

'BETTER HEALTH, FAIRER HEALTH' CONFERENCE 4 OCTOBER 2007

WORKSHOP SESSION: 'ACHIEVING A GOOD DEATH'

Facilitator: Nonnie Crawford, Director of Public Health, Sunderland TPCT

Notes: Keith Aungiers, Public Health North East

Introduction

Nonnie Crawford introduced the session by referring to cases where people had reported bad experiences of death. These might arise from the amount and quality of care and attention given to the dying, to the bereaved, or both. For the NHS and Care services failing to ensure 'a good death' could be seen as an indictment of individuals and organisations.

Key Messages

Whilst the including the concept of 'a good death' in a strategy for health and well-being might seem strange to some people, delegates expressed delight at its inclusion in the *Better Health, Fairer Health* consultation document. End of life care was seen as an important area of focus for a regional strategy.

Practical steps to making change happen need to be driven and underpinned by an understanding of research evidence and good practice in the care of the dying and bereaved.

Detailed Discussion

There was considerable discussion about the concept of 'achieving a good death', what this might mean in terms of the consultation questions and the practical steps that need to be taken to make progress in this area.

What is meant by 'a good death'?

- Important to include 'achieving a good death' as part of a strategy for health and well-being.
- This subject might need to be expanded through a separate but strategy or statement of priorities for action.
- Society at large needs to have a more comfortable and sophisticated attitude to talking about and dealing with death.
- This might be achieved by more social marketing around death.
- What do we mean by a good death?
 - for the dying (e.g. knowing when death is likely to happen and having measures in place to deal with this)
 - bereavement counselling post death
 - need to distinguish between 'expected' deaths and 'sudden deaths' as these raise different issues

- deaths can occur at any age and this should not just be seen as an issue for services related to 'old age'
 - all deaths are different and there is a need to avoid being too prescriptive about what support and services are needed
 - Is death at home perceived to be 'a good death': what is the choice for individuals?
 - Is 'a good death' dependent upon a good quality of life?
- What statistics and other information do we have?
 - Deaths at home
 - Deaths in hospital
 - Sudden, 'acute' and unexpected deaths
 - Deaths that occur over a longer period ('expected')
 - Deaths at different ages.

A charter for end of life care?

- The "Liverpool charter" might be built upon and there might be others that could be used to develop a charter for the North East.
- A charter should be seen as a statement of rights and entitlements for all concerned, including the dying, the deceased and the bereaved.
- To be effective a charter needs commitment and 'sign` up' and to have some power to make real changes.
- A charter needs to take account of a range of services and settings for end of life care:
 - Hospitals – terminal care
 - Residential care homes – local authority and private
 - Hospices – palliative care
 - Care at home – paid and unpaid
 - Bereavement counselling and other emotional support to families pre and post death.
- These services may be provided by statutory and non-statutory organisations, including the third sector and friends and family.
- Need to take account of variation in types and ages of deaths - different care and services required in different situations.
- There is a perceived gap between social services and medical services and a need to join these up to provide a holistic person-centred approach.
- In some cases additional resources may be required but in others a shift in attitude may be more effective at no cost.
- Other issues for a charter:
 - Practical design issues to help people live at home
 - Building social capital and cohesion
 - Learning from good practice: e.g. children's services, cancer services.

Making change happen

- Considering the matrix of areas for making change happen the most important area is research and development, including learning from good practice.
- It is important to establish what R&D has already been done and what additional work might be required.
- Social marketing needs to take account of the need for raising consciousness and making the terminology of 'a good death' widely accepted and understood.
- Lobbying and legislation is dependent upon the outcome of R&D: need to know what is required and needs to be lobbied for and where lobbying might be successful.
- Service changes and funding are also dependent upon knowing what is meant by 'a good death' and what processes need to be put into place to deliver this on a consistent basis.
- Flexibility is required in providing training for people who deal with death and helping people to prepare for death.
- Links to other strategies and initiatives are important, such as:
 - housing
 - winter deaths and fuel poverty
 - workforce development
 - dignity in care
 - personalisation
 - engaging faith communities.
- No clear views at this stage on the role of Measurement and Standards or Governance.

'BETTER HEALTH, FAIRER HEALTH' CONFERENCE 4 OCTOBER 2007

WORKSHOP SESSION: 'PHYSICAL ACTIVITY'

Facilitator: Elizabeth Shassere, Acting Director of Public Health,
North Tees PCT

Notes: Ruth Stevens, Public Health North East

Research & Development

- What information do we already have? Who has it and where does it sit? Can we share the information in the right way across the region?
- Agreement on a minimum data set would enable sharing of information between initiatives
- Role of NEPHO
- Sharing of best practice / bringing it all together
- Where should information be fed back to? Data from programmes being collected, not sure why? What happens to the data? Often asked for the same information by different organisations.
- Standard information and data sets to enable comparisons
- An opportunity to get people together to share 'best practice'. Publicise what's happening.
- Does the NHS have a responsibility to promote health with those with future risk? Preventative agenda
- Complexity of physical activity and range of partners from play to rehabilitation. Even more complex is best value and value for money
- There will be always arguments about how physical activity should be funded. We should pool available resources with a common purpose
- We should lobby for appropriate use of resources but how do we achieve them? Someone has to take the risk.
- Data sharing could help publicise physical activity 'best practice' to influence funding decisions
- Physical activity is a local authority responsibility. Voluntary sector responsibility as well.
- Innovative projects in reality are short term funded and become precious. The funding system should mainstream funding these projects. The minimum data set should enable this.

Social Marketing

- Use the experiences of participants – a strong message. But how can we do this in the region and encourage change?
- In the region we should critique short term funded projects and make funding decisions for mainstream funds whether suitable or not. Objective decision making.
- Schools should have a more diverse range of physical activity opportunities available. Children interested in alternative physical activity- regional evidence from LEAP project in Durham Dales
- PE in curriculum should be legislated to increase hours per week. Has been shown to improve educational attainment
- Regional Sport and PA strategy – issues about promoting physical activity and sport. An over emphasis on sport which will not help to achieve PSA targets. Sports board need to promote physical activity message. Perhaps start by changing the name of the regional sports board
- Strong link to regional spatial strategy and planning. RSS updated due out now
- Strong link to community strategies and lobbying local authorities
- NHS to support LA's to promote to walking and cycling – e.g.: walking to school, town planning, designing traffic schemes that promote physical activity
- Broaden out to workplace / improving work lives
- Workplace health - a more economic workforce – link to priorities of One NE and transport policies
- Physical activity continuing through the life structure not just for young and older people
- DWP launched health of the working age population consultation documentation. Needs to join up at Government level
- At a regional level need to make physical activity the easy choice for families and an enjoyable choice
- Need to try and reach those not engaged in health (physical activity – What is correct language to engage with these people? Also need men only and women only sessions – separate from family friendly sessions
- Social Marketing – Can health budgets ever complete with business budgets? Regional examples – Idle Eric
- Health trainers as a concept
- A lot of other people are 'Health Trainers'. Health trainers should not be in the NHS. However the NHS should commission health trainers. Should support and mentor and signpost to relevant services or support mechanisms. The personality of health trainers is very influential
- Career paths for people working in health / physical activity. Difficult to make a long term career. The region should recognise their role, skills and an infrastructure / development / pay that recognise skills / knowledge. Personnel to support the promotion of physical activity.
- For health trainers as a concept to be successful people in the community need to want to do something in their local area. Local

people want to become health trainers. Support and mentoring. At a regional level need to share this bottom up community approach

Funding

- Clear statement on where the responsibility for funding may lie. In particular those at risk and rehab services. Take the ambiguity and uncertainty out
- Guidance on a regional standard for commissioning physical activity – funding, training, delivery, monitoring and evaluation
- Governance - Common sense approach to physical activity
- Link to LSP's – 12 LAA's. Good practice in LAA's – guidance required
- Consultation Question 10 – Current risk in the NHS / future risk in partnership. Not as straight forward as this
- Is the division purely a funding issue?
- Does it not just define two groups of people who need physical activity
- At a local level, LSP, all partners should sign up to these issues and money pooled in LAA's. So all contribute to physical activity promotion. A whole systems approach. Need to construct a policy argument. Then accountable to partnerships rather than organisation. Partners prioritise
- The risk of separating groups, risks separating funding. The division is artificial. Need partnership funding / agreement to promote physical activity
- Take out diagnosed psychiatric illness change to mental illness
- Physical activity to help people who are ill and as a lifestyle choice

'BETTER HEALTH, FAIRER HEALTH' CONFERENCE 4 OCTOBER 2007

WORKSHOP SESSION: 'BROADER ACTION'

Facilitator: Alyson Learmonth, Director of Public Health, Gateshead PCT

Notes: Tracey Sharp, Public Health North East

Introduction

Alyson began the workshop by asking everyone what they felt the key issues should be in this section of the health strategy and what wanted to discuss. Their responses were as follows:

- It should link to sustainable development
- Urban Design
- Link the strategy to the refurbishment of schools
- SNR and regional strategy
- Warmth, design and energy
- Education, employment and wider determinants
- Impact on mental health
- Empowering communities
- Impact of poverty and fuel poverty (not just insulation). Declarations are available but there has been slow NHS take up.
- Public sector as employers
- Building capacity for Public Health interventions amongst others
- Community leadership role
- Engaging businesses and employers

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

- Cautiously yes – but what about people not in employment. Well-being is key to the centre of the framework and any strategy shouldn't just be about employment and work. Further debate on this is important.

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

- Important to include young adults (NEETS) and other disadvantaged adults
- Include those dropping out of the system using different pathways
- There are many links with this to poor housing and fuel poverty (e.g. no place for home study, poor income means no museum trips / books etc)
- There is a role here for the CAMHS services and support to teachers

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

- Needs thinking through – balance of encouraging play versus fear of anti-social behaviour
- There is a perception of a threat that is often not real
- Community garages can take cars off streets
- There is an issue with the metro – people can't take bikes on the metro and there is nowhere to leave it
- We could explore the use of bike pools at transition points
- Workplace is important to engage employers is developing a healthy workforce
- The RDA could demand healthy work policies in new businesses being set up
- Employers should look not just at physical activity and health promotion but also life long learning which can improve business too

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

- A good idea but this isn't just about insulation
- How do we identify the 'at risk' people?
- Needs broader approach around (fuel) poverty
- Broader approach needed around non-planners
- We should be looking at targets in this area that are of meaning to other partners

COMMUNITY LEADERSHIP / CAPACITY BUILDING

- This should be a cross-cutting theme
- The strategy needs to be owned by ANEC / LAs and Councillors
- What is meant by well-being (is it being used in this document in the same way as it is used by LAs?)

'BETTER HEALTH, FAIRER HEALTH' CONFERENCE 4 OCTOBER 2007

WORKSHOP SESSION: 'MENTAL HEALTH'

Facilitator: Peter Heywood, Locality Director of Public Health,
Middlesbrough PCT

Notes: Neil Johnson, Public Health North East

Key priorities

1. Development of meaningful outcome measures re: proxy indicators of mental health and wellbeing (under 'Measurement and Standards' on matrix). Mental Health has always struggled with the lack of indicators so need 'softer' measures e.g. social, physical, voluntary activity. These are not always recognised by LAAs/Community Strategies so this needs to be an early priority
2. Provision of Information, Advice and Guidance (IAG) is important to allow people to take control of their own lives. This can be achieved, to a certain extent, by normalising access to talking/self-help therapies. Furthermore, the reference to Bereavement Counselling (3.8.7) should be extended to cover the extension of talking therapies for all mental health communities
3. NHS organisations should be taking the lead in terms of employing people with mental health problems
4. The regional social marketing campaign should focus on the '5 fruit and vegetables of mental health' i.e. keeping physically active, eating well, drinking in moderation, valuing oneself and others, talking about one's feelings, keeping in touch with friends and loved ones, caring for others, getting involved and making a contribution, learning new skills, doing something creative, taking a break and asking for help [Making It Possible, 2005]
5. There should be a regional commissioning steer re: the needs of the 3rd sector i.e. ensuring medium and long-term planning rather 1 or 2 year projects
6. Mental Health and Wellbeing as a concept should be mainstreamed within regional strategies (as has occurred with gender and BME issues)

Role of a Regional Public Health Strategy

- To provide a regional lead to LSPs to ensure that mental health is a core component in Community Strategies
- Involve communities in the process and ask them what should be included. Meaningful involvement provides control and this benefits individual and community wellbeing

Matrix

- Mental Health is a cross-cutting theme so should be on the horizontal axis (as well as the vertical) as it impacts on all of the other issues e.g. smoking, physical activity, diet and obesity etc.
- Weight management is a key concern as many of the new antipsychotics lead to weight increases
- Physical activity – it is scandalous that people with mental health needs have the poorest health outcomes and this needs addressing
- Social marketing – this should focus on user involvement and their experience

Where should we be in 25 years time?

- All acute In-Patient services should have been closed with all treatment/support provided in the community
- There should be acceptance among young people that having a mental health issue shouldn't be stigmatising
- Happiness quotient – 'the north east is the best place to live and bring up a family'
- Every employer/employee has been trained in Mental Health First Aid

General issues

- The group couldn't relate the section on mental health to the 'real' issue or what mental health teams were actually doing
- It needs to be made clear that everyone has a mental health issue so mental health and wellbeing should be cross-cutting. Everyone has a place on the spectrum of mental wellbeing and it should be the role of Public Health to ensure that people remain at the 'lower' end
- The group was concerned to see that Domestic Violence had been linked to mental health. If this was included, the strategy could undo all of the work that has been done to reduce stigma and remove connections between mental health, violence, public fear and the concept of 'dangerousness'. Indeed, people with a diagnosis of a mental illness are more likely to harm themselves rather than harm others
- A key message should be that the focus is on mental health and wellbeing rather than mental ill-health (1st sentence of 3.7.5)
- 3.7.2 contains too much of a sweeping statement as there are many areas where community cohesion is non-existent

'BETTER HEALTH, FAIRER HEALTH' CONFERENCE, 4 OCTOBER 2007

**NOTES OF WORKSHOP SESSION:
'RECEIVING HELP AT THE EARLIEST OPPORTUNITY'**

Facilitator: David Landes, Deputy Director of Public Health,
County Durham PCT

Notes: Denise Orange, Public Health North East

- Some felt there is not enough in the consultation document around prevention – as opposed to dealing with consequences of ill health although the timeline does indicate that this is not a medical model
- At-risk communities should be targeted e.g. through education (not just in schools but community as a whole)
- The people most likely to benefit are those most resistant e.g. seeing it as the 'nanny state' interfering or playing truant so not receiving health messages at school
- Individuals and families should take responsibility but need support to do so
- Social marketing needed to produce cultural change
- Access to support e.g. bereavement counselling is important to prevent more serious issues developing
- Use parenting/peer groups and community groups to influence. Good local example is 'Healthy Horizons' self-help group in Chester-le-Street which has looked at food labelling etc.
- There is an issue around the amount of 'unhealthy choices' available, e.g. in relation to food. Some work on labelling and advertising, but should there be lobbying around availability of high fat/sugar products?
- Ours is an ageing population – particularly in the North East. Services should take this into account. This is another cross-cutting issue which should be reflected in the strategy – particularly in light of the demographic framework, since this is a 25 year strategy. nb. the North East has considerable expertise in age-related research
- Older people should not be seen as a burden. In fact they make a huge contribution to voluntary and community work, caring for grandchildren etc.
- Access to GPs e.g. out of hours/weekends is an issue for everyone
- Skills set required for basic health promotion interventions across all agencies

- Statutory organisations should be shifting focus and funding towards prevention
- This strategy should not be considered in isolation from others and work which is already taking place within the region e.g. play strategies
- Sexual Health – does not appear to be included although it is a high priority area
- Governance around the scrutiny of both institutions and people caring for others is important
- In residential care, support can be largely medical and they can be isolated from the community
- Social exclusion must be tackled so people aren't marginalised from society
- Negative publicity in the media e.g. around MRSA can actually put off elderly and other people from receiving help at an early stage. Little publicity about the good work being done
- Better promotion of services needed, not relying on leaflets in GP surgeries
- Publicity campaigns (as there were around smoking) for other issues e.g. healthy eating may be useful
- We should concentrate on 2-3 things that will make the biggest impact e.g. smoking, physical activity

'BETTER HEALTH, FAIRER HEALTH' CONFERENCE, 4 OCTOBER 2007

WORKSHOP SESSION: 'DIET AND OBESITY'

Facilitator: Ken Ross, County Durham and Darlington PCT

Notes: Roselle Oberholzer, Public Health North East

MODEL – OBESITY

- Are people comfortable with this?
- Any other suggestions
- Feel that 'nutrition' is missing
- Should be more about knowledge of good nutrition than 'diet'
- Lack of knowledge with staff e.g. in care homes
- Word 'diet' is centre productive. 'Diet' has the wrong connotation
- Agent (Calorie intake) – couldn't understand anti-obesity drug being placed here. Better placed elsewhere?
- Model not best fit
- Also think 'poverty' should be mentioned in the model as it has a huge impact
- Other suggested models
- Biophysical etc needs to include other aspects of life course
- Planning / the built environment impact on food choices needs to be included – types of shops available etc
- Good to be conceptualise not intervention focus
- 4 A's need to be captured
- Access / Affordability / Awareness/ Acceptability. Social / Economic / Physical all need to be there.
- Needs to state 'physical activity' as apposed to 'leisure' activity

INTERVENTIONS

- What do people think about the broad actions given? What can be done regionally?
- Simple messages that can be related to are important. Consistency is also important
- High level support for activities / funding
- Regional bodies need to take a stand around obesity in order to influence local action
- Regional level we should be lobbying for advertising, packaging, signposting etc that encourages in healthy choices and should also put pressure on reducing use of formula milk and promoting breastfeeding
- More emphasis on education in terms of linking more with the extended salads services
- RES and special strategy. Make links to build on excellent work with Sure Start, Children's centres etc.
- Link other targets and strategies to obesity through: e.g. LSC literacy, numeracy, etc.
- More community use of salads and other buildings for cooking, exercise etc

STANDARDS

- Joining up and promoting examples of best practice – Protecting lunchtimes
- Should be encouraging employers to provide good lunchtime opportunities and promoting health and well being generally
- Create a ‘Passionate about food and health’
- Lead on marketing of food and health – build on North East identity
- Market positive images
- Have a regional campaign on healthy eating
- Trying to shift culture
- Need to use social marketing approach to look at how
- Need to build on interventions that are already happening rather than reinventing the wheel
- Need more research about what works. Region could lead on increasing this evidence base.
- Link diet behaviours to life long learning
- Provide evidence and direction to target and tie in interventions to education
- Strategic input needed relating to culture change within NHS e.g. need to shift focus on to obesity and well being and away from ‘illness’ targets.
- RDPH and Regional bodies need to be championing this shift and supporting LAs to do this
- Need a coordinated approach and direction from region. Leadership is important. If region are behind the LAs they can deliver.
- Communication is a problem
- Over reorganisation done to ‘fix’ mistakes.

TREATMENTS

- Issue – How we identify those people who are overweight.
- Region could possibly support training of staff for this
- Better training / consistency needed.
- BMI recording is poor in GP’s – need to increase
- Use regional influences on GP’s, practitioners etc.
- Need to de-normalise overweight and obesity.
- People don’t understand the risks – need to take a similar approach to smoking
- Support for idea of integrated services – also need to normalise being physically active and eating healthily.
- We have become very lazy as a society – lots of people know what they should be doing but environment and lifestyle doesn’t permit healthier choices.
- Need to create a positive food culture. What message does our high street give?
- Regionally we need to push for more resources to carry out the work
- Need regional investment in workforce all professions

RECLAIM STREETS

- Open them for activity
- Also promote healthy eating.
- Build on Great North Run.
- Shift focus of North East to health and well being and away from drinking
- Make better links to local producers if food. Procurement policies and practices. Food Coops/ Allotments/Box schemes/ Food chain North East etc.
- Always seeking funding on a yearly basis – No Sustainability

SURGERY

- Should we be raising the bar?
- Issue – often don't see the importance of the investment only the cost
- Even if people have access to surgery they still need dietetic advice / follow up.
- Need more research and development around building public confidence, self actualisation

'BETTER HEALTH, FAIRER HEALTH' CONFERENCE, 4 OCTOBER 2007

NOTES OF WORKSHOP SESSION: "ALCOHOL"

Facilitator: Tricia Cresswell, County Durham and Darlington PCT

Notes: Margaret Kynoch-MacDonald, Public Health North East

There needs to be more in the strategy about the provision of and access to treatment services for people where alcohol is already causing problems and harm.

There should be a complete pathway of Alcohol Care across the Region fully staffed and appropriately resourced at all levels. Nervous about implementing screening and brief interventions as there are not sufficient treatment services. Referral pathway must be easy to follow.

- Treatment Services should be commissioned across all services from primary, secondary and tertiary care
- Liver is the 5th highest cause of death in this country
- Need to be aware of additive effects
- Need to strengthen the services for Young People - early education with some focus – The strategy needs to have a Young Person focussed section
- There is also a need to target parents and raise their awareness about the harms alcohol can cause and the problems which are being caused by them buying alcohol for their children
- It is key how the population is segmented and what the message is for the different groups.
- A lot of work needs to be done on what the message is. Need consistent messages at all levels being given by a wide range of people
- Need to be able to measure and evaluate any actions taken or services provided
-
- Need to get alcohol recording in GPs in an up-front consistent manner
- Partnership working, i.e. with police, as it is felt that they are not using the powers they have under the new licensing laws
- Recording through criminal justice – crucial

- Need to tackle issues about taxation and happy hours. The money raised in the increase in taxation should be put back into alcohol services
- All DATs should become DAATs to put alcohol on an equal footing on the agenda
- Lobby for NTA to take alcohol on properly. NTA should be charged in dealing with substance misuse rather than just drugs with a high level push to allow money for alcohol
- Need Targets for alcohol as money follows targets.
- Strong evidence-based argument in NHS for putting in investment early to save large later costs
- Must remember positive messages, not all doom and gloom
- Must remember older people, i.e. falls etc
- Positive support for Alcohol Office and what the office should do e.g.:
 - Links with customs & excise – contraband alcohol lobbying
 - Stronger links with Local Authorities
 - Complex social marketing
 - Lobbying, legislation
 - Upward messages. Role of NTA, DAAT
 - Alcohol pathway of care
 - Measurement, standards

As alcohol is cross-cutting must ensure there are linkages with other strategies e.g. Respect, children, families, smoking, obesity and it should be a theme in all children's and Young People's plans.

- Must take the opportunity and get hold of the hidden harm agenda.
- Alcohol use in pregnancy - problems need to be highlighted.
- There is now a need to over-invest in alcohol capacity just to catch up.

'BETTER HEALTH, FAIRER HEALTH' CONFERENCE, 4 OCTOBER 2007

NOTES OF WORKSHOP SESSION: 'SMOKING'

Facilitator: Ian Atkinson, North Tyneside PCT

Notes: Ailsa Rutter, Fresh North East

SMOKING

- Agree what needs to be done and then what is required to do it
- Presentation was more powerful than consultation document

STOP SMOKING SUPPORT

- Need to learn from each other
- Should resources be targets to deprived areas? Promote range of services provided by the NHS but stop smoking services is measured
- Other setting – workplaces, Sure start, pub's and shopping centres
- Are there too many public health issues that conflict with each other?
- Lack of focus of what need to be done next?

SMOKING IN PREGNANCY

- Social habit needs to be tackled
- Is smoking in pregnancy the only issue in the next 25 years?
- Smoking at 12 weeks is too late – smoking and fertility

SOCIAL MARKETING

- Peer pressure
- Pockets of social marketing locally – regional support essential particularly research
- Leaflet delivery / posters (e.g. about dangers etc)

LEGISLATION

- Strategy needs to recognise other strategies / policies
- Smoking in cars
- Regional action on illegal cigarettes

TARGETS

- Area targets may be better than regional - no ward has below x% prevalence
- Regional target must be underpinned by area target for super output areas
- No variance 2% above

QUESTION 7 – OTHER ACTION

- Social marketing needs to be clearer and more central in strategy
- Young people – broader prevention agenda and healthy schools
- Evidence based approach