health problems and health services sometimes forget that physical activity is good for people with dementia as well as other mental health problems. Our perception was that older people with mental health problems who are not in work do not get nearly as much attention as working age adults, because services are geared towards getting people back to work.</p> <p>Treatments – it is often not clear to older people and their family, friends and communities how to get help if you have a mental health problem. Partly, the stigma around mental illness is a disincentive for people to seek help, and means that it is also less likely that your friends, relatives and neighbours seek help for you.</p> <ul style="list-style-type: none"> • Low level mental health problems in older people are poorly diagnosed and treated- this needs more attention. People need to be encouraged to seek help. • Intergenerational – local schools linked to homes with people with dementia to increase understanding • Mental health care needed for all generations • Endorse the inclusion of mental health in the strategy but needs to be more focussed on older people • Mental Health – need to focus on preventative measures like social engagement through gym membership, libraries. <p>One group at the consultation event felt that the first and one of the most important priorities should be in educating and improving health care professionals understanding and recognition of the mental health issues for older people, and that they are not just ‘a sign of old age’.</p> <p>A greater emphasis should also be placed on the recognition that there is a need to treat people holistically and not to treat individual conditions.</p> <p>The strategy should also ensure that PCTs have the right skills mix for staff to assist older people in this area.</p> <p>It was also felt that the strategy should focus on;</p> <ul style="list-style-type: none"> • insisting on and implementing better partnership working between and inside statutory organisations, • better and earlier intervention and support, • a proactive media campaign which influence the images portrayed in the media and also provides community education around mental health. <p>For further suggestions see Appendix 1</p> <p>[Ceri Mather A50 - Health Improvement Solutions / TPHN] CBT and Counselling</p> <p>[Richard Briggs A51 - Cruse Bereavement Care] We support the key actions listed but would reiterate the point that access to bereavement counselling and support needs to be available to all age ranges including very young children.</p> <p>In recent years Cruse Bereavement Care has taken part in most of the international and national emergencies helping people in such traumatic circumstances. The North East Region of Cruse Bereavement Care is taking part in the setting up of Regional Resilience Teams to cover major instances of traumatic death. We feel that</p>

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	<p>reference to the Regional Resilience Teams should be included in the section on mental health.</p> <p>[Richard Pow A54 - Forestry Commission] There is growing evidence of the beneficial effects of connecting people to nature, whether that be through them growing their own vegetables, enjoying regular countryside walks, volunteering with a local conservation project or simply enjoying a more green and leafy local environment. Doing more to promote green exercise and green infrastructure should therefore be seen as a priority for improving the regions mental health.</p> <p>[Andy Roberts A56 - Ncle CC Children's Services] Children and young people seek support from their peers and we need to increase awareness of the importance of emotional wellbeing and improve the skills of young people to help each other and access services.</p> <p>[Jan Bostock A57 - Northumberland Care Trust and NYW NHS Trust] It is good to see the improving mental health section but it should appear earlier in the document, perhaps after alcohol, as mental health problems are so prevalent and have a big influence on public health.</p> <p>[Cynthia Games A59 – Living Streets] The significant impact of improving greenspace and the built environment upon mental health should not be underestimated within the strategy. See the fuller Living Streets response attached.</p> <p>[Tricia Cresswell A61 - Durham & Darlington PCTs] Build in links to the worklessness agenda. Also, stigma and discrimination remain massive issues that it would be useful to see a lead role played at a regional level. Again, the role of social marketing would be key.</p> <p>The point made in 3.7.1 that mental health improvement should be at the beginning of the document underlining the fact that without good mental health the motivation and self esteem individuals' require to buy into a the whole range of healthy lifestyle choices is unlikely to be there</p> <p>There are a number of key issues which need to be addressed strategically to place mental health improvement in a place where it can have due influence on the whole system. This includes the improvement of information and intelligence (which is acknowledged), improving partnerships with commissioning and building capacity for mental health improving services across the board- this needs to be captured under a more detailed regional strategy for mental health improvement in the same way as other topic areas are represented regionally</p> <p>Regarding support for those with mental health problems, this is extremely varied and it may be clearer in a very short section to emphasise the importance of having a range of timely, accessible and appropriate treatments, from opportunities for social activity through to specialist clinical treatment and therapy and everything in between (ie a comprehensive stepped care system). This should acknowledge a range of providers.</p> <p>Agree professional education is a key area- however it is unclear why domestic violence has been selected to highlight the point</p> <p>Regarding LSP s' it is good to see they are acknowledged as a key vehicle for mental health improvement. A focus on social capital could be misleading and narrow the scope of what they are able to achieve in relation to the issues raised above</p> <p>[Tim Blackman A62 - Wolfson Research Unit] (In addition to the above) We agree that mental health has a key influence on well-being, and not just in the sense of an absence of mental illness. In addition to detecting severe mental illness early and addressing its physical health consequences, there are a number of other targets for public health intervention which should be considered. The North East has the highest rate of hospital presentations for self-harm in England, which remains a target for suicide prevention. Depression has profound consequences on physical health and a person's ability to seek healthcare or access prevention- so action on this could have a more global effect on health (noting the current CBT drive). The strategy should link up explicitly with government efforts to help those with mental health problems to return to the workplace rapidly- there is excellent evidence on what works, but it is hardly implemented at all (evidence on individual placement and support). Stigma and discrimination against those with mental health problems remains a huge problem which compounds disability and social cost. The strategy should include support for the mental health first aid initiative, which has the potential to address stigma and complement early intervention media campaigns and suicide prevention strategies. In terms of life course, child and adolescent mental health problems should be a special target of early intervention in all the areas above.</p>

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	<p>Mental health needs to be recognised as not just about an absence of mental illness, and as a continuum with strong links to socioeconomic circumstances. There is a tendency in the document to view mental health and happiness as something separate from economic security, which is not evidence-based.</p> <p>Overall, the section needs to be underpinned by current evidence and guidance. It is unclear, for example, why media campaigns are likely to be effective, why social capital is always a good thing, and why access to interventions like cognitive behavioural therapy is ignored in the draft.</p> <p>There are links that can be made to the draft's concern with environmental sustainability in terms of the importance of contact with greenery and nature for mental health.</p> <p>[VONNE A64] As VONNE do not consider ourselves experts in the field of mental health we defer to, and endorse, the joint response given in answer to this question by Mental Health North East, GVOC mental health group (Gateshead's third sector mental health network) and VOLSAG (Newcastle's third sector mental health network).</p> <p>There response to this question is as follows:</p> <p>The proposals do not capture the key actions or focus on appropriate issues involved in improving mental health. Where the document refers to the "many signs of happiness.....in the North East "(3.7.2), the reality is that all indications are that the region has more mental health problems than other regions of England. Whilst it is important for the strategy to have a positive focus and be aspirational in nature, it is of crucial importance that our current position is highlighted. If there is to be a regional health strategy, it should make mental health a priority area. Para 3.7.1 hits the right note.</p> <p>"The importance of improving mental health is often understated in policies, yet it is probably the single most essential element of well-being, and an enormous influence more broadly on health"</p> <p>The "Life Course" diagrams in the document do not refer to positive mental health or mental ill health and yet mental health problems are said to affect 1 in 4 of the population.</p> <p>The strategy needs to address both the preventative aspects of mental health and also service delivery issues for those who already have developed mental health problems.</p> <p>In terms of those with developed mental health problems, the strategy should stress the key importance of all working towards Social Inclusion, across, health, social, leisure, educational and vocational/employment fields. There is a need for Commissioners to support service developments which aim for positive outcomes in all of these areas for service users throughout statutory and voluntary sector services and the Strategy should highlight this. The Strategy should emphasise the importance of how all services should focus on the key components needed to maintain positive mental health, - relationships, purpose and feeling safe and secure. Such an emphasis needs to include the aim that service users are involved, not only in planning, but also running and evaluation of services</p> <p>There is a need to ensure that there is appropriate accommodation with support for people with mental health problems. Poor housing exacerbates mental health problems and lack of appropriate housing and support can lead to many delayed discharges from inpatient services, increased re-admissions and in some cases homelessness.</p> <p>The emphasis on domestic violence within this section is misplaced – a much clearer link is with issues of alcohol and substance misuse.</p> <p>A further general media campaign on depression and suicide risk is not thought to be particularly helpful, or a good use of expenditure. However there is a continuing need to press for recognition and treatment of mental distress across the age range at the earliest point, particularly in Primary Care.</p> <p>Anti stigma work and education packages which focus on promoting emotional resilience, and recognition of mental health issues, should be targeted at children and young people. This approach should support positive change in the long term.</p> <p>The reference to funded support for physical activity (under 3.7.5) is relevant to positive mental health, not simply for people with developed problems but as a preventative measure in avoiding depression/anxiety.</p> <p>Similarly there is a need to focus on the availability of access to counselling and a range of Psychological therapies including but not exclusively CBT. Further support should also be encouraged for self-help and self-</p>

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	<p>management</p> <p>There is an issue of poor diet and poor physical health generally for people with mental health problems which is not addressed.</p> <p>[Caroline Wild A66 - Learning Disability Directorate NTW NHS Trust] It is really important to not confuse mental health and learning disability, they are often discussed together in strategies and that is not helpful or appropriate.</p> <p>There needs to be a focus on health improvement for people with a learning disability.</p> <p>[Dave Parkin A67 - Wallsend Town Hall] Agree. Possibly look at an increase in out of hours services/helplines for people with mental health problems/depression</p> <p>[Emma Gibson A69 - Gateshead Partnership Board] The strategy needs to address both prevention of mental ill health and also treatment services for those that have already developed mental health problems. The strategy in order to be effective needs to influence planning processes at all stages, however in order to do this, health firstly needs to be recognised in the planning process.</p> <p>The strategy does not capture the main priorities or key actions for improving mental health and does not present the true picture of mental ill health in the region. Figures suggest that the North East has more mental health problems than any other area in England. The strategy should provide a positive note for future actions but the current position needs to be highlighted in the regional strategy rather than the document just referring to “many signs of happiness and satisfaction in the North East.” Mental health should be a priority and this is reflected in 3.7.1, that mental health improvement is probably the most important element influencing health and well being.</p> <p>The strategy needs to emphasise the importance of all services and organisations focusing on key areas for improving positive mental health and ensure service users are involved at all stages of planning and review of services.</p> <p>The strategy should promote positive mental well being and social inclusion as a priority for those with established mental health problems. Social inclusion should be stressed as a priority for all key agencies across health, social care, employment, leisure and education.</p> <p>It would be useful to have a regionally agreed core set of indicators to measure mental health and particularly low level mental ill health in the population and at different levels, including ward level.</p> <p>Incorporated into the focus on social capital, all Local Strategic Partnerships in the region should develop local action plans to implement measures outlined in the Social Exclusion Unit’s Mental Health and Social Exclusion Report, with delivery arrangements mainstreamed through their Community Strategies (as recommended in previous Mental Health NSF Autumn Assessment criteria.)</p> <p>Access to funded physically activity treatment (3.75) is important for the prevention of mental health problems in addition to helping those with developed problems. Evidence supports that both mental and physical improvement go hand in hand and this is further supported by the number of referrals from mental health services into the exercise referral programmes for physical activity interventions.</p> <p>Further lifestyle issues such as poor diet and housing are not addressed in the strategy. The potential impact of good nutrition on improved mental and physical health and the potential for mental health problems to be exacerbated by poor housing conditions need to be considered. There is a need for appropriate accommodation to support people with mental health problems, as lack of appropriate housing can cause problems with delayed discharged and increased readmissions.</p> <p>A regional media campaign on depression and suicide risk would not be cost effective or useful at this time, however recognition and treatment of mental health across age groups at the earliest point is a priority. To support positive changes in the long term, anti stigma education work should be targeted at young people.</p> <p>A sustained campaign on domestic violence with evidence based interventions needs to be linked to alcohol and substance misuse and seems to fit more clearly into these sections.</p> <p>Mental health is essential for good health and wellbeing and is a cross cutting theme that impacts upon all specific key areas identified in the strategy document and therefore needs to be acknowledged as a priority</p>

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	<p>area in the regional plan.</p> <p>[Stephen Blair A70 - North of Tyne PEC] Action to reduce use of drugs and workplace health are both omitted.</p> <p>These proposals seem to alternate between very broad brush aspirational strategies to very specific operational detail such as the mention of bereavement counselling</p> <p>[Craig Duerden A71 – Middlesbrough Community Network] A number of organisations gave their views on this question and they did not all agree on the points being made. To be faithful in recording these views the points are set out in full alongside the name of the organisation:-</p> <p>Neurological Alliance</p> <p>There are a number of issues that need to be considered in terms of mental health and the different aspects to it. Different groups and impairment related mental health will need to be considered, e.g. age is a factor in mental health and the well known suicide rate of young men.</p> <p>Where chronic conditions are considered not life threatening, there is a considerable lack of knowledge as to the level of morbidity that is prevalent. SUDEP (Sudden Unexpected Death in Epilepsy) accounts for 900 – 1000 death per annum. There are identifiable levels of risk for the likelihood of SUDEP but no recognition of the psychological effects on families, carers or peer group, particularly in newly diagnosed teenagers.</p> <p>The suicide rate of 16 – 25 year old patients with epilepsy is twenty times the UK average.</p> <p>There is a pronounced lack of recognition of the level of depression inherent in a number of neurological conditions and an urgent need for accessible psychological support. One of the most significant problems for those newly diagnosed with Motor Neurone Disease, Multiple Sclerosis and Dystonia is relationship breakdown due to lack of post0diagnoses support from statutory services.</p> <p>The lack of statutory mental health support available is now at crisis level.</p> <p>Similarly, there is no impetus to enable access to suitable social care personnel to develop care pathways where the service-user/patient has elderly parents/carers. Most prevalent for those with learning disability, but also Asperger Syndrome (Autistic Spectrum Disorder), uncontrolled Epilepsy and younger age Huntington’s Disease, Stroke or Multiple Sclerosis.</p> <p>There is a significant level of self-harming amongst teenage girls and a young woman, which is categorised as low entitlement to mental health services. GP’s are ill equipped to deal with the issues beyond a baseline anti-depressant and referral to mental health services are not followed up to ensure needs are being met.</p> <p>Media campaigning to promote recognition of depression and suicide risk will raise the level of stigma, enhance the labelling and value judgement processes and further marginalise those that need, offering a perception of support availability that cannot be met under the current service structure or professional resource levels.</p> <p>Hereby stands a particular issue of definition of entitlement. The current manifest of gate-keeping encourages a very typical stereotypical view of mental health needs with patients being referred to as ‘lazy’.</p> <p>Middlesbrough Mind</p> <p>The Strategy needs to state a clear definition of what is meant by “Mental Health”. A definition is required as this area is widely misunderstood and is different from the absence of metal illness.</p> <p>The Strategy in section 3.7.2 focuses upon the regions’ happiness, satisfaction and identity rather than its disadvantage. This can be misleading, as there is happiness and satisfaction in the North East similar to other regions, but rates of mental illness are associated with deprivation and the levels of mental illness in Middlesbrough are higher than the national average.</p> <p>The Strategy needs to be clear about the meaning of “Social Capital” and the link to mental health.</p> <p>Middlesbrough Mind would strongly support the routine use of measures of quality of life. Mental health is not immeasurable and there are well researched and evidenced tools to measure it.</p> <p>The actions listed at 3.7.5 does not provide a comprehensive list of priorities; on the contrary the list seems to</p>

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	<p>be random:-</p> <ul style="list-style-type: none"> • The link between physical and mental health needs to be much more widely recognised and understood by health and social care professionals – currently people with mental illness receive very poor physical health care and people with physical health problems receive poor mental health care, • Access to counselling and other talking therapies is required for a wide range of mental health difficulties – not just bereavement. These services are still only available to a tiny proportion of people who would benefit. , • Intermediate care for mental health problems is complete lacking in many areas (including Middlesbrough), • More support for people who experience post-natal depression is lacking and is a priority – as is support for parents to understand and meet the emotional needs of their children, • Agree that a media campaign would promote recognition of depression and suicide would be stigmatising. This work needs to be done at grassroots level in communities, through information, training and community development activities. All community workers need a greater understanding of mental health and how to promote it within their communities. A targeted and appropriate campaign to promote Mental Health First Aid, along with additional resources for delivery, would be much more useful. <p>North East Refugee Service</p> <p>The recognition of the specific needs of certain hard-to-reach groups needs to be considered in particular people seeking asylum who have and are suffering from trauma and loss due to their experiences.</p> <p>Woman's Support Network</p> <p>Information from the Cross Government Action Plan on Sexual Violence and Abuse stated that: studies have reported between 50-60% of inpatients and 40-60% of outpatients in mental health services have been physically and / or sexually abused as children. There should, therefore, be some mention of access to free sexual abuse counselling.</p> <p>Trinity Community Centre</p> <p>There is also a link to the built environment with the importance of maintaining our open spaces and parks as places people can feel in touch and unenclosed.</p> <p>In terms of mental health and children the importance of developing children's emotional literacy and spiritual development in schools cannot be forgotten about.</p> <p>Focus Group Meeting</p> <p>This was observed as the weakest category and greater focus should be given to improving the emotional well being of the population increasing 'happiness' is a priority and will impact on all of the other key areas.</p> <p>[Joanne Lavender A74 - NE Chamber of Commerce] There has been recognition of the need to reduce the stigma surrounding mental health, which can act as a barrier when people are in or seeking employment. Early recognition and response to mental health concerns at the level of primary care trusts should be incorporated. Employers should also be given support to help deal with such issues.</p> <p>[Martin White A77 - Institute of Health & Society] The evidence on social capital is poor, with many poor quality and ecological studies. The concept is also poorly defined and operationalised. These two factors make these proposals unworkable at the present time. More high quality longitudinal epidemiological and experimental studies are needed.</p> <p>The nature of the media campaigns is very unclear and we need evidence that they will work before investing huge amounts of money.</p> <p>Nevertheless, mental health problems are common, particularly for those who live in deprived areas, and the issue probably needs greater priority.</p> <p>Overall we felt the strategy is light on mental health and, in particular, does not refer at all to the evidence on interventions for emotional and behavioural disorders in children and young people, with the potential for improving a wide range of social outcomes (educational attainment, reducing crime and substance abuse etc)</p>

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	<p>as well as mental health.</p> <p>[Ruth Stevens A78 - NE Physical Activity Group] Welcome the link made between physical activity and mental health, though as previously noted, interventions recommended are not appropriate for all</p> <p>An annual progress report on social capital is an excellent idea but as well as looking at social context we need to look at how we foster greater emotional literacy so that individuals are more resilient and able to deal with the problems that lead to mental ill health.</p> <p>One of the areas missing from this section is any specific mention of mental health in older people. Older people as a group have higher than average levels of depression and anxiety and high levels of suicide, particularly in men. Preventive interventions to reduce social isolation and to keep older people active and involved could produce an excellent return on investment by reducing demand for expensive statutory services.</p> <p>[J Chexal A81 - Soroptomist Society] We support these actions to improve mental well being. The link between alcohol and drug misuse and mental ill-health should receive greater attention. There should be further action to combat bullying in schools and workplaces.</p> <p>[Gateshead Public Health Partnership A82] Importance of improved recognition of depression (especially linked to long term conditions and older people's lives) by "concerned recognisers". Applies particularly to primary care professionals. Also crucial that an adequate response is made ie treatment options are offered including talking therapies. Non-medical pathways should be considered, Older people in care homes should be included.</p> <p>[Alma Laing A83 - Local Engagement Board Gateshead PCT] Yes</p> <p>[Nonnie Crawford A90 - Individual] Focus very medical model ignores a few standards in NSF...there is good practice out there</p> <p>[Joyce Leeson A93 – Individual] Need more on support for care and quality of life for those with long standing disabling mental illness.</p> <p>[Nic Best A94 – Campaign to Protect Rural England] In our view, the concept of good mental health and its links to quality of life and tranquillity are underdeveloped.</p> <p>Wording to reduce the stigma of poor mental health eg emphasizing the prevalence of acute mental health problems and the prospects for recovery would strengthen this section.</p> <p>The high level of suicide risk in rural areas should be highlighted and addressed.</p> <p>[Gateshead Healthier Communities Overview and Scrutiny Committee on Health Inequalities Core Group A96] It would be useful to have a regionally agreed core set of indicators to measure mental health and wellbeing, as well as low levels of mental ill-health in the population at different levels, including ward level</p> <p>Incorporated into the focus on social capital, all Local Strategic Partnerships in the region should develop local action plans to implement measures outlined in the Social Exclusion Unit's Mental Health and Social Exclusion Report, with delivery arrangements mainstreamed through their Community Strategies (as recommended in previous Mental Health NSF Autumn Assessment criteria.)</p> <p>[Jean Blair A97 – Individual] Don't forget mental health problems for older people.</p> <p>[Nicholas Baumfield A98 – Arts Council England, North East] There is perhaps more evidence of the contribution of the arts to improvement in mental health than in any other area. The proposals need to embody this. The arts should be identified within assessments of social capital and happiness within communities.</p> <p>[Alisa Rutter B01 – Fresh – Smoke Free North East] Agree with this and as such mental health is an overarching element to all the key areas- certainly it plays a large role in smoking.</p> <p>There is a need for much better support for physical health needs within mental health settings as well and this isn't really acknowledged here. This sector could and should play a bigger public health role</p>

Q20	<p>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?</p>
	<p>[Edwin Pugh A04 – professor of palliative care – individual] Very happy to see end of life included. This requires action at both a clinical governance level (we are not doing what we know to work well-well) and a societal level where death and dying are not seen as a normal part of life.</p> <p>I would advise against focussing too much on independent hospices. They have a role to play as centres of excellence however they cater for only the minority of patients (6% of deaths) and still have a bias towards cancer which is only one of the major categories of ‘illness’ needing end of life care. The others are organ failure and dementia/frailty. The vast majority of EOL care takes place outside hospices. (Having been a Medical Director of a hospice and now working on the NHS I see this daily.</p> <p>AS Chair to the Darzi NHS Review for End of Life Care I am sure public health will feature in the action points. This is also true for the department of health EOL work chaired by Professor Mike Richards. The regional strategy should be in tune with these major pieces of work.</p> <p>Finally, I am sure there will need to be commissioned research on various areas. It would be good to prioritise the main research priorities to see Regionally who is best to carry out the work.</p> <p>Finally, a Charter would seem to be a good first step as long as it was developed with wider society and not limited to the medical model.</p> <p>[Kath Mannix A06 – palliative care consultant] I have read the consultation document ‘Better Health, Fairer Health’ with interest.</p> <p>The very small investment proposed by the DH would support SHA-wide implementation and maintenance of the Liverpool end of life care pathway (or similar tool), which has demonstrated benefit in ensuring that comfort care, carer support and information, spiritual care and discontinuation of burdensome treatment is considered and implemented by the patient’s caring team.</p> <p>By liaison between organisations, we could also:</p> <ul style="list-style-type: none"> respect the ‘preferred place of care’ requests of dying people: this requires negotiation and support between hospitals, ambulance trusts, out-of-hours GP and DN services, hospices etc., to allow a dying person to safely be transferred, with DNAR order in place, to their preferred destination, even if they may die during transit. This requires Board level agreement from a variety of agencies and could be brokered by the SHA. To achieve this, end of life care packages for support at home must be readily and quickly available; currently, people longing to be at home may die in hospital waiting for a mattress to be delivered or a carer shift to be negotiated to enable care at home. Resolution of the longstanding dispute about ‘social v health’ funding for end of life care is imperative. Experience shows that not all people who express a hope to die at home, subsequently choose to die at home once the circumstance arises. Research is needed to establish what proportion of people, given free choice at the end of their lives, would actually choose to die at home. A significant proportion choose differently at the point of death: hospitals and nursing homes need to be able to deliver appropriate end of life care for people in their care. Shared end-of-life care teams across a wide geographical area could ensure that additional expertise and support is available urgently for staff in nursing homes or those hospital wards where death rarely occurs (similar to an obstetric flying squad). Such inter-agency collaboration could be fostered by the SHA. The strategic direction for palliative care is struggling during frequent reorganisations of stakeholder organisations, particularly commissioning organisations. SHA overview may help to steady the direction and ensure PCO interest for an under funded, unglamorous but essential area of care. <p>In addition, the area of Children’s palliative care is neglected. The Craft/Killen report to the DH (May 07) gives SHAs the responsibility for ensuring availability of palliative care for children. In our own SHA we have excellent palliative care for children with cancer, but no expert team to advise about symptom management or end of life care for children with other life-limiting disorders. An opportunity is arising to discuss this via the Directorate of</p>

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	<p>Children's Services in NUTH, which will be attended by the consultant in paediatric palliative care recently appointed to James Cook Hospital and the experienced consultant from Alder Hey Hospital in Liverpool. Attendance by a relevant member of the SHA team would be timely. (I am about to discuss with Sam Crammond).</p> <p>I would be happy to become more actively involved in this area of SHA planning.</p> <p>[Janine A Ogilvie A07 – North East Community Forests] I absolutely agree end of life should be a focus!!</p> <p>Other commitments should be to the individual dying, to access natural and therapeutic treatments and or INFORMATION on non medical healthcare, such as massage, etc from a nominated agent in the care pathway.</p> <p>In particular, counselling services should be available to every individual in end of life in order to have quality of death.</p> <p>[Mike Lauerman A09 – CSIP – individual] Yes; encourage a debate about all these topics is crucial especially given some of the unhelpful positions of the disability lobby.</p> <p>[Jan Welbury A12 – consultant paediatrician – individual] Definitely, but MUST include adequate provision for end of life care for children and young people, offering a range of menu options including adequate support to choose death at home.</p> <p>[Brian Hedley A14 – Newcastle CC Strategic Housing Service] Principle of a Charter is very laudablenot sure how compliance with the Charter can be secured across the board.</p> <p>[David Chappel A16 – NEPHO – individual] No strong view on this.</p> <p>[Karen Horridge A17 – consultant paediatrician – individual] Definitely, but MUST include adequate provision for end of life care for children and young people, offering a range of menu options including adequate support to choose death at home.</p> <p>[David Chappel A18 – NEPHO response] Hospices independent sector making this complex. Can't understand value of charter and implementation at local level. Dubious evidence base. Commitments all a bit woolly.</p> <p>[Bharat Sibal A20 – Public Health Trainees Group] This section is an important focus for any regional PH strategy. A greater emphasis on carer and family support during end of life care is required. Again, there is no reference to paediatric palliative care services, and this should be considered. We are not sure about the wording of the title of this section (Achieving a good death)- ?whether it might be better to focus on the quality of end-of-life services as title.</p> <p>Additional commitments should include:</p> <ul style="list-style-type: none"> ▪ Coordination across the area re: pathways of care and how these might be resources, also agreements with voluntary agencies ▪ Campaigning / lobbying government re: the needs of this group and resources to support the work <p>Additional comments (Section 3.8)</p> <p>3.8.1 In the context of an ageing population, this is essential</p> <p>3.8.2 Needs to focus not just on groups and settings / buildings, but on pathways which can be applied to many different groups and will ensure more seamless care, transfer between settings and ideally continuity of professionals. The expertise of the voluntary sector e.g. Macmillan should be made best use of and this type of care contracted out where most appropriate</p> <p>3.8.3 Achieving a go</p> <p>3.8.4 od death is not just about palliative care. It is about maximising quality of life and care for older people and the terminally ill in general</p> <p>3.8.5 How will this be transmitted to agencies? Needs to be made real and practical through links to the pathway of care. Support through e.g. Help the Aged / carers' groups</p> <p>Longer-term support is a good aim. How can this be supported by e.g. churches / faith groups who may have expertise in counselling and may also provide social networks to the patient and their families. The important (and evidence based) role of spiritual health should be considered in both this section and 3.7</p> <p>[Vivien Hollyoak A21 – North Tyneside PCT] "Achieving a good death" is out of place in a Regional Public</p>

Q20	<p>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?</p>
	<p>Health Strategy.</p> <p>[Gwen Ellison A27 – Health Trainers Coordination] Yes, end of life should be a focus and is often neglected.</p> <p>[Elaine Richardson A29 – Jobcentre Plus NE Region] Yes agree, particularly as many Jobcentre Plus customers need support following bereavement as the proposal 3.8.7 will support recovery. Research shows ‘work can also be a support in coping with a bereavement’</p> <p>[Leah Blacklock A37 – Community Action on Health] We agree that end of life care should certainly be a focus and as highlighted, the link between this and mental health is a strong one.</p> <p>The need for public sector funding and defined referral pathways into hospice care is crucial in this area as is partnership working.</p> <p>[Janice McColm A40 – Tees Valley Rural Community Council] Sustain and promote Independent living where possible</p> <p>Training for individuals dealing with end of life care. The hospice movement and other voluntary sector organisations need adequate funding to enable them to help people cope and have a ‘good death’. This is a very important regional strategy which cannot be properly addressed within the NHS as it is presently operating.</p> <p>[Charlotte Clarke A44 – University of Northumbria] End of life which is often neglected in the public health agenda. That said, the public health dimension of end of life care needs to be enhanced to clarify how for example it is distinguished from the primary care role</p> <p>[Chris Drinkwater A46 – West End Health Resource Centre] Agree with the sentiments expressed but charters, agreements and standards will not deliver unless there is a serious commitment to drive through cultural change so that older people are treated with dignity and respect across all services.</p> <p>[Heidi Jobling A47 – Newcastle Healthy City Project] yes</p> <p>[Karen Evans A49 – Age Concern and Years Ahead] Yes, Age Concerns in the North East and the Regional Forum on Ageing ‘years ahead’ agree that end of life care should be a focus of a regional strategy and yes these are the right commitments. We felt this section should be longer and more detailed.</p> <p>The title of this section ‘Achieving a good death’ met with a mixed response at our consultation event. Some people commented that it was a poor title, and that they would like to see ‘achieving a good end of life’ which is not just about the deceased person. Carers and family are also important. It should be comfortable and dignified, with choice and control. Others felt that ‘a good death’ was a good title as it contributed to overcoming taboos that exist around death and dying.</p> <p>It was considered that by a “good death” we mean one that is pain free, with family and friends around, (i.e. not alone) with dignity, choosing where you want to die.</p> <p>Other comments from the consultation included the need for :-</p> <ul style="list-style-type: none"> • A better death and choice of place to die – including palliative care for people with dementia • Dignity for everyone • Palliative care for people, good to focus on a good death. Can palliative services for older people be on par with people suffering from cancer • End of life care should be multi disciplinary and multi partnership – it should be prioritised with Local Authorities. • Ageism – you shouldn’t be treated differently because ‘you’ve had a good innings’ to any other group in society in the level of care that is available or offered • Include training and information on: Choice of place to die, palliative care, supportive care, carer support, spiritual support and advance directives. Training should particularly recognise the needs of people with dementia and their carers. <p>Point 3.8.4 was welcomed: ‘It is proposed that the region should establish a charter for end of life care’.</p> <p>Comments at our consultation event suggested that in the end of life charter, attention should be paid to sudden deaths (including suicides) as well as those who die from terminal illnesses.</p>

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	<p>Bereavement Care – older people welcomed point 3.8.7 ‘entitlement to bereavement support / counselling available to all who need it’, especially as at the moment it was felt that services were patchy and unclear as to how they are accessed.</p> <p>Proposal – Clarify who this entitlement would be for in more detail in the strategy.</p> <p>It is important that the entitlement extends to friends and neighbours and not just those in an obvious relationship such as spouse or family. This is especially true, for example, where lesbian gay and bi-sexual people who die may have partners .</p> <p>For further suggestions see Appendix 1</p> <p>[Ceri Mather A50 – Health Improvement Solutions / TPHN] Yes</p> <p>Why are hospices funded through vol contributions not mainstream, why are hospices primarily for cancer victims what about CHD and other terminal illnesses?</p> <p>Not my area of expertise so may not have correct understanding of this, but as a relative of people needing this function that was my experience.</p> <p>[Richard Briggs A51 – Cruse Bereavement Care] We agree that end of life care should be a focus of a regional strategy. We think that the commitments are right but consider that the ending of section 3.8.5 should be amended to “...in support of terminal care and bereavement support services”. We agree paragraph 3.8.6 in relation to establishing standards and expectation of training since Cruse Bereavement Care requires all its volunteers who have client contact to undertake (and pass) appropriate Cruse training courses and to accept continued in-service training and supervision. We especially endorse paragraph 3.8.7 regarding the entitlement to bereavement support/counselling available to all who need it. In accordance with other comments we have made, bereavement care needs to be available to people of all ages, including young children. Our experience shows that people often come for help years after the particular occurrence.</p> <p>[Sue Gordon A53 – PH Consultant – Individual] “Achieving a good death” is out of place in a Regional Public Health Strategy.</p> <p>[Andy Roberts A56 – Ncle CC Children’s Services] Yes</p> <p>[Cynthia Games A59 – Living Streets] End of life care and a good death are important. However see above for comments on care and support resources for an ageing community</p> <p>[Tim Blackman A62 – Wolfson Research Unit] Yes, as part of a health and well-being strategy. Given the research base in the region, there is an opportunity to lead developments nationally.</p> <p>[VONNE A64] VONNE welcome the inclusion of end of life care as a key focus of a regional strategy and agree with the commitments included. We would also add:</p> <ul style="list-style-type: none"> • End of life care should be multi-disciplinary and a multi-partnership, prioritised within local authorities. • Access to bereavement support / counselling should not be restricted to loss of life and should recognise its benefits with regard to issues such as the loss of health. <p>[Dave Parkin A67 – Wallsend Town Hall] Agree. Have regard to spiritual issues and the impact of living wills</p> <p>[Stephen Blair A70 – North of Tyne PEC] Clearly of paramount importance but would not include this in a Public Health Strategy</p> <p>[Craig Duerden A71 – Middlesbrough Community Network] An end-of life strategy is vital. Many people choose to remain in their own home but the true cost to family carers involves additional health risks, loss of income and quality of life in addition to the perceived lack of dignity outside the home.</p> <p>The region’s Hospices now offer 30% of places for respite and palliative care of those with end-stage neurological conditions such as MND, MS and Brain Tumour yet receive 11-15% of funding from statutory sources. A suggestion may be to provide Hospices through mainstream funding.</p> <p>A proposal of entitlement to bereavement support or counselling must include any family member supporting those with MND, MS and Brain Tumour, to include children’s bereavement services.</p> <p>[Joanne Lavender A74 – North East Chamber of Commerce] In the context of an aging society, it is important that this should be a focus.</p>

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	<p>[Angela Dinsdale A76 – St Cuthberts Hospice] Yes agree as access varies considerably. Entitlement to bereavement support would require significant investment. Would like to actively support Charter development. Hospices should also include hospice at home services.</p> <p>[Martin White A77 – Institute of Health & Society] Yes, happy with these proposals. There is much to be said for a concentration on end of life care. It is not clear what is meant by terminal care services. Much terminal care is provided in primary care, or in general hospitals rather than specialised hospices, and there is indeed much that can be done to improve this. For example, there is a widely promoted Liverpool care pathway for end of life care within hospitals. See http://www.mcpcil.org.uk/liverpool_care_pathway It is now extensively used in hospitals, as well as hospices and the community, and forms part of the government's end of life care programme, which is linked to via: http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Endoflifecare/DH_4106262 There is also another side to this issue where people admitted to hospital in terminal phases of an illness are often over investigated and have unnecessary interventions. This is not to deny older people access to appropriate and effective intervention, but often an over-heroic approach is maintained beyond the time that is appropriate.</p> <p>[Ruth Stevens A78 – NE Physical Activity Group] Agree with the sentiments expressed but charters, agreements and standards will not deliver unless there is a serious commitment to drive through cultural change so that older people are treated with dignity and respect across all services.</p> <p>[J Chexal A81 – Soroptomist Society] We agree that end of life care is a neglected area. Funding needs to be increased to hospices, hospice at home schemes etc.</p> <p>[Gateshead Public Health Partnership A82] Encourage people to express their choices and ensure that options are available in practice – in particular support to die at home. Again, ensure inclusion of people in care homes.</p> <p>[Alma Laing A83 – Local Engagement Board Gateshead PCT] Yes, it should be included</p> <ul style="list-style-type: none"> • Choice” in place of death • Standards/Protocols for a “a good death” e.g. dignity, side rooms, no jargon, consistency and clarity of information • Research re: good and bad experiences • Measurement of who dies and what settings • Lack of information and awareness re: options • More statutory funding for hospices <p>Aspirations over the next 25 years:</p> <ul style="list-style-type: none"> • Everyone entitled to a good death <p>[Paul Hanson A89 – North Tyneside Council] This should be an area where local action is taken, whilst we recognise the importance of this issue we are not sure that a regional approach adds value.</p> <p>[Nonnie Crawford A90 – Individual] Yes and look back to info from regional event...</p> <p>[Joyce Leeson A93 – Individual] Yes. Most death will continue to occur in hospitals inc acute wards and A&E. All staff need training and support to improve care in these setups</p> <p>[Nic Best A94 – Campaign to Protect Rural England] This section is very welcome. Emphasis should be on years of healthy life. The importance of linking health care and social care provision should not be restricted to this section.</p> <p>[Joanne Lavender A95 – NE Chamber of Commerce] In the context of an ageing society, it is important that</p>

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	<p>this should be a focus.</p> <p>[Gateshead Healthier Communities Overview and Scrutiny Committee on Health Inequalities Core Group A96] Yes. This is a crucial and resource intensive time with inadequate choices offered and poor ability to discuss options with those concerned. This is likely to impact most on those with least resources.</p> <p>[Jean Blair A97 – Individual] Achieving a good death – it is called “end of life” all the way through the document – is a disrespectful title. It could include a “dignified end of life”. It is to do with the dying process not just death.</p> <p>[Nicholas Baumfield A98 – Arts Council England, North East] The arts are an integral part of the Centre for Ageing and a new strategy on arts and older people is to be launched early in 2008. The arts should be a part of discussions about quality of life and death</p>

Q21	<p>Do you agree that there to 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?</p>
	<p>[Janine A Ogilvie A07 - North East Community Forests] Obesogenic Environment, impact on health and wellbeing.</p> <p>Yes there should be an integrated approach.</p> <p>[Louise Wilson A08 - Individual] Local/regional evaluation of the dominance/monopoly of supermarkets and its impact on health and local communities.</p> <p>[Mike Lauerman A09 - CSIP - individual] Yes: the great thing about research is that we always need more!! Our ability to relate what we know already to policy and practice is the bigger challenge.</p> <p>[Louise Wilson A10 - Northern CFS/ME Clinical Network] Yes, but recognising the importance of engaging the front-line practitioners in research, development, audit and evaluation. More emphasis on dissemination too. Urgent topic for research is CFS/ME – both medical, psychological and social aspects, and specifically looking at incidence/prevalence in the North East, and how this maps with recognition/diagnosis at a local level. The wider impact across education, health, social care and wider communities/networks has been recognised in national/international studies, but remains an under-considered topic in the NE considering the strategic impact of the condition and numbers affected.</p> <p>[Jan Welbury A12 - consultant paediatrician - individual] Sounds an excellent idea.</p> <p>There is an urgent need for high quality research into the health needs of vulnerable children and young people and their families,. Access to services for this group is anecdotally patchy, lacks the immediacy it can often require with inequitable health outcome chances.</p> <p>A good start would be to define who this group are and to start looking at the evidence for which interventions have most impact on quality of life (and quality of death where appropriate). A coordinated, regional approach to this would be most helpful.</p> <p>[Philip Wynn A13 - Durham CC Occupational health service] Recent work in Durham County Council has established an association between sickness absence rates in local authority employees and local levels of deprivation. Hence there appears to be evidence that even in employed groups' deprivation impacts on individual health and organisational indicators. These issues have not been extensively explored in research to date and establishment of the mechanism by which deprivation leads to absence from work is merited. Subject to the outcome of this a number of work based interventions may be worthy of consideration, such as individual health screening of target groups and psychological support mechanisms. Such approaches when previously implemented have not been subject to rigorous evaluation for effectiveness in a public health context.</p> <p>[Brian Hedley A14 - Newcastle CC Strategic Housing Service] Yes</p> <p>Which factors outside the NHS have the biggest impact on premature death and loss of quality of life</p> <p>Yes</p> <p>[Patricia Coombes A15 - Jobcentre Plus] Jobcentre Plus is working with other partners to try to coordinate/integrate research and labour market information to inform strategic decision-making. Adopting a similar approach to health-related information would be beneficial.</p> <p>Although not specifically mentioned in the strategy document, it would be useful to other public sector service providers if this included workplace health-related information, eg the type of illnesses/conditions of people moving into, or already in, work.</p> <p>[David Chappel A16 - NEPHO - individual] Yes. This is very important. Needs reconsidering once the result of the UKCRC bid is known.</p> <p>NB in the table in 4.1.1 there is a key dimension missing from the top row: "education, training and workforce".</p> <p>[Karen Horridge A17 - consultant paediatrician - individual] Sounds an excellent idea.</p> <p>There is an urgent need for high quality research into the health needs of disabled children and young people, as this group is too often forgotten. Access to services for this group is anecdotally patchy, with inequitable health outcome chances.</p>

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	<p>A good start would be to define who this group are and to start looking at the evidence for which interventions have most impact on quality of life (and quality of death where appropriate). A coordinated, regional approach to this would be most helpful.</p> <p>[David Chappel A18 - NEPHO response] Yes. This is very important. Obesity and alcohol are priorities. Needs reviewing once the result of the UKCRC bid is known. NB in the table in 4.1.1 there is a key dimension missing from the top row: “education, training and workforce”.</p> <p>[Denise Orange A19 - Regional Health in the Workplace Group] Although there is strong evidence of the positive effects of work on health and wellbeing (as shown in the review by Waddell, G, Burton AK, 2006 ‘Is work good for your health and wellbeing’) there is a need for further research in relation to the economic benefits to business. A positive impact on the health and wellbeing of the North East population as a result of employers engaging in workplace health is most likely to be achieved with a stronger evidence base on this, specifically related to the North East</p> <p>[Bharat Sibal A20 - Public Health Trainees Group] As far as the research is concerned, there needs to be a broad approach to the research encompassing both qualitative and quantitative research. There also needs to be an assurance that there will be an emphasis on public health and that it is not lost in the broader health care agenda.</p> <p>The matrix illustrated (Figure 7, Page 40) is a useful starting point and helps to frame the discussion. We feel there is a need to make more explicit the links between PCT commissioning and the need to link it to the research and the evidence. It would also be useful to ensure that the research contributes to decommissioning those practices where there is no evidence for effectiveness. It is important to ensure that there are procedures in place to allow for dissemination of evidence to as many people as possible.</p> <p>[Vivien Hollyoak A21 - North Tyneside PCT] We endorse the principles of focussing on evidence based change and the consideration of effectiveness and cost effectiveness of interventions. Collaboration to obtain the evidence is important but additionally the region must ensure that the evidence is implemented and practice is changed as appropriate. A strategic regional lead to encourage the development of evidence based practice, and its sharing and implementation would be helpful.</p> <p>We agree that an integrated approach which encourages partners in academia across the North East to jointly develop and share strong areas of research. Hopefully a successful bid for the Centre for Public Health Research will provide the catalyst for this. More inter-university collaboration will strengthen R & D in the region and the region’s profile nationally.</p> <p>The single structure for R & D discussed relates only to funding to support research governance and the support costs of portfolio only research i.e. research funded by nationally recognised funders e.g. DH, MRC, other national charities and the pharmaceutical industry. A Regional Strategy for support for non-portfolio but strategically important research is required. Pilot, feasibility and student research linked to further degrees for NHS staff also requires funding.</p> <p>[John Woodhouse A25 - HPA] the HPA would strongly support an integrated North East approach to public health research. We really believe there is a shortfall capacity for research that is focused on practical and pragmatic interventions. We believe that the combined universities together with the appropriate external partners, including ourselves, are well placed to promote research to inform action. We believe there is too much researches of descriptive nature and we need more research on the effectiveness of different interventions.</p> <p>[Rachel Turnbull A26 - Northumberland CAB] Mental ill health and the causes and effects of that on individuals, family, community and society and the link between good mental health and free, independent, impartial information, guidance and advice.</p> <p>[Gwen Ellison A27 - Health Trainers Coordination] Yes, integrated NE public health research is needed for collaboration, economies of scale, avoidance of duplication and competition and development of knowledge. Specific areas of research for development could include quality of life years from non-medicalised interventions</p> <p>[Angela Ellins A28 - C&L GONE] Raising aspirations in Young people – research needed on what works Impact of experience at times of transition on young peoples achievements</p>

Q21	<p>Do you agree that there to 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?</p>
	<p>Social norm theory – young people behaviour</p> <p>Impact of transport schemes on health</p> <p>[Elaine Richardson A29 - Jobcentre Plus NE Region] Yes agree to support overall aims for North East. Unable to comment further</p> <p>[Louise Wilson A30 - Sport England] We welcome the high profile that research is given within the strategy and support the notion of an integrated approach to research in the region. We would like to see such an approach to ensure that any new research will fully take into consideration data gathered by partner agencies (such as our Active People survey), and feel that to achieve this it is important that the health sector fully engages with wider partners, like Culture Northeast.</p> <p>We feel that there is a need to have up to date and reliable data on obesity prevalence in the region. We do not feel that research into ‘relationship of food access to car journeys’ is a high priority at the moment.</p> <p>[Barbara Harrison A33 - National Offender Management Service] Yes, NOMS NE agrees that an integrated North East approach to public health research would be beneficial. It might also be appropriate to refer to and learn from work being carried out in other regions and countries, to ensure an effective and collaborative approach to all areas of public health research.</p> <p>[Kevin Rowan A35 - TUC] The TUC believes there is a case for further research into the impact of occupational ill health and health and well-being generally. The increasingly fragmented workforce and workplace means that the capacity to understand, over time, the health of workers through the impact of work has been gradually diminished.</p> <p>Little is known about future health risks from emerging technologies. Nanotechnology, for example, is a rapidly emerging sector of the north east economy, growing out of the pharmaceutical and chemicals clusters in the region. There are clear concerns about the potential impact of nanoparticles on the cardiovascular system of workers, particularly in the process elements of nano industries, as well as on the wider environment and on users of nano products. The Institute of Medicine and the Health and Safety Executive have both expressed concern about the lack of occupational health intelligence about this sector.</p> <p>Yet, in the UK, 150 times more is spent on developing the commercial potential of nano products than is spent on developing an understanding of the occupational health impacts. Trade union organisations are increasingly concerned that we are working toward another industrial epidemic on the scale of asbestos.</p> <p>Action is needed now to develop much greater understanding of the occupational health risks involved in nanotechnology processes and products and to identify hazards and appropriate control measures.</p> <p>[Martin Shaw A36 - Natural England] Yes. We need to see a better linkage and alignment between economic, health and environmental indicators (ref 4.8.2). We need to encourage the NERIP, working closely with the Regional Health Observatory, to better define, collect and collate this key data.</p> <p>We also need to do more to quantify the preventative benefits of regular low level exercise, and to demonstrate the cost effective delivery that green exercise can offer.</p> <p>[Leah Blacklock A37 - Community Action on Health] CAOHA agrees that there should be an integrated North East approach to public health research.</p> <p>[Janice McColm A40 - Tees Valley Rural Community Council] Research into the particular health problems and needs of individuals living in the Rural Areas.</p> <p>[Peter Heywood A41 - Middlesbrough PCT - Individual] Yes!</p> <p>Research needed on best implementation of available evidence. Why is it that we know so much about what should be done to deliver the best available services and interventions and yet this does not happen all the time in all places? There is still too much evidence that is not being implemented.</p> <p>[Ann-Marie Gibson A42 - National Energy Action] NEA agrees that an integrated approach to public health research would be useful for the region.</p> <p>[Charlotte Clarke A44 - University of Northumbria] It is encouraging to see that there is a R&D section and the support of an integrated and collaborative approach across the universities in the region. There does</p>

Q21	<p>Do you agree that there to 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?</p>
	<p>however appear to be an intervention bias to the research agenda, and maybe the translational and upstream dimensions need to be endorsed and enhanced. There appears to be little discussion on some of the foundation work for public health interventions. For example, the functions, configurations and development of social networks and social capital.</p> <p>The solution here to integration appears to lie with the universities, who will whatever the outcome of the UKCRC, will continue to need to develop individual portfolios that may not be without local university competition. There may therefore be some room for the research and especially evaluation element of service to be more clearly funded and with some cumulative approaches rather than short time scale specific intervention evaluation approaches.</p> <p>Any streamlining and coordination for adhering to governance requirements is to be welcomed.</p> <p>[Chris Drinkwater A46 - West End Health Resource Centre] Agree that there needs to be an integrated approach to public health and healthcare research. Priorities should be:</p> <ol style="list-style-type: none"> 1. Transforming research findings into effective operation delivery – what are the blocks, barriers and enablers 2. Effective ways of supporting and maintaining behaviour change – obesity, physical activity etc. 3. Cost-effectiveness of social marketing. <p>[Heidi Jobling A47 - Newcastle Healthy City Project] Yes. Urgent – the culture of illness/ill health in the North East. Hopefully this will involve multi disciplinary research partnerships, as well as inter-university.</p> <p>[Karen Evans A49 - Age Concern and Years Ahead] Yes, Age Concerns in the North East and the Regional Forum on Ageing ‘years ahead’ agree that there needs to be an integrated North East approach to public health research. Our changing demographics and ageing population should be a priority issue for research.</p> <p>It would be useful if there was an integrated approach to all health care research in the region.</p> <p>Other issues for research could include: Possible areas for research could include studying the number of winter deaths in relation to age; how to improve the health and wellbeing of people with dementia; how to change the perceptions and understanding of the wider population of this illness; Palliative care for older people given greater emphasis.</p> <p>Achievements of our universities and Institute for Ageing and Health should be recognised and worked with to ensure the results of their research are adopted for the benefit of people in the region.</p> <p>[Ceri Mather A50 - Health Improvement Solutions / TPHN] This does not all have to be high level academic, we should be better at utilising data collected routinely by front line staff eg HVs DNs to ascertain whether services are targeted effectively and whether interventions are working. We need to instill a research culture throughout organisations to improve the quality of data collection and then we need to feed it back to people to make sure they understand the relevance. Too often data goes into a black hole, no-one sees any outcomes so quality of data collection suffers.</p> <p>I was horrified to hear national radio coverage of a NE project that had examined excess weight and maternal and perinatal deaths. The researcher constantly berated the fact that the wrong sort of data was being collected. My question is why not rephrase the research question to reflect the data you have OR work with the Trusts to get the data that is needed. It is this academic prissyness that puts people off “good enough” is better than none at all and we need to learn what we need to collect. Research is useless unless it has implications for pragmatic implementation.</p> <p>[Richard Briggs A51 - Cruse Bereavement Care] We agree.</p> <p>[Richard Pow A54 - Forestry Commission] An integrated North East approach to public health and other health care research sounds sensible. Research that explores further the role of nature, particularly green exercise and access to quality greenspace, in health and well-being would be valuable.</p> <p>[S.C.Paske A55 - Regional STI Action Group] We would like to see some quality research done across the region to try to understand some of the underlying causes of worsening sexual health</p> <p>[Andy Roberts A56 - Ncle CC Children's Services] Yes</p>

Q21	<p>Do you agree that there to 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?</p>
	<p>We need a shared indicator for the emotional wellbeing of children and young people.</p> <p>[Tricia Cresswell A61 - Durham & Darlington PCTs] Yes.</p> <p>Everything should be intelligence led but question whether we have the resources to build capacity and ensure it is more integrated</p> <p>[Tim Blackman A62 - Wolfson Research Unit] We support the suggestion for supporting regional research, and in particular the proposal for building two way links between research and practice and the exploration of methods for engaging practitioners. We consider that practitioner perspectives and priorities could usefully inform the initial programme of public health and well being research. The rationale for choosing the specific elements of research cited in n section 4.2.8 could be expanded upon.</p> <p>Priority research needs include understanding health-related behaviours, evaluation (including practitioner/policy feedback), addressing inequalities through primary care services, understanding the specific local role of interventions in the wider determinants of health, and conditions for effective partnership working and an analysis of the effectiveness of local strategic approaches to tackling health inequalities.</p> <p>Barriers to the implementation of public health interventions should be researched, such as professional behaviours. Health inequalities can be highly variable on a small-area basis, and researching this variation may enable us to better target public health approaches.</p> <p>[VONNE A64] VONNE would welcome an integrated approach to public health research and seek a clear statement of the inclusion of the VCS in this approach. We would also welcome a similar approach for all health care in the region, and would seek the inclusion of a mechanism which allows VCS access to all the research findings.</p> <p>With regard to the specific areas of research most urgently needed, VONNE suggests that there is a clear need to collate and map the impact the VCS has on health and well-being in the region. Whilst recognising that this would be a large piece of work, we suggest that the primary focus should be on those VCS organisations delivering health and social care services and activities.</p> <p>[Dave Parkin A67 - Wallsend Town Hall] Agree. Research into causes and the care of sufferers of dementia is needed in addition to strokes, cancers and heart disease</p> <p>[Angus Anderson / Arthur Probert A68 - Attend Rights to Warmth] We can see there being value in an integrated approach to public health research across the region and support the call for greater NHS research in the region. We would however expect that any integrated approach would allow for specific local initiatives.</p> <p>With regard to most urgently needed areas of research, we note that the matrix for action on page 40 makes no reference to cold or winter deaths. This omission needs to be corrected as we believe that significant work needs to be done in this area. Our research to date into the prevalence of mild hypothermia within the population and its impact within clinical care, upon social care and general well being is based on reviewing a series of small-scale studies. There needs to be more rigorous research into the prevalence of mild hypothermia, into general attitudes towards cold, the need for concerted, multi-agency programming, including social marketing on a community peer to peer basis, the development of patient led care strategies and changes in health and clinical procedures.</p> <p>[Stephen Blair A70 - North of Tyne PEC] Yes would fully endorse an integrated NE approach to public health research</p> <p>[Craig Duerden A71 – Middlesbrough Community Network] It is agreed that there needs to be an integrated approach to public health research in the North East. There are, however, several areas that are not listed which need to be considered. It is apparent that in Middlesbrough a number of very successful Voluntary and Community Sector (VCS) projects funded through the Health Living Centre programme are under threat because the evidence for justifying continuation funding is simply not there. This compares to statutory sector projects where evidence is available. Therefore the VCS impact on health improvement and well-being has to be a priority for public health research.</p> <p>There is also very little documentary evidence on the effects of sexual violence and its knock on effects in terms of costs to health and social care services. Support services are available, again predominantly through VCS services, and basic evidence suggests that (early) intervention can curtail victims on-going health and social</p>

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	<p>care contact. Again research into this area may prove invaluable. Similarly research into alcohol and domestic violence is urgently required.</p> <p>In terms of health care research this should not be linked with localised specialisms within hospitals as this may hinder processes that re needed with these and other areas.</p> <p>The proposals to consider changes to the built environment to increase physical activity appear to be flawed. It is questionable how much this would impact on a persons health and well-being and secondly to impose environmental changes should not conflict with the rights of individuals – in particular access to the built environment by people who are mobility impaired. We would, therefore, not agree with research into this area.</p> <p>[Joanne Lavender A74 – North East Chamber of Commerce] Taking an integrated regional approach to achieve world class health and health care research status for the North East is priority. The proposal to aim to double NHS R&D funding in the North East is fully supported and the North East clearly has expertise it can build upon. The proposal should contribute to existing strategies including Newcastle Science City and every opportunity to lobby the government to increase support for healthcare research in the North East should be taken.</p> <p>NECC will assist where it can to support this work.</p> <p>[Martin White A77 - Institute of Health & Society] Yes. We are already trying to achieve this through the UKCRC Centre proposal. But, we still need to seek a commitment from the major stakeholders to make it happen in the long term, since this funding is for 5 years only.</p> <p>We do not particularly like the ‘matrix for action’, which is somewhat ill-conceived and needs to be better thought through – we can help on this, if you are interested (contact: Prof Martin White).</p> <p>The method by which the public health research programme (para 4.2.9) is to be implemented is not clear and, as a major stakeholder, we’d want to be centrally involved.</p> <p>Yes, we agree there should be an integrated approach to all health care research in the North East, but this should not in any way stifle current and emerging excellence in biomedical and clinical sciences.</p> <p>There is perhaps insufficient emphasis on evaluation and on methods of rapid implementation and spread. Furthermore, the evidence that cross university collaboration necessarily leads to better research may be lacking, although the aspirations for that are nevertheless supported. Equally, we do not need our local universities to undertake every form of research appropriate to local health problems, although services do need to be able to access the evidence base from wherever it is generated. Equally we do need to build upon academic strengths where they exist. There is a risk of academia becoming a servant to every possible local question and becoming too diffuse and too localised. If there is a need for further academic development to the service it probably most appropriately lies in terms of implementation research and developing skills for local implementation and evaluation.</p> <p>[Ruth Stevens A78 - NE Physical Activity Group] Agree that there needs to be an integrated approach to public health and healthcare research. Priorities should be:</p> <ol style="list-style-type: none"> 1. Transforming research findings into effective operation delivery – what are the blocks, barriers and enablers 2. Effective ways of supporting and maintaining behaviour change – obesity, physical activity etc. 3. Cost-effectiveness of social marketing. <p>[J Chexal A81 - Soroptomist Society] An integrated approach to all health related research is essential. Such research should be prioritised to encompass only what is most useful. We are unable to comment on the specific proposals for research as we are not aware of the research that is already being undertaken across the region.</p> <p>[Gateshead Public Health Partnership A82] There needs to be an integrated approach to public health research but also need to be clear on approaches to build capacity to deliver the vision too.</p> <p>[Alma Laing A83 - Local Engagement Board Gateshead PCT] Yes</p> <p>[Paul Hanson A89 - North Tyneside Council] We would agreed to an integrated North Tyneside approach to public health research which will need to dovetail with a regional approach.</p>

Q21	<p>Do you agree that there to 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?</p>
	<p>[Nonnie Crawford A90 - Individual] Yes...would expect to see much more integrated working from the Uni's and colleges. Require a better understanding of the triggers to 'ask' for an intervention and how this 'ask' might come earlier. Obviously health care research needs to continue apace but social and sociological research required to keep pace. Possible need to understand more of why practitioners still resistant to making different approaches (thinking of primary care and resistance to targeted interventions still)</p> <p>[Steve Brooker A91 - NE Sustainability Officers] Yes, wherever the issue that requires research has an impact across the region i.e. is not pertinent to a particular sub-region. Wherever appropriate, research at a national level should be lobbied for.</p> <p>[Joyce Leeson A93 – Individual] Topics – add contribution of alcohol intake to obesity: components of quality of life: what is sustainable physical activity/ (hypothesis – only walking).</p> <p>[Joanne Lavender A95 - NE Chamber of Commerce] Taking an integrated regional approach to achieve world class health and health care research status for the North East is a priority. The proposal to aim to double NHS R&D funding in the North East is fully supported and the North East clearly has expertise it can build upon. The proposal should contribute to existing strategies including Newcastle Science City and every opportunity to lobby the government to increase support for healthcare research in the North East should be taken.</p> <p>NECC will assist where it can to support this work.</p> <p>[Gateshead Healthier Communities Overview and Scrutiny Committee on Health Inequalities Core Group A96] Yes. An action learning/ reflective practice approach is required to help bridge the gap between academic systematic reviews and the application of evidence, to whole system complex real life situations. This approach will help improve evaluation and begin to build evidence from the ground up. In work with deprived communities community members should be involved with the research and build their skills as research investigators.</p> <p>[Nicholas Baumfield A98 – Arts Council England, North East] An integrated approach would seem entirely appropriate. The North East contains one of the country's leading arts and health research centres – the Centre for Arts and Health Management, based at Durham University. At present subject to the market-place of funded research opportunities its contribution could be maximised through integrated regional research enhancement</p> <p>[Alisa Rutter B01 – Fresh – Smoke Free North East] Yes agree- welcome the UKCRC success which should help to achieve this.</p>

Q22	<p>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?</p>
	<p>[Janine A Ogilvie A07 – North East Community Forests] In addition to the list I strongly suggest, Obesity and unacceptability of obesity be a priority.</p> <p>I would also suggest STRESS be included.</p> <p>[Mike Lauerman A09 – CSIP – individual] Yes; also in violence and bullying should go further than domestic; cycle lanes yes anything to enhance and protect them and their users.</p> <p>[Jan Welbury A12 – consultant paediatrician – individual] Children are missing again.</p> <p>Smoking in pregnancy and in the company of children is great, but what about SMOKING IN CHILDREN AND YOUNG PEOPLE?</p> <p>Insufficient emphasis overall on the importance of improving the health and life chances of children, including disabled children.</p> <p>[Brian Hedley A14 – Newcastle CC Strategic Housing Service] Yes. Creation of more social capital through more self-help community groups.</p> <p>[Patricia Coombes A15 – Jobcentre Plus] The priorities for marketing health campaigns (section 4.4) mention health and well-being as criteria for assessing regional economic developments, but it is not clear whether or not this includes promoting work as a form of improving health and well-being.</p> <p>[David Chappel A16 – NEPHO – individual] These seem fine.</p> <p>[Karen Horridge A17 – consultant paediatrician – individual] Disabled children are missing again.</p> <p>Smoking in pregnancy and in the company of children is great, but what about SMOKING IN CHILDREN AND YOUNG PEOPLE?</p> <p>Insufficient emphasis overall on the importance of improving the health and life chances of children, including disabled children.</p> <p>[David Chappel A18 – NEPHO response] Need more clarity about what approach going to be used in this area? (e.g. Campaigns. Are market segmentation techniques Mosaic, Experian needed.</p> <p>[Denise Orange A19 – Regional Health in the Workplace Group] Again, workplace health is a significant omission from this section. We would like action on reducing sickness absence levels as a result of better health in the workplace to be included as well as employment and retention of socially excluded groups</p> <p>[Bharat Sibal A20 – Public Health Trainees Group] Need to clarify when the regional campaigns listed will be established, since at the moment this looks a bit woolly – need definite timescales etc. Who decided what should be on this list, since there are endless areas for which social marketing strategies could potentially be used? Need to make sure the right people made this decision. Support needed to use social marketing strategies seems appropriate.</p> <p>Agree with the need for a local centre that links with the national programmes. There also needs to be a strong and local evidence base for social marketing – what works. Social marketing principles need to be applied in the design and planning of all health improvement programmes. Frameworks and checklists can be produced to enable programme leads and commissioners to evaluate the marketability of health programmes and interventions. Regarding the list of priorities for social marketing, some of them need to be made more explicit and some are predominated by health improvement themes with little mention of health service quality, patient safety and health protection.</p> <p>Additional comments (Section 4.3)</p> <p>Pleased to see that the importance of cultural factors is being taken into consideration. Agree with the aspirational target of making the health in the North East to be the best in the world. The culture changes suggested focus on change in individual and public perceptions public and the lobbying nationally and locally which are key to achieving health improvement. There however is no mention of culture change within the NHS (structural and procedural). This culture change should include amongst other things changes in attitudes and views on primary prevention, better ad ring fenced funding and commissioning of health improvement</p>

Q22	<p>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?</p>
	<p>programmes, funding of these programmes. Other examples include changing the the culture of constant reorganisation, public health funds being an easy target for covering financial deficits.</p> <p>[Vivien Hollyoak A21 – North Tyneside PCT] The proposed regional infrastructure for social marketing is welcomed as is the suggestion that alcohol should be a campaign issue.</p> <p>[John Woodhouse A25 – HPA] we strongly support the approach of such marketing in addressing those problems that lend themselves to be addressed in this way. We would strongly support the use of social marketing to change sexual behaviour and improving sexual health.</p> <p>[Rachel Turnbull A26 – Northumberland CAB] Need to go beyond just recognising depression/suicide risk – also promote ways in which becoming depressed/stressed can be controlled/avoided – e.g. seeking information, advice and guidance.</p> <p>[Gwen Ellison A27 – Health Trainers Coordination] A priority is tackling obesity within the general population.</p> <p>[Elaine Richardson A29 – Jobcentre Plus NE Region] Agree</p> <p>[Louise Wilson A30 – Sport England] We are concerned that physical activity is not mentioned as a theme for social marketing, particularly in view of all of the social marketing activity planned around this area. Sport England has a wealth of data that could support this approach, which is already being accessed by the National Social Marketing Centre.</p> <p>[Caroline Airs A31 – Gateshead Advocacy Information Network]</p> <ol style="list-style-type: none"> 1. Campaigns in relation to educational aspiration and expectation of the region’s children need to include the region’s disabled children and children from other minority groups, and should include awareness raising of the rights of all children to have high aspirations, and to achieve their full potential 2. Any campaigns in relation to Getting Help Early need to include specific campaigns aimed at marginalised groups, and awareness raising campaigns amongst provider staff in relation to the needs of marginalised groups <p>[Barbara Harrison A33 – National Offender Management Service] The campaigns listed on page 43 all focus on pertinent issues and it would be worthwhile pursuing them at a regional level. As noted in the answer to question 11, it would be useful to highlight the links between alcohol and offending generally, as opposed to focusing purely on violent crime. It will also be important to ensure that the campaigns are targeted and evaluated. Information for information’s sake can be counter-productive and it is essential that any campaigns have clearly defined and achievable outcomes.</p> <p>[Jennifer Taylor A34 – Tees Public Health Dept] “The effects of smoking are notably one of the most important areas of concern for this region. The evidence is comprehensive in maintaining the best methods of encouraging young people to quit is to encourage adults to do so, however, young people can be a forceful voice and are keen to join focus groups/ action groups when they realise that the tobacco industry has lied to them. Work going on in Liverpool with young people is worth examining.”</p> <p>[Martin Shaw A36 – Natural England] Welcome the social marketing role of developing a new vision for economic, social and environmental development. Important in helping to establish the new wider partnership needed to take this agenda forward (see 3.5.12).</p> <p>Physical activity should be a social marketing theme in its own right. We need to build on previous work to establish physical activity (including green exercise) as a critical, cost effective prevention – in terms of the region’s health and wellbeing.</p>

Q22	<p>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?</p>
	<p>[Leah Blacklock A37 – Community Action on Health] CAOH agrees with the campaign issues but would suggest thinking about innovative ways of getting the messages across and consulting with communities about the most effective ways of doing so.</p> <p>[Janice McColm A40 – Tees Valley Rural Community Council] Mental Health should be a priority. Encourage people to buy local grown produce</p> <p>[Ann-Marie Gibson A42 – National Energy Action] NEA supports the proposal of an annual Winter Health Protection Plan and would urge that this be adopted as a priority because of the health and well being benefits that action on fuel poverty can deliver. For example, improvements in: mental health (reduction of stress, anxiety, depression,); educational attainment; cold-related morbidity and mortality. However, this plan should not rely on current provision to meet the need.</p> <p>[Charlotte Clarke A44 – University of Northumbria] Caution needs to be exercised by acknowledging that social marketing is not an alternative to population participation</p> <p>[Chris Drinkwater A46 – West End Health Resource Centre] The four things that are missing from the list are:</p> <ol style="list-style-type: none"> 1. Promoting physical activity 2. A campaign targeting parents in areas with high levels of obesity 3. Promoting autonomy and independence in older people 4. Men's health <p>[Heidi Jobling A47 – Newcastle Healthy City Project] 4.4.4. is potentially misleading –</p> <p>1] the emphasis on link between drunkenness and domestic violence as significant violence occurs without alcohol consumption.</p> <p>2] 'building educational aspiration' suggest there is a lack in some children (see response to q.13)</p> <p>3] Social Marketing may not be the best instrument for promoting debate about health and well being criteria.</p> <p>[Karen Evans A49 – Age Concern and Years Ahead] Age Concerns in the North East and the Regional Forum on Ageing 'years ahead' agree with the social marketing and campaigns issues listed. However we would like to see more focus on the health and wellbeing of older people in the campaign issues, particularly in relation to people adding 'healthy' years to life.</p> <p>[Ceri Mather A50 – Health Improvement Solutions / TPHN] Teenage conceptions is missing</p> <p>Wonder if there are too many , don't want to reach death by social marketing</p> <p>Also We have to deliver, if we keep asking the questions we have to deliver what they ask for NB the Stanley Clock example</p> <p>[Richard Pow A54 – Forestry Commission] We are surprised that physical exercise is not included among the list of priorities for campaigns, given the key part it has to play in addressing obesity and other health issues facing the region. If such a campaign was mounted we would be very happy to link with it through our own work to encourage woodland based physical activity such as Active Woods.</p> <p>[S.C.Paske A55 – Regional STI Action Group] We agree that a social marketing and lobbying approach is a good one. We would like to see social marketing increasingly used to normalise the use of condoms and to make practising unsafe sex more socially unacceptable.</p> <p>[Andy Roberts A56 – Ncle CC Children's Services] Breastfeeding.</p> <p>Promoting the benefits of seeking emotional support.</p> <p>[Cynthia Games A59 – Living Street] Marketing campaigns, when appropriately targeted, can be most effective. However, it would also be cost-effective to build upon good practice which has already been achieved in reaching the public, and in sustaining the success of what is already working well.</p>

Q22	<p>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?</p>
	<p>Living Streets is already taking the lead in promoting walking as an everyday lifestyle choice. Among other campaigns, Living Streets co-ordinates:</p> <ul style="list-style-type: none"> • the national Walk to School campaign (which is already successfully used by 82% of Local Authorities in England at primary school level and will expand into secondary schools in 2008) • Walking Works • Fitter for Walking (which launches in 2008) <p>These campaigns are having a demonstrable impact on hearts and minds across the country and it is hoped to sustain this success, subject to funding and partnership working arrangements</p> <p>[Tricia Cresswell A61 – Durham & Darlington PCTs] Yes, although would add physical activity particularly because of the north east's involvement in previous advertising campaigns for example the Everyday Sport programme.</p> <p>[Tim Blackman A62 – Wolfson Research Unit] The evidence base for social marketing is not strong enough in all areas to make general major commitments; the approach should be one of pilots and evaluation, with alcohol and perhaps mental health as the first priorities. Moreover, more detail is needed on the form and spread of regional campaigns and their effectiveness in comparison with national or local campaigns, or other kinds of intervention designed to engage with various groups.</p> <p>[Madeleine Johnson A63 – PHNE – Individual] I am pleased to see that screening has been included, but this needs to be supported by appropriate narrative in section 3.6.2</p> <p>[VONNE A64] Although we welcome all of the proposed areas, we do have a slight concern with regard to a social marketing campaign linking alcohol and domestic violence. Domestic violence is not solely caused by excessive alcohol consumption. Even where alcohol is a factor it is only one of many. We would argue that domestic violence is a form of abuse and whether perpetrators have consumed alcohol or not is irrelevant. We would not wish to establish in the mindset of the general public that excessive alcohol consumption leads to domestic violence or vice versa, as we believe this may have a negative impact on both reporting and conviction rates.</p> <p>We would welcome further debate on the issues, but would rather a social marketing campaign focuses on a zero tolerance approach to domestic violence.</p> <p>With regard to excessive alcohol consumption we would welcome a campaign which reiterates the dangers of becoming a victim of crime after consuming excessive amounts of alcohol.</p> <p>With reference to the other areas identified we refer you to our previous comments within this consultation response.</p> <p>[Caroline Wild A66 – Learning Disability Directorate NTW NHS Trust] Social marketing needs to be tailored for all diverse groups, in particular it should be accessible for people with a learning disability.</p> <p>[Dave Parkin A67 – Wallsend Town Hall] Agree. Nothing to add</p> <p>[Angus Anderson / Arthur Probert A68 – Attend Rights to Warmth] We agree that the Winter Health Protection Plan should be one of the campaigns pursued, provided that it encompasses the wider effects of cold that we have discussed earlier.</p> <p>[Stephen Blair A70 – North of Tyne PEC] This is welcomed</p> <p>[Craig Duerden A71 – Middlesbrough Community Network] The proposals for social marketing are generally welcomed and it is agreed that this has a role to play in the increased health and well-being of the North East. However specific campaigns may not bring about a significant impact, for example, the Winter Health Protection Plan may be scaled down to focus on specific intervention that re proven to work. In terms of environmental changes it may be wiser to concentrate on the effects of summer heat waves in the future.</p> <p>[Kirsty Foster A75 – Health Protection Agency] As above, work should be considered on sexual health and migrant health (reducing stigma, normalising some positive aspects of behaviour and targeting specific risk behaviours)</p> <p>[Martin White A77 – Institute of Health & Society] Yes, all important, but there is some rather rigid thinking here. There is clearly a need to do some initial research to develop better insights into the issues that could most effectively be tackled using this approach; presently this whole approach seems not to be based on clear</p>

Q22	<p>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?</p>
	<p>evidence.</p> <p>Key issues that might be amenable to a Social Marketing approach:</p> <ul style="list-style-type: none"> Healthy pregnancy (smoking, particularly focussing on the young before they get pregnant; alcohol; diet; physical activity) (the right mix for development and delivery of interventions needs to be researched) (contacts: Drs Ruth Bell and Judith Rankin) Breast feeding Teenage pregnancy Healthy parenting Physical activity, diet (including children's diet), obesity (the right mix of these to reduce obesity needs to be researched) (contacts: Prof Martin White, Dr Ashley Adamson, Dr Ruth Bell). <p>Sexual health.</p> <p>[Ruth Stevens A78 – NE Physical Activity Group] The three things that are missing from the list are:</p> <ol style="list-style-type: none"> 1. Promoting physical activity 2. Promoting autonomy and independence in older people 3. Men's health <p>[J Chexal A81 – Soroptomist Society] The Social Marketing and campaigning issues listed seem to be appropriate. However, campaigns can be costly and we need to ensure that the methods used are cost effective. We need to take a positive approach, including the promotion of healthier alternatives.</p> <p>[Gateshead Public Health Partnership A82] Add changing perceptions of old age (see page 16) and removing the stigma of mental health problems.</p> <p>Building social marketing capacity should be a regional priority</p> <p>[Nonnie Crawford A90 – Individual] They are all important...still think we're missing adopting a gender as well as age sensitive approach to our stratification but mortality data identifies where we need to go...</p> <p>[Joyce Leeson A93 – Individual] Social marketing should put heavy stress on running media for real health issues, attractive and credible role models, sensible discussion etc. Always be available to comment. In accessible way, about latest fads etc.</p> <p>[Nic Best A94 – Campaign to Protect Rural England] There are a number of cultural shifts required and implied by the strategy which could be better developed. These include: general attitude to risk, the social-consumerist attitude to alcohol, attitudes to death and attitudes to mental health.</p> <p>[Gateshead Healthier Communities Overview and Scrutiny Committee on Health Inequalities Core Group A96] The concept of social marketing is good but there are not enough practical examples of implementation yet. Social marketing has a useful role in understanding the values placed by different groups in the population on health related issues, however it can not be seen as a single solution. For example social marketing to reinforce the messages on diet during pregnancy is best placed as part of a more general campaign on obesity, as well as ensuring access to healthy food, and local activities to promote its uptake.</p> <p>[Nicholas Baumfield A98 – Arts Council England, North East] Participation in cultural activity would for the Arts Council be a priority for social marketing campaigning.</p> <p>[Alisa Rutter B01 – Fresh – Smoke Free North East] Caution required here- the biggest impact on smoking and pregnancy is unlikely to come from a social marketing campaign at pregnant women in isolation of other measure and real caution needed in what this campaign would entail.</p> <p>The earlier section on smoking has outlined some of the key areas for social marketing and also advocacy campaigns.</p> <p>There is a real need for much better communication amongst all the relevant policy leads to ensure that there is no wastage of resources, mixed messages, overload to key target audiences. The Institute's role is crucial to help to ensure that work is coordinated, evidence based and everyone starting from the same understanding of social marketing- this is not in place currently</p>

Q23	<p>Are the legislative objectives appropriate? What other changes to law and current practice might enhance health and well being in the North East?</p>
	<p>[Janine A Ogilvie A07 - North East Community Forests] Yes the legislative objectives are appropriate. In addition I suggest we consider the development of new and MAINTAINANCE of existing cycle/walk paths across the north east. Green Corridors that provide the infrastructure for people to travel independently/actively, to and fro, home, work, school and play.</p> <p>[Louise Wilson A08 - Individual] See comments on town planning and the dominance/monopoly of supermarkets on health and local communities.</p> <p>[Mike Lauerman A09 - CSIP - individual] Yes; let us try and deliver on these rather than seek even more.</p> <p>[Jan Welbury A12 - consultant paediatrician - individual] Legislative objectives must include ensuring that ALL planned activities and facilities are fully accessible to ALL, including disabled children, young people and adults.</p> <p>[Brian Hedley A14 - Newcastle CC Strategic Housing Service] Reduction of speed limits in residential areas. More pedestrianised shopping areas to encourage walking More park and ride to reduce town centre car traffic</p> <p>[David Chappel A16 - NEPHO - individual] These seem fine.</p> <p>[Karen Horridge A17 - consultant paediatrician - individual] Legislative objectives must include ensuring that ALL planned activities and facilities are fully accessible to ALL, including disabled children, young people and adults.</p> <p>[David Chappel A18 - NEPHO response] These seem fine.</p> <p>[Bharat Sibal A20 - Public Health Trainees Group] Many of the changes listed (Section 4.5) are piecemeal and although few would disagree with these suggestions, a larger picture needs to be considered.</p> <p>What about legislation to bring public transport back into public ownership? That way, public transport could be organised in a way to promote health and well being rather than profitability e.g. compared with other cities the North East has now fallen well behind the promotion of accessible and integrated public transport (Sheffield, Manchester, even London now)</p> <p>What happened to the need for HIAs in planning and traffic proposals? If this was part of the legislative process then health and well-being would have to be given a higher priority</p> <p>There should be a campaign to ban smoking while driving. It is against the law to use a phone or eat or drink while driving so it is bizarre that smoking is allowed. This would help reduce further non-smokers and particularly children's exposure to second hand smoke. It will further limit where smokers can smoke and thereby reduce their consumption further.</p> <p>Lobbying for a change from the death and destruction messages on cigarette packets could have a very positive impact e.g. last year 500,000 people gave up smoking or you are four times more likely to give up successfully if you use the NHS stop smoking services. Every year some 80% of smokers consider giving up and there is much more we can do to help them.</p> <p>Increased taxation is an essential part of getting to grips with our alcohol problems but raising taxes will not be popular with our politicians. However if it was made clear that the extra revenue from the taxation would all be ploughed back into alcohol treatment facilities, and better services for domestic abuse and child abuse it could also serve as a reminder of the many devastating effects that alcohol can have on innocent bystanders.</p> <p>We also need improved labelling of alcohol so it is easier to work out accurately how many units we are consuming.</p> <p>Within the regional strategy, local organisations should be supported and encouraged to campaign locally for legislative changes, e.g. in regional planning, LA bylaws, etc.</p> <p>What about climate change legislation following from the Stern Review? e.g. reducing emissions would impact favourably on those with many chronic diseases and improve the quality of life for the whole population. But climate change is wider than just emissions. e.g. legislation against building houses on flood plains should be promoted.</p> <p>What about enforcement of current legislation that is largely ignored, e.g. access to goods and services under</p>

Q23	<p>Are the legislative objectives appropriate? What other changes to law and current practice might enhance health and well being in the North East?</p>
	<p>the Disability Discrimination Act?</p> <p>Promoting the use of stairs is a good idea provided it is not at the expense of those in our society who are unable to use them.</p> <p>[Vivien Hollyoak A21 - North Tyneside PCT] There is little evidence that the regional public health lobby can be effective in initiating legislative change. Issues need political impetus before the regional office can usefully get behind them. We doubt whether this will be the most effective use of time and resource.</p> <p>[Rachel Turnbull A26 - Northumberland CAB] Changing the work/life balance and the pressures this entails. Increasing the wages of the lowest paid/ those dependent on benefit – making sure that people really are better off in employment.</p> <p>Improving the whole benefits/tax credit system.</p> <p>Tackling over indebtedness and the general poverty that many still live in and improving financial inclusion.</p> <p>Increased funding for agencies providing information advice and guidance in a recognition of the important work they do.</p> <p>Increased funding for agencies working with people with mental health problems/illness.</p> <p>[Elaine Richardson A29 - Jobcentre Plus NE Region] Agree</p> <p>[Caroline Airs A31 - Gateshead Advocacy Information Network] 1. Any schemes designed to shift priority to walking, cycling and public transport should not discriminate against people for whom these are not viable options.</p> <p>2. Changes to building regulations to prioritise stairs would undo what limited progress has been made over recent years to achieve equality of access for disabled people</p> <p>[Peter Wright A32 - NE Chief EHOs Group] Lobbying is also needed for outcomes short of legislation:</p> <ul style="list-style-type: none"> • Changes to the national curriculum so that health literacy, high self-esteem and assertiveness become part of the desired outcomes of education • Changes to the QOF so that some patient data is recorded regularly, eg smoking status • Changes to the national planning guidance so that it is much easier to saturate an area with fruit shops than it is hot food take aways <p>[Barbara Harrison A33 - National Offender Management Service] Legislative objectives are appropriate, but within the correct context. For example, an independent Office for the Safe Consumption of Alcohol would be much better placed than any governmental body to lobby for increased taxation on alcohol, greater regulation of outlets, restricted cut-price sales etc.</p> <p>[Leah Blacklock A37 - Community Action on Health] In terms of legislation, improved regulation of alcohol sales and counterfeit tobacco is particularly important but we do support all of the suggestions made.</p> <p>[Janice McColm A40 - Tees Valley Rural Community Council] The legislative objects are appropriate but perhaps lobbying to increase the age you need to be to buy and consume alcohol from 18 to 21 would be advantages to help stem the culture of binge drinking in young people.</p> <p>Perhaps further legislation on young people driving high powered motored vehicles when they have just passed their driving test needs to be considered to cut down the high percentage of younger people being killed in road accidents.</p> <p>[Chris Drinkwater A46 - West End Health Resource Centre]</p> <ol style="list-style-type: none"> 1. Campaigning for hypothecated taxes on alcohol to be used to fund alcohol treatment services 2. Use of carbon offsetting to incentivise energy efficient buildings/organisations. <p>[Karen Evans A49 - Age Concern and Years Ahead] Yes, Age Concerns in the North East and the Regional Forum on Ageing 'years ahead' consider the legislative objectives appropriate.</p> <p>[Ceri Mather A50 - Health Improvement Solutions / TPHN] yes</p>

Q23	<p>Are the legislative objectives appropriate? What other changes to law and current practice might enhance health and well being in the North East?</p>
	<p>[S.C.Paske A55 - Regional STI Action Group] We believe that lobbying for legislative change should have as a priority the inclusion of quality sex and relationships education in the National Curriculum, also the removal of VAT on condoms and a change in the current practice of only being allowed to broadcast advertising for condoms after the 9pm watershed.</p> <p>[Tricia Cresswell A61 - Durham & Darlington PCTs] The legislative objectives are appropriate. Advertising/promotion/sponsorship of products to children and young people eg alcohol, food etc. There is a big need for the public health community to work with other to be the ‘eyes and ears’ to monitor advertising and report any suspected breaches to the relevant bodies. In addition, lobby for more stringent legislation on products that have a health damaging impact.</p> <p>Suggest the public/private contracts for new building infrastructure should be impacted assessed for their health impact. Also suggest legislative changes to ensure appropriate provision for indoor/outdoor physical activity within any new build.</p> <p>[Tim Blackman A62 - Wolfson Research Unit] Yes, but could include licensing the sale of cigarettes and stronger health labelling of alcohol.</p> <p>[VONNE A64] We would refer you to our previous comments and would add that additional lobbying should be undertaken to change the way central government funding allocation for the regions are calculate.</p> <p>At present the majority of funding calculations work on the basis of population size. As recognised in the draft strategy document, the North East needs to move further and faster than other regions to ensure the achieve parity. We propose that funding calculations should be based on the percentage of a population living in a deprived area and active lobbying should be undertaken on this issue.</p> <p>[Dave Parkin A67 - Wallsend Town Hall] Agree</p> <p>[Angus Anderson / Arthur Probert A68 - Attend Rights to Warmth] We would advocate the extension of the Warm Front scheme to make it available on basis of health needs, and not just related to the receipt of selected benefits.</p> <p>[Arthur Probert / Angus Anderson A68– Attends Rights to Warmth] We would advocate the extension of the Warm Front scheme to make it available on basis of health needs, and not just related to the receipt of selected benefits.</p> <p>[Craig Duerden A71 – Middlesbrough Community Network] A general comment about this is that there does not appear to be anything new or innovative in these objectives. There are some good suggestions and clear linkages e.g. the cycling routes proposals connects a number of key focus areas and also supports initiatives on climate change. These broader arguments perhaps need to be made more forcibly.</p> <p>The changes to building regulations to prioritise stairs and activity promotion cannot be supported as it conflicts with equality of access issues as identified in other parts of this response.</p> <p>[Joanne Lavender A74 – North East Chamber of Commerce] Caution must be taken in this area given that public money should only be spent when there is a significant coalition of support. Business may be unable to support some of these proposals for changes particularly if it is only for the North East and not UK wide.</p> <p>Any changes to building regulations to prioritise stairs and activity promotion should not alter the requirements of existing regulations.</p> <p>[Martin White A77 - Institute of Health & Society] Yes.</p> <p>Restrictions on planning consent for fast food outlets, and may be some other types of food outlets in deprived areas (there is evidence on this that needs to be considered).</p> <p>Ban: smoking while driving; cigarette vending machines; cigarette packets from view</p> <p>Bike lanes need to be physically separated from car/bus lanes (e.g. using a curb), as they are in some European cities, there is evidence to support this (just cycle around Newcastle in the dark during rush hour...)</p> <p>[Ruth Stevens A78 - NE Physical Activity Group] Campaigning for hypothecated taxes on alcohol to be used to fund alcohol treatment services</p>

Q23	<p>Are the legislative objectives appropriate? What other changes to law and current practice might enhance health and well being in the North East?</p>
	<p>Use of carbon offsetting to incentivise energy efficient buildings/organisations.</p> <p>[J Chexal A81 - Soroptomist Society] These legislative approaches are appropriate. As mentioned earlier, we would not wish to see increased use of chewing tobacco.</p> <p>Can we move towards a ban on alcohol advertising, as has happened with tobacco?</p> <p>And elimination of duty free sales of tobacco and alcohol?</p> <p>[Gateshead Public Health Partnership A82] We believe that the region can build on the success of the campaigning for the smoke free legislation and champion other legislative changes. The suggested legislative changes are appropriate.</p> <p>[Nonnie Crawford A90 - Individual] Yes...there will be others but most likely need to be in conversation to think of them rather than like this!</p> <p>[Steve Brooker A91 - NE Sustainability Officers] There is a need to look at how Local Authorities choose where to place cycle lanes. It can be counter-productive to have a cycle lane that suddenly ends in a dangerous situation. It gives the perception that 'ticking the box' on kilometres of cycle lane produced is more important than encouraging more cycling by making it safe.</p> <p>[Peter Wright A92 - NE Public Protection Chief Officers Group] Lobbying is also needed for outcomes short of legislation:</p> <ul style="list-style-type: none"> • Changes to the national curriculum so that health literacy, high self-esteem and assertiveness become part of the desired outcomes of education • Changes to the QOF so that some patient data is recorded regularly, eg smoking status • Changes to the national planning guidance so that it is much easier to saturate an area with fruit shops than it is hot food take aways <p>[Joyce Leeson A93 – Individual] V good. Suggest for alcohol prominent display of alcohol content and reduced tax on lower alcohol products.</p> <p>Nic Best A94 – Campaign to Protect Rural England] There are a number of cultural shifts required and implied by the strategy which could be better developed. These include: general attitude to risk, the social-consumerist attitude to alcohol, attitudes to death and attitudes to mental health</p> <p>[Joanne Lavender A95 - NE Chamber of Commerce] Caution must be taken in this area given that public money should only be spent when there is a significant coalition of support. Business may be unable to support some of these proposals for changes particularly if it is only for the North East and not UK wide.</p> <p>Any changes to building regulations to prioritise stairs and activity promotion should not alter the requirements of existing regulations.</p> <p>[Gateshead Healthier Communities Overview and Scrutiny Committee on Health Inequalities Core Group A96] Lobbying is also needed for outcomes short of legislation:</p> <ul style="list-style-type: none"> • Changes to the national curriculum so that health literacy, high self-esteem and assertiveness become part of the desired outcomes of education • Changes to the QOF so that some patient data is recorded regularly, eg smoking status • Changes to the national planning guidance so that it is much easier to saturate an area with fruit shops than it is hot food take aways • Changes to procurement rules to make local products more attractive eg cost in food miles • Ensuring Health Inequality Impact Assessment is part of all decision making processes.

Q24	<p>Are the proposed NHS Service changes justified and necessary?</p>
	<p>[Janine A Ogilvie A07 – North East Community Forests] Agree with proposal.</p> <p>[Mike Lauerman A09 – CSIP – individual] What even more change!!</p> <p>[Jan Welbury A12 – consultant paediatrician – individual] Please read all the comments above. This document does not adequately address the health needs of children and young people and specifically does not address the needs of disabled and vulnerable children.</p> <p>[Brian Hedley A14 – Newcastle CC Strategic Housing Service] Not convinced that an Office for the safe consumption of alcohol will have any tangible, marked impact</p> <p>[David Chappel A16 – NEPHO – individual] Apart from bullet 7 – see Q11</p> <p>[Karen Horridge A17 – consultant paediatrician – individual] Please read all the comments above. This document does not adequately address the health needs of children and young people and specifically does not address the needs of disabled children.</p> <p>[David Chappel A18 – NEPHO response] Apart from bullet 7 – see Q11. What is the evidence base for these changes?</p> <p>[Bharat Sibal A20 – Public Health Trainees Group] Any further service reconfiguration must be mindful of the impact on staff of yet more re-organisation</p> <p>There should be an integrated research strategy and annual regional funding for this should be welcomed. It should be responsive to local needs and agreed priorities.</p> <p>Research should focus not just on academic research but applied research undertaken by practitioners. It needs to be undertaken in collaboration with academic institutions, local authorities, transport providers, etc.</p> <p>For public health, that may mean some re-alignment of finances from clinical trials to research around public health interventions and approaches. It would also mean providing support and backfill to allow practitioners the time to actually undertake this.</p> <p>There also needs to be a mechanism for sharing and disseminating research findings and good practice locally, to avoid the “re-inventing the wheel” syndrome.</p> <p>Increased availability of brief interventions for alcohol is an excellent idea but does not go far enough. Every man, woman (+dog) in the NHS should be trained to give brief interventions for alcohol and smoking and more opportunities should be taken to measure peoples blood pressures and carbon monoxide levels. Few people get through a hospital outpatient appointment without their urine being tested for glucose but often their blood pressure is not measured and their carbon monoxide levels are almost never measured.</p> <p>It is high time that QOF required GPs to engage in brief interventions for alcohol, smoking and level two stop smoking interventions.</p> <p>It was disappointing not to see “looked after children”, prisoners and cardiovascular disease prevention mentioned in this section especially as we should be aspiring to closing the inequalities gap and promoting prevention.</p> <p>[Vivien Hollyoak A21 – North Tyneside PCT] We support the changes proposed.</p> <p>[Gwen Ellison A27 – Health Trainers Coordination] Yes but non-NHS services need to change too and these need to be identified within this strategy. .</p> <p>[Elaine Richardson A29 – Jobcentre Plus NE Region] Agree as they support overall objectives, but unable to comment further</p> <p>[Barbara Harrison A33 – National Offender Management Service] It is increasingly important to allocate funding according to need and this principle applies to the NHS as much as any other organisation. In accordance with the notion of ‘fairer health’, it is also important to extend and improve access to services for all, including socially excluded groups, such as offenders.</p> <p>[Martin Shaw A36 – Natural England] Strongly support the need to fund referral for physical activity but as per comments under 3.3.4 – the definition of who and what to fund needs to be widened. There is however room for debate as to how the numerous public players across the health and economic spheres can come together to deliver this goal. Important to build systematic, long term maintenance into rehabilitation and exercise referral programmes.</p>

Q24	<p>Are the proposed NHS Service changes justified and necessary?</p>
	<p>[Leah Blacklock A37 – Community Action on Health] We believe that the proposed changes are justified and would welcome them.</p> <p>[Janice McColm A40 – Tees Valley Rural Community Council] More assistance for people who need to recuperate at home after a short stay in hospital is important so that they are not on a roundabout and end up having to go back into hospital due to lack of support. Also the provision of good public transport to health services needs to be looked at as a matter of urgency, especially for people living in rural areas.</p> <p>[Chris Drinkwater A46 – West End Health Resource Centre] Change obesity treatment to obesity management</p> <p>We should put a time limit on national best rates of surgery and drug management of obesity. The long term aspiration should be to have lower rates of obesity with decreasing rates of surgery and drug treatment.</p> <p>Unhappy with division into current and future risk – see response to Q10.</p> <p>Systematic long-term maintenance needs to be built into rehabilitation programmes.</p> <p>Brief interventions for alcohol and health improving encounters need more work to ensure effective operational delivery.</p> <p>[Heidi Jobling A47 – Newcastle Healthy City Project] yes</p> <p>[Ceri Mather A50 – Health Improvement Solutions / TPHN] Do we need an office for alcohol?? This should be writ large in every JSNA and pressure should be put on CDRP?H&WB partnerships to collaborate to address these issues eg Nightsafe etc. Spend the money on the problem NOT another office.</p> <p>[Richard Briggs A51 – Cruse Bereavement Care] In general we would agree but consider that the reference to “NHS funding for hospice and terminal care services (section 3.8.5)” should be amended as follows “NHS funding for hospice, terminal care and bereavement support services (section 3.8.5)”</p> <p>[Sue Gordon A53 – PH Consultant – Individual] Specific service developments would need to be considered within a programme pathway - the best return on investment for obesity levels may not be more surgery.</p> <p>[Tricia Cresswell A61 – Durham & Darlington PCTs] Yes, justified and necessary to assist the process of giving a clear focus to the addressing health inequalities agenda.</p> <p>[Tim Blackman A62 – Wolfson Research Unit] Yes but see qu. 1.</p> <p>[VONNE A64] VONNE welcome the proposed changes and would add that new services should be introduced to support victims of abuse, as well as domestic violence.</p> <p>We also seek the provision of additional services and resources to support carers, which accounts for approximately 1 in 6 people in the UK.</p> <p>[Dave Parkin A67 – Wallsend Town Hall] Agree</p> <p>[Stephen Blair A70 – North of Tyne PEC] We would support the proposed changes</p> <p>[Craig Duerden A71 – Middlesbrough Community Network] The changes to NHS services can be justified if target funding is appropriate to the priorities set. This will be the key to this area as well as recognition that the voluntary and community sector have a role to play and an entitlement to appropriate funding.</p> <p>The proposal for an “office” for alcohol issues is perhaps a step too far and a suggestion would be to create appropriate teams in each locality rather than establishing an office. Stating this, however, some of the partners in Middlesbrough are concerned that alcohol is a real problem and will need high profile attention to have an impact.</p> <p>[Martin White A77 – Institute of Health & Society] Yes.</p> <p>However, there is a need to add brief interventions for smoking, and carbon monoxide measurements.</p> <p>[Ruth Stevens A78 – NE Physical Activity Group] Change obesity treatment to obesity management</p> <p>We should put a time limit on national best rates of surgery and drug management of obesity. The long term aspiration should be to have lower rates of obesity with decreasing rates of surgery and drug treatment.</p>

Q24	Are the proposed NHS Service changes justified and necessary?
	<p>Unhappy with division into current and future risk – see response to Q10.</p> <p>Systematic long term maintenance needs to be built into rehabilitation programmes.</p> <p>Brief interventions for alcohol and health improving encounters need more work to ensure effective operational delivery.</p> <p>[J Chexal A81 – Soroptomist Society] Yes, except that we would prefer the emphasis for obesity to be on prevention and community and family based management rather than on surgery and drug treatments.</p> <p>[Nonnie Crawford A90 – Individual] Yes</p> <p>[Joyce Leeson A93 – Individual] Yes</p> <p>[Gateshead Healthier Communities Overview and Scrutiny Committee on Health Inequalities Core Group A96] Yes. Although the programme for Health Improving Encounters should be much broader than the NHS and include Local Authority and other front line staff eg Voluntary Sector.</p> <p>Jean Blair A97 – Individual] Yes</p> <p>[Alisa Rutter B01 – Fresh – Smoke Free North East] Would welcome referencing to NICE guidance on smoking and ensuring that NHS rapidly adopts these.</p>