Herefordshire Council

Agenda

Health, Care and Wellbeing Scrutiny Committee

Date: **Friday 23 September 2022**

Time: **2.00 pm**

Place: **The Conference Room, Herefordshire Council Offices, Plough Lane, Hereford, HR4 0LE**

Notes: Please note the time, date and venue of the meeting.

For any further information please contact:

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Agenda for the meeting of the Health, Care and Wellbeing Scrutiny Committee

Membership

Chairperson	**Councillor Elissa Swinglehurst**
Vice-chairperson	**Councillor Peter Jinman**
	Councillor Carole Gandy
	Councillor Trish Marsh
	Councillor Tim Price
	Councillor David Summers
	Councillor Kevin Tillett

Agenda

Pages

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. NAMED SUBSTITUTES

To receive details of members nominated to attend the meeting in place of a member of the committee.

3. DECLARATIONS OF INTEREST

To receive declarations of interests in respect of Schedule 1, Schedule 2 or Other Interests from members of the committee in respect of items on the agenda.

4. MINUTES 9 - 16

To receive the minutes of the meeting held on 22 July 2022.

HOW TO SUBMIT QUESTIONS

The deadline for the submission of questions for this meeting is 9.30 am on Tuesday 20 September 2022.

Questions must be submitted to councillorservices@herefordshire.gov.uk. Questions sent to any other address may not be accepted.

Accepted questions and the responses will be published as a supplement to the agenda papers prior to the meeting. Further information and guidance is available at www.herefordshire.gov.uk/getinvolved

5. QUESTIONS FROM MEMBERS OF THE PUBLIC

To receive any written questions from members of the public.

6. QUESTIONS FROM MEMBERS OF THE COUNCIL

To receive any written questions from members of the council.

7. OBESITY IN HEREFORDSHIRE 17 - 66

To present background information for the committee to consider the ways in which the council and partners currently tackle obesity in the local population and to make any recommendations around future provision.

8. STROKE SERVICES 67 - 100

The report attached at Appendix A provides an update on NHS Herefordshire and Worcestershire ICS on stroke services across Herefordshire and Worcestershire. This includes a paper on Improving Stroke (including TIA) Services across Herefordshire and Worcestershire, September 2022. The committee is asked to consider and comment on the information provided and seek assurance that the wider public engagement undertaken on this will be focused on delivering the required improvement further inform possible solutions.

9.	**PROGRESS REPORT** This report provides a brief summary update on issues previously considered by the Health, Care and Wellbeing Scrutiny Committee, including responses to information requests made by the committee, updates on resolutions made by the committee, including reports and recommendations to the executive and the executive response and executive decision made in respect of scrutiny reports and recommendations.	101 - 106
10.	**DATE OF THE NEXT MEETING** Friday 25 November 2022, 10.00 am	

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Herefordshire Council

The seven principles of public life

(Nolan Principles)

1. Selflessness

Holders of public office should act solely in terms of the public interest.

2. Integrity

Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3. Objectivity

Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

4. Accountability

Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

5. Openness

Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

6. Honesty

Holders of public office should be truthful.

7. Leadership

Holders of public office should exhibit these principles in their own behaviour and treat others with respect. They should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.

Herefordshire Council

Minutes of the meeting of the Health, Care and Wellbeing Scrutiny Committee held in The Conference Room, Herefordshire Council Offices, Plough Lane, Hereford, HR4 0LE on Friday 22 July 2022 at 2.00 pm

Committee members present in person and voting:	**Councillors: Carole Gandy, Peter Jinman (Vice-Chairperson), Trish Marsh, Tim Price, David Summers, Elissa Swinglehurst (Chairperson) and Kevin Tillett**

Others in attendance: B Baugh (Democratic Services Officer), M Carr (Interim Statutory Scrutiny Officer), J Coleman (Democratic Services Manager), H Hall (Corporate Director Community Wellbeing), Councillor D Hitchiner (Leader of the Council), Dr F Howie (Public Health Consultant), Councillor F Norman, M Pearce (Director of Public Health) and M Willimont (Head of Public Protection)

1. APOLOGIES FOR ABSENCE

All committee members were present. Apologies for absence were noted from Councillor Pauline Crockett, Cabinet Member Health and Adult Wellbeing, and Christine Price, Chief Officer of Healthwatch Herefordshire.

2. NAMED SUBSTITUTES

There were no named substitutes.

3. DECLARATIONS OF INTEREST

Councillor Peter Jinman declared an 'other interest' in the agenda item 'Task and Finish Group Report: The Impact of the Intensive Poultry Industry on Human Health and Wellbeing' due to interests in farming and farming related matters, as disclosed previously in the Register of Interests.

4. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions had been received from members of the public.

5. QUESTIONS FROM MEMBERS OF THE COUNCIL

No questions had been received from councillors.

6. ROLE AND OBJECTIVES OF THE HEALTH, CARE AND WELLBEING SCRUTINY COMMITTEE

The Interim Statutory Scrutiny Officer introduced the report on the role and remit of the committee, and on the committee's objectives for 2022-2023.

It was noted that the Scrutiny Management Board had considered a 'Statement of Intent' at its inaugural meeting on 16 June 2022 [minute 6 of 2022/23 refers] and attention was drawn to the twelve draft objectives for the committee, as set out in Appendix 1 to the report.

There was a discussion about the objectives and related provisions in the council's Constitution [Section 4 – Scrutiny Functions refers], the key points included:

i. The remit of the Scrutiny Management Board in terms of 'Where a matter falls within the remit of one or more Scrutiny Committees, decide which Committee will consider it and whether a spotlight, task and finish or standing panel review is appropriate' and the implications for the individual scrutiny committees were discussed.

ii. The remit of the Scrutiny Management Board in terms of 'To undertake the scrutiny role in relation to areas which are cross cutting nature eg. Corporate Strategy and Finance (Budget), People and Performance and Corporate Support' and the need for clarity about how the individual scrutiny committees could contribute towards the scrutiny of the budget. It was noted that the remit of this committee included 'Adults and Communities budget and policy framework' but no other reference to the budget was made in the remits of the other scrutiny committees.

    The Interim Statutory Scrutiny Officer advised that the Scrutiny Management Board would consider how the scrutiny of the budget would be conducted at its next meeting. A number of members commented on the need for the broader involvement of councillors in this scrutiny activity.

iii. It was noted that the scrutiny committee had the power 'to review and scrutinise any matter relating to the planning, provision and operation of the health service in its area… In this regard *health service* includes services designed to secure improvement – (i) in the physical and mental health of the people of England…' and a committee member commented on the potential need to consider issues for residents along the England – Wales border. The Interim Statutory Scrutiny Officer clarified that this provision reflected the fact that the legislation in relation to overview and scrutiny was different in England and in Wales.

RESOLVED:

That the general role and remit of the scrutiny committee be noted, and the Health, Care and Wellbeing Scrutiny Committee objectives for 2022-2023 be agreed.

7. HEALTH, CARE AND WELLBEING SCRUTINY COMMITTEE ANNUAL WORK PLAN 2022-2023

The Interim Statutory Scrutiny Officer introduced the report on the committee's annual work plan for 2022-2023, noting that the plan had been drafted in consultation with members of the committee and with input from officers from the Community Wellbeing Directorate.

[Note: there was an adjournment for fifteen minutes to address a technical issue with the live streaming of the meeting]

The principal points raised during the discussion included:

i. Access to Council Wellbeing Services – Signposting

Referring to consideration of 'Access to health and care for Herefordshire residents living on the border with Wales', the Chairperson noted that Herefordshire and Worcestershire Clinical Commissioning Group (now Integrated Care System) had drafted a protocol.

ii. Reserve Items

Comments were made about recent changes to West Midlands Ambulance Service and to NHS 111, and the potential need for a watching brief on developments in relation to urgent and emergency care services.

iii. Obesity and Nutrition

It was noted that the Children and Young People Scrutiny Committee had undertaken a 'Dental Health and Childhood Obesity Spotlight Review' [minute 36 of 2018/19 refers]; the subsequent executive response was agreed by Cabinet [minute 39 of 2018/19 refers].

The Chairperson suggested that this topic should be looked at in the context of all ages commissioning and a 'whole family' approach.

A committee member commented that Talk Community had held a number of practical events on obesity and nutrition.

The Vice-Chairperson noted the need to focus on the role of the council and on opportunities to have an impact locally.

RESOLVED:

That the Health, Care and Wellbeing Scrutiny Committee Annual Work Plan 2022-23 be agreed.

8. TASK AND FINISH GROUP REPORT: THE IMPACT OF THE INTENSIVE POULTRY INDUSTRY ON HUMAN HEALTH AND WELLBEING

The committee received the report of the Task and Finish Group on 'The Impact of the Intensive Poultry Industry on Human Health and Wellbeing'.

On behalf of the committee, the Chairperson expressed thanks to the councillors and officers involved, and to the witnesses and members of the public for their contributions.

Councillor Felicity Norman, Chairperson of the Task and Finish Group, introduced the report, the key points included: the process had been interesting but the limited evidence available had been frustrating; the group had comprised lay people with no professional expertise in this area; attention was drawn to the sentence 'We did not find enough evidence to conclude that Intensive Poultry Units (IPUs) are harmful to health, although there were many indications and much anecdotal evidence that this may be the case, especially the impact on mental health and wellbeing'; and further research was needed on this topic and related issues.

The key points of the discussion included:

1. A concern was expressed about the level of government regulation and action.

2. The absence of information was significant and the limited engagement of the Environment Agency was unfortunate, particularly the refusal of the request to identify 'how many complaints concerning these IPU premises have there been in

2021/22 so far' on the basis that it was 'likely to involve a significant cost and diversion of resources from our other work'.

3. The Chairperson acknowledged the subjective nature of odour nuisance but suggested that a sense check of modelled assessment against actual performance of an installation could provide additional assurance in the planning process for IPUs. A committee member added that an independent consultant could be utilised to review the assessments provided in planning applications.

4. The Chairperson considered that some of the recommendations may go beyond the original scope of the Task and Finish Group and others recommended to the committee should be directed to the executive.

5. The Vice-Chairperson recognised that the report was well intentioned but expressed reservations about aspects of the content and tone, including:

    a. The need for a systematic review of the scientific literature.

    b. Caution and balance was important in terms of the absence of evidence.

    c. Some of the conclusions drawn were considered scientifically unsound.

    d. There was no breakdown by species and types of poultry production.

    e. In terms of flocks under 40,000 birds, there was a need to test the statement that 'there are very few of these in the county' given the requirement to register flocks over 50 birds.

    f. It was understood that there were limited resources but there was a need to be suitably critical if reports were to be used as a basis for policy making.

    g. There were broader questions about task and finish groups, including the need for methodology, research, and logical processing to inform conclusions and recommendations.

    h. The recommendation about engagement with relevant bodies was welcomed but this also needed to include producers.

    i. Statements made about anti-microbials were challenged, with an outline provided of current UK and EU regulations.

    j. There was a need to be careful about the selective use of certain World Health Organisation reports, as these may not reflect the position in the UK.

    k. In view of the residents employed through the industry or those with units themselves, care was needed to avoid any unnecessary alarm.

    l. The finding that there was not 'enough evidence to conclude that Intensive Poultry Units (IPUs) are harmful to health' was welcomed but the comment that 'there were many indications and much anecdotal evidence that this may be the case' was disputed, particularly in view of the small number of respondents and given that the comments and suggested causations were untested.

    m. The birds themselves, given fragile respiratory systems, were an indicator of any problems and there was extensive monitoring within modern units.

n. There was a need to work collaboratively, including with the industry.

6. A committee member commented that: the report could be improved but there were finite resources; there was the potential for cumulative impact from ammonia and particulates being discharged into the air; people experienced distress from odour related issues; the Environment Agency could use annual fees levied on operators more effectively; and air pollution was a public health concern.

7. The Chairperson drew attention to the Health and Safety Executive's technical and legal guidance on poultry dust and related document 'Controlling exposure to poultry dust: An occupational hygiene standard of good working practice for poultry farmers'. In view of the potential health hazards in the workplace, the Chairperson did not consider it unreasonable to question the potential implications of wider exposure.

8. A committee member noted the difficulties to prove causation in terms of respiratory diseases and questioned the effectiveness of the Environment Agency.

9. Councillor Norman made a number of comments, including: an update to the Health Protection Agency (2006) Position Statement: Intensive Farming was overdue; not all IPUs were operated from modern buildings or to the same standard of management; and it was acknowledged that the number of respondents was relatively small but other anecdotal information came from constituents or through comments made on planning applications.

10. The Vice-Chairperson commented on: the need for focus on the question of human health and wellbeing; acknowledged the concerns about direct contact with poultry but consideration had to be given to the dilution factor beyond such settings; the need for strong evidence and for careful use of language; and the literature referenced needed to be understood in the context of the methodology used and any subsequent criticism.

11. The Chairperson suggested that the potential for voluntary monitoring of ammonia and particulates could be explored further with producers.

12. The Head of Public Protection was invited to comment, the key points included: the importance of evidence; the arrangements for and limitations of environmental permits; air quality screening work undertaken at the planning application stage had not found any IPU in breach the particulate matter standards; odour issues were emotive; dilution factors and other sources of particulate matter; the Task and Finish Group's interest in the position with the Rivers Wye and Lugg, and the issues identified in the resident feedback; there was a small number of consultants available to planning authorities; national research was to be undertaken on avian influenza outbreaks; and the frustrations of the group were understood but the findings had to be robust.

13. In response to a question, the Head of Public Protection outlined the monitoring requirements in relation to smaller units, commented on the concept of best available techniques not entailing excessive costs, and emphasised that the Environment Agency was responsible for policies and guidance notes.

14. The Vice-Chairperson noted that: the majority of avian influenza outbreaks had not been in broilers; there was a need for all agencies and industry sectors to address water pollution; the First Minister for Wales had held a summit at the Royal Welsh Show on reducing pollution in rivers; and there was a distinction between people identifying concerns and diagnosable mental health conditions.

15. In response to a comment from a committee member about encouraging producers to upgrade older units, the Vice-Chairperson commented on a new broiler directive and on the 'Better Chicken' programme.

16. There was a brief discussion about the perceptions and actualities of animal welfare.

17. A committee member commented that various agricultural activities caused distress to people and there was a need for evidence-based recommendations.

18. The Vice-Chairperson offered to assist the Task and Finish Group on appropriate revisions to the report.

The committee discussed the recommendations in turn, the principal points arising included:

5.1 Promotion of public engagement and awareness

It was considered that the recommendations could be supported. In particular, a myth-busting document was considered important but this should not necessarily be based on Appendix 1 and 2 to the report, and it should avoid potentially alarmist language.

5.2 Joint working with partners and external agencies

The promotion of the use of task and finish group findings within the council and encouraging participation by a wide range of groups and industry bodies reflected good practice. As this should be part of regular scrutiny activity, the recommendations were not considered necessary.

5.3 Planning and permit issuing

It was considered sensible to consult health partners on planning applications where appropriate.

The Public Health Consultant commented that a Supplementary Planning Document in relation to health impact had been developed in Worcestershire and elsewhere.

The Public Health Consultant also commented that: the UK Health Security Agency had recently confirmed that it was working on an update to the Health Protection Agency (2006) Position Statement; work with colleagues in primary care had not found any link between increasing respiratory conditions and the proliferation of IPUs; it was important to recognise people's experiences but also to put this into the statistical context of the county; and the 2006 position statement had concluded that 'intensive farms may cause pollution but provided they comply with modern regulatory requirements any pollutants to air, water and land are unlikely to cause serious or lasting ill health in local communities'.

The Vice-Chairperson suggested that the concept of 'One Health', i.e. human, animal and environment, should be part of any health impact assessment.

In addition to exploring matters relating to issuing and regulating IPU permits, the Chairperson suggested that consideration could be given to a recommendation to request the executive to engage with the industry to develop a voluntary code in relation to monitoring.

The Chairperson considered that the recommendation to 'formulate and encourage the adoption of a countywide waste manure management strategy' was out of scope of the Task and Finish Group but the point could be noted in some other way. It was noted that Cabinet was due to consider the establishment of a Phosphates Commission.

5.4 Inspection, regulation and monitoring

The Chairperson acknowledged the need to work collectively and constructively on the 'best available techniques' but also to encourage innovation.

In view of the recently updated technical and legal guidance, it was not considered necessary to make a recommendation in relation to the Health and Safety Executive.

It was considered that the recommendation to 'request accurate monitoring and recording of national quantities of manure and manure management' was out of scope.

5.5 Independent research

The Chairperson suggested that the recommendations needed to be reframed to take account of the UK Health Security Agency work on updating the position statement. It was commented that the council could work with and assist the UKHSA.

There was a brief discussion about ensuring that the report was robust and credible before sharing it with other bodies.

A committee member commented on the opportunity to work with Herefordshire and Ludlow College.

It was considered that the recommendation 'Continue to take samples from the county's private water supplies and wells to test for any potential link between poultry manure spreading and pollution' was not necessary as there was an existing statutory duty.

5.6 Mental health awareness

It was suggested that the thematic summary of the responses received from the public be shared with primary care services but it was not necessary to highlight specific issues.

5.7 Publicising the report

The Chairperson considered that task and finish group reports should be treated and publicised in a consistent way.

It was noted that a further draft report would be considered by the committee for recommendation to the executive, and the executive responses would be reported back to the committee. Although the committee would wish to maintain an interest in developments following this, it was not considered necessary to identify a specific timescale to revisit this issue in the work programme.

In response to questions, the Head of Public Protection commented on conditions included in planning permissions to minimise offensive odours beyond site boundaries and considered it unlikely that the government would accept the

reintroduction of a minimum distance between IPUs and residential properties given the variables involved. The Chairperson suggested that the executive could be asked to consider the inclusion of such a distance factor in supplementary planning guidance.

RESOLVED:

That consideration of the item be deferred and members of the Task and Finish Group be invited to review the draft report and recommendations, in consultation with members of the committee and the Interim Statutory Scrutiny Officer, taking into account the views and suggested revisions made by the committee, with a further iteration to be presented to the next scheduled meeting of the committee.

9. DATE OF FUTURE MEETINGS

The dates for scheduled meetings for the remainder of the 2022/23 municipal year were noted, with the next scheduled meeting being Friday 23 September 2022 at 2.00 pm.

The meeting ended at 4.53 pm **Chairperson**

Herefordshire Council

Title of report: Obesity in Herefordshire

Meeting: Health, Care and Wellbeing Scrutiny Committee

Meeting date: Friday 23 September 2022

Report by: Director of Public Health

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards)

Purpose

To present background information for the committee to consider the ways in which the council and partners currently tackle obesity in the local population and to make any recommendations around future provision

Recommendations

That:

a) the committee notes the council's strategies to tackle obesity in line with the council's planned priorities and objectives, and

b) the committee offer any further constructive challenge, define any further action or recommendations to inform and support the development of a new Obesity Plan for Herefordshire.

Alternative options

1. No further investment or activity to reduce obesity rates across the Herefordshire. This is not recommended as obesity is a significant burden on our health and social care system, economy and wider communities. Obesity has been a national government commitment, since 2016, to prevent and tack obesity through the Childhood Obesity Plan

Key considerations

2. There has been increased government commitment, since 2016, to preventing and tackling obesity through the Childhood Obesity Plan[1]. The plan aimed to significantly reduce England's rate of childhood obesity within ten years and included such commitments as introducing a soft drinks levy, working with food producers to reduce sugar in foods and introducing food school standards. More recently, the government further published a National Obesity Strategy in July 2020 which outlined actions the government intended to take to tackle obesity and help adults and children to live healthier lives.

3. Both of these strategies are complemented by the NHS Long Term Plan[2] which was published in 2019 and set outs specific actions to support people in managing their weight. This includes:

    a) access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30

    b) Expanding the NHS Diabetes Prevention Programme over the next five years, including a new digital option

    c) Test an NHS programme supporting very low calorie diets for obese people with type 2 diabetes

    d) Take action on healthy NHS premises

    e) Nutrition training, and an understanding of what is involved in achieving and maintaining a healthy weight, this currently varies between medical schools

4. Whilst Herefordshire does not have a specific Healthy Weight Strategy, our current Joint Health and Wellbeing Strategy[3] includes a number of priority areas where reducing levels of obesity can make an important contribution to achieving these. A new Health and Wellbeing Strategy is currently being developed and this will be published early 2023. As part of the development of the strategy the council will be reviewing our priorities for the future.

Community impact

5. The council's County Plan includes a number of commitments that will contribute to reducing levels of obesity in Herefordshire through the three focus areas; Environment, Community and Economy. This includes actions to tackle climate change such as increasing active travel, utilising our natural resources more effectively, supporting communities and ensuring our children are healthy.

6. The council's 2020/22 delivery plan prioritises tackling health and wellbeing inequalities. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing. They also impact on the care that people receive and the opportunities that people have to maintain wellbeing and lead healthy lives. Specific commitments aim to ensure all children are healthy, safe and inspired to achieve and improvements to the overall mental and physical health and wellbeing of residents of all ages with a more diverse and increased level of support that helps people to make healthy food and lifestyle choices.

[1] Childhood obesity: a plan for action - GOV.UK (www.gov.uk)
[2] NHS Long Term Plan
[3] Health and wellbeing strategy 2016 (herefordshire.gov.uk)

Environmental impact

7. There are no direct environmental impacts connected with this report or the outcomes it seeks to deliver. Initiatives and programmes to promote a healthy weight will likely have a positive impact on the environment e.g. food sustainability, reduced carbon admissions, increased active travel.

Equality duty

8. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

   A public authority must, in the exercise of its functions, have due regard to the need to –

   a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
   b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
   c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

9. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services. The ambitions and actions set out in this report will directly lead toward delivering these outcomes.

Resource implications

10. Fulfilling the recommendations and considerations outlined in the report will require investment from the council and wider partners (e.g. Integrated Care Board) aligned with commissioning responsibilities. Funding for weight management services will need to come from the Public Health Ring Fence Grant. There will also be a requirements for increased staffing resource to oversee this work programme and co-ordinate across partners.

11. As part of the Covid-19 economic and recovery plan, the council invested £850,000 Government Grant funding in an initiative called Get Active. The aim of *Get Active* was to increase opportunities for individuals of all ages to become more active and experience new opportunities through culture and leisure facilities. The programme's focus was on supporting physical activity, in particular enabling inactive people to become more physically active through a combination of support to address barriers to participation and a diversification of opportunities to be more active, including improved infrastructure and access to green space. There are no plans in place to continue many of these initiatives.

Legal implications

12. This report provides background information to allow the committee to consider the ways in which the council and its partners could better tackle obesity in Herefordshire and therefore there are no legal implications arising from the report.

Risk management

13. The associate risks to human health as a result of childhood obesity are set out in Appendix A.

Consultees

None

Appendices

Appendix A: Obesity in Herefordshire

Background papers

None Identified

Herefordshire Council

Appendix A

Report to the Health, Care and Wellbeing Scrutiny Committee, 23rd September 2022

Report Title:	Obesity in Herefordshire
Corporate Director:	Hilary Hall - Corporate Director Community Wellbeing
Report Author:	Matt Pearce - Director of Public Health
Committee Date:	23rd September 2022
Report Deadline:	13th September 2022

1.0 Officer recommendations

That the committee notes Herefordshire Council's strategies to tackle obesity in line with the Council's planned priorities and objectives.

2.0 Purpose of the report

The purpose of this report is to present the background information for the committee to consider the ways in which the council and partners currently tackle obesity in the local population and to make any recommendations around future provision.

3.0 Introduction

Obesity is a complex issue influenced by many factors. While at an individual level the main causes are poor diet and sedentary lifestyles, the Foresight report (2007) identified over 100 "wider determinants" of individual, and family eating and physical activity habits (see appendix 1). These include the food and physical activity environments in which people live, work and play; their income; education; occupation and mental health and wellbeing. Over the last 20-30 years society has become characterised by environments and lifestyles that promote the consumption of high calorie food and drink, and sedentary behaviour, so it is now widely agreed that obesity is a normal 'passive' biological response to these changes.

3.0 Health and Economic Consequences

There is strong evidence to show that adult obesity is associated with a wide range of health problems which include type 2 diabetes, coronary heart disease, some types of cancer (such as breast cancer and bowel cancer) and stroke. Obesity can also impact on people's quality of life and lead to psychological problems, such as depression and low self-esteem. More recently overweight and obesity has been associated with major causes of ill-health and identified as one of the most prominent risk factors of severe COVID-19, increasing disease mortality, even in childhood[1]. It has also been associated with a greater risk of long covid[2].

[1] Stavridou, A., et al., Obesity in Children and Adolescents during COVID-19 Pandemic. Children (Basel, Switzerland), 2021. 8(2): p. 135.
[2] Aminian, A., et al., Association of obesity with postacute sequelae of COVID-19. Diabetes, Obesity and Metabolism, 2021. 23(9): p. 2183-2188.

The financial burden of obesity is also significant. Modelling on the costs of obesity were last undertaken in 2014, where the cost of obesity and related ill health to the NHS in England was estimated at £6.1 billion per annum.[3] Obesity also impacts local authorities' social care budgets: direct costs attributed to obesity are estimated at around £352 million per annum.[4] Conditions linked to obesity, such as type 2 diabetes, although not yet systematically quantified, are likely to impose a significant additional social care burden. The costs to the wider economy are even greater, estimated at £27 billion per annum[5].

4.0 National Context

There has been increased government commitment, since 2016, to preventing and tackling obesity through the Childhood Obesity Plan[6]. The plan aimed to significantly reduce England's rate of childhood obesity within ten years and included such commitments as introducing a soft drinks levy, working with food producers to reduce sugar in foods and introducing food school standards. More recently, the Government further published a National Obesity Strategy in July 2020 which outlined actions the government intended to take to tackle obesity and help adults and children to live healthier lives.

Both of these strategies are complemented by the NHS Long Term Plan[7] which was published in 2019 that set outs specific actions to support people in managing their weight. This includes:

- access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30
- Expanding the NHS Diabetes Prevention Programme over the next five years, including a new digital option
- Test an NHS programme supporting very low calorie diets for obese people with type 2 diabetes.
- Take action on healthy NHS premises
- Nutrition training, and an understanding of what is involved in achieving and maintaining a healthy weight, varies between medical schools

5.0 Local Context

Whilst Herefordshire does not have a specific Healthy Weight Strategy, our current Joint Health and Wellbeing Strategy[8] includes a number of priority areas where reducing levels of obesity can make an important contribution to achieving these. A new Health and Wellbeing Strategy is currently being developed that will be published early 2023. As part of the development of the strategy we will be reviewing our priorities for the future.

Herefordshire's County Plan includes a number of commitments that will contribute to reducing levels of obesity in Herefordshire through the three focus areas; Environment, community and economy. This includes actions to tackle climate change such as increasing active travel, utilising our natural resources more effectively, supporting communities and ensuring our children are healthy.

[3] Scarborough, P. et al. (2011), The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006–07 NHS costs. J Public Health 33(4):527-35 The direct cost to the NHS in 2006/07 of people being overweight and obese was £5.1bn. These costs have been updated to £6.1bn to take into account inflation
[4] Unpublished analysis of Health Survey for England combined data 2011 and 2012. Obesity Knowledge and Intelligence. PHE 2014. Cost of extra formal hours of help for severely obese compared to healthy weight people.
[5] Health matters: obesity and the food environment - GOV.UK (www.gov.uk)
[6] Childhood obesity: a plan for action - GOV.UK (www.gov.uk)
[7] NHS Long Term Plan
[8] Health and wellbeing strategy 2016 (herefordshire.gov.uk)

6.0 Epidemiology – What does the data tell us?

6.1 Children

Data for child obesity comes from the National Child Measurement Programme (NCMP) for England that records height and weight measurements of children in Reception (aged 4-5yrs) and Year 6 (aged 10-11yrs) enabling analysis of prevalence and trends in childhood obesity levels.

The last three years' worth of data shows an increase in the prevalence for children who are overweight and obese. However, it is worth noting that participation rates during 20/21 were impacted by the pandemic. Provisional data for 21/22 suggests a slight reduction in the prevalence of overweight and obesity amongst Reception and Year 6 children, although this data needs to be validated.

Prevalence of overweight and obesity in reception age children for 19/20 is statistically higher than both the national average (23%), but similar to the regional average (24.6). During the academic year 20/21 data collection period there was a national requirement to achieve a 10% uptake of the eligible population. However, locally we achieved 75% which provides comparative data (as yet unpublished) for 20/21 in Herefordshire.

Period 2018/19	No. eligible children	Participation (number / %)	No. underweight children	No. / % overweight children	No. / % very overweight children	Total (overweight + very overweight)
Reception children (4-5 year olds)	1784	1779 99.7%	**	13.4%	10.3%	23.7%
Year 6 children (10-11 year olds)	1760	1758 99.9%	**	13.7%	21%	34.7%
Period 2019/20	No. eligible children	Participation (number / %)	No. underweight children	No. / % overweight children	No. / % very overweight children	Total (overweight + very overweight)
Reception children (4-5 year olds)	1709	1709 100%	**	15.6%	10.1%	25.8%
Year 6 children (10-11 year olds)	1770	1770 100%	**	14.2%	19.2%	33.4%
Period 2020/21	No. eligible children	Participation (number / %)	No. underweight children	No. / % overweight children	No. / % very overweight children	Total (overweight + very overweight)
Reception children (4-5 year olds)	1875**	1340 74.5%	**	13.1%	13.4%	26.9%
Year 6 children (10-11 year olds)	1985**	1425 76.4%	**	16.1%	22.6%	38.7%

Table 1 – NCMP data for Herefordshire 2018/19 – 2020/21

There is a strong relationship between deprivation and childhood obesity. Analysis of data from the National Child Measurement Programme (NCMP) shows that obesity prevalence among children in both Reception and Year 6 increases with increased socioeconomic deprivation (measured by the Index of Multiple Deprivation (IMD) score). Obesity prevalence amongst reception age children in the most deprived 20% children in Herefordshire is 12.4% compared to the least deprived quartile of 7.2%. This difference is more profound in Year 6 children whereby 23.9% of children are obese in the most deprived quintile compared to 13.8% in the least deprived quintile.

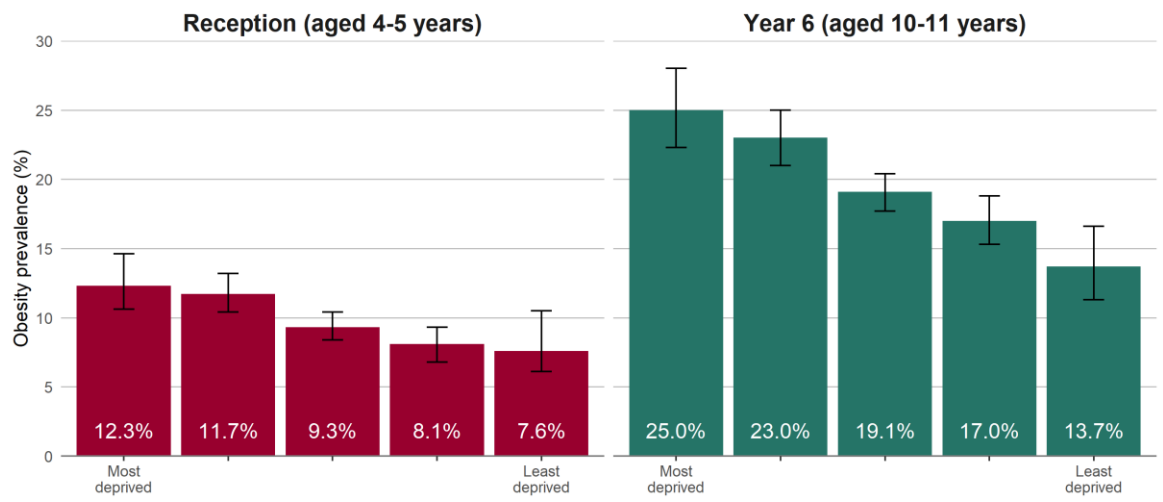


Figure 1. Obesity prevalence by deprivation and age, 2015/16-2019/20

Figure 2 identifies areas of highest levels of excess weight. The wards known to have the highest levels of excess weight for reception age are the following: Golden Valley North, Ledbury South, Llangarron, Hope End, Bromyard West, Bromyard & Bringsty, Redhill, Newton Farm, Tupsley, Widemarsh & Kings Acre.

The wards with the highest levels of excess weight for year 6 age are the following: Golden Valley North, Ross East, Sutton Walls, Hinton & Hunderton, Redhill, Saxon Gate, Aylestone Hill, College & Widemarsh.

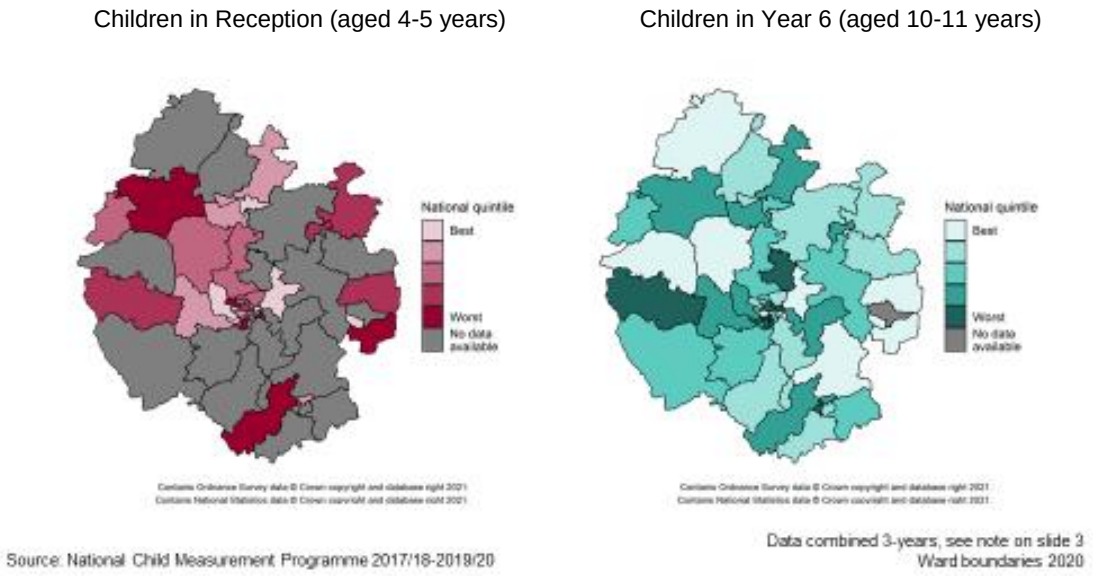


Figure 2. Prevalence of obesity by age and ward, 2017/18-2019/20

6.2 Adults

The Active Lives Survey conducted by Sport England collects data on self-reported height and weight among adults aged 18 years and over in Local Authority areas across England. The Office for Health Improvement and Disparities (OHID) uses this data to produce estimates of adult excess weight prevalence for the Public Health Outcomes Framework.

Estimates indicate that 30.9% (48,700) of adults are obese in Herefordshire which is statistically higher that the national average (25.3%) and the regional average (28.1%). Approximately 67% of adults in Herefordshire are overweight or obese which is similar to the regional average of 66.8%[9]. This equates to approximately 105,592 individuals across Herefordshire who are above a healthy weight threshold.

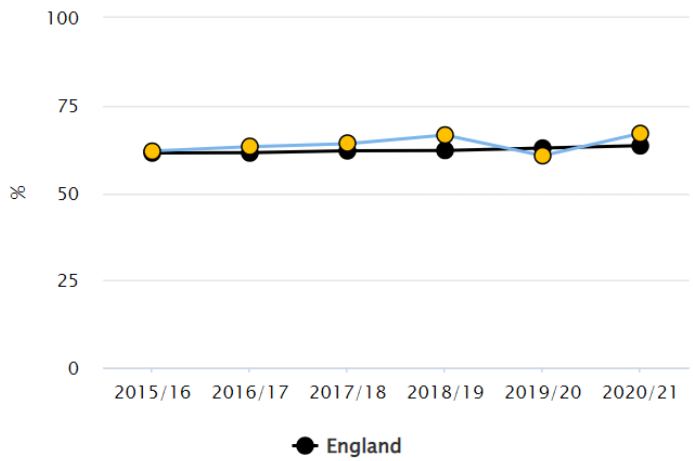


Figure 3 Percentage of adults (aged 18+) classified as overweight or obese (2015/16 – 2020/21). Please note this does not include latest 21/22 data

Some local data is available from primary care through the Quality and Outcomes Framework (QOF), however this data are highly influenced by other factors, such as the proportion of registered patients who visit the practice over a 15 month period and the proportion of these patients that have their BMI measured by the GP. The data are therefore not considered representative of true prevalence, but broadly mirror the picture of local variance as outlined above. Local primary care data indicates that 19,126 of patients (16+) in Herefordshire are recorded as obese which equates to 9% of the overall Hereford adult population. From those recorded as obese on the register, 22% have more than 1 long term condition and 7% have more than 2 long term conditions.

6.21 Maternal Obesity

There is a large body of evidence which links maternal obesity to adverse pregnancy outcomes. Data on the prevalence of maternal obesity are not collected routinely in the UK, but there are currently around 11 million women of childbearing age (16 to 44 years) in England, of which around 2 million (19%) are obese. Data from the public health outcomes frameworks for 2018/19 estimates that 23.6% of pregnant women were obese (BMI>=30kg/m2) at the time of booking appointment with midwife. This is slightly higher than the national average, although this difference is not statistically significant.

There is some evidence that mothers who breastfeed provide their child with protection against excess weight in later life. Breastfeeding rates in Herefordshire are measured from birth and whether breastfeeding continues until 6-8 weeks. The percentage of babies whose first feed is breastmilk in Herefordshire is 67.8% which is similar to the national average of 67.4%, but higher than the regional average 62.5%. Over the last few years there has been a slow decline in the proportion of mothers breastfeeding at 6-8 weeks, however, during the last quarter we have seen an increase in rates to 48%. The low rates were likely down to the pandemic and as visits by health visitors were not face to face and the support was not available for peer supporters.

[9] Obesity Profile - Data - OHID (phe.org.uk)

6.22 Health Inequalities

Research indicates that a relationship exists between the determinants of obesity and socioeconomic status. It has been shown that Individuals from lower socioeconomic backgrounds may have diets rich in low cost energy dense foods[10] participate less in sports and physical activity[11] and have lower weight control awareness. Energy dense foods often represent the lower-cost option to the consumer.[12]

Children from lower social classes are more likely to become overweight or obese than are children from higher social classes and are more likely to remain overweight or obese throughout early adulthood.[13] Poor maternal nutrition is associated with deprivation and can lead to low birth weight. This is often followed by rapid 'catch-up' growth leading to adolescent obesity.

Risk factors for obesity which are associated with deprivation include unemployment, employment as an unskilled manual worker, limited educational achievement or residing in poor neighbourhoods with limited access to cheap and healthy food and sporting/play facilities. Different ethnic groups are associated with a range of different body shapes, and different physiological responses to fat storage. Therefore caution needs to be taken when considering the prevalence and health consequences of obesity within different ethnic groups.[14] This is of particularly importance for Asian groups as they have been found to being more prone to higher rates of obesity.

6.23 Who are most at risk?

According to research, the following sectors of the population are at considerably higher risk of developing obesity, with an associated increase in the incidence and prevalence of related comorbidities.[15]

Children

- For genetic and/or environmental reasons from families where one or both parents are overweight or obese[16]
- Children living within households with the lowest level of household income have higher rates of obesity than children from households with the highest level of household income. Individuals from particular [17]

Black Minority Ethnic (BME) groups

- South Asian populations are at greater risk of ill health at lower BMI levels than European populations[18]

[10] Lu N, Samuels ME, Huang K (2002) Dietary behavior in relation to socioeconomic characteristics and selfperceived health status. J Health Care Poor Underserved 213:241–57.
[11] Stamatakis E. Physical activity (2004). In: Sporston K, Primatesta P, eds. The Health Survey for England 2003, Cardiovascular Disease. London: The Stationery Office, 2004. –
[12] Drewnowski A et al 'Poverty and Obesity: the role of energy density and energy costs.' The American Journal of Clinical nutrition Jan 2004 Vol.79 no.1 p6-16
[13] Kinra S, Nelder R, Lewendon G. Deprivation and childhood obesity: a cross sectional study of 20,973 children in Plymouth, United Kingdom. J Epidemiol Community Health 2000;54:456 –60
[14] National Obesity Observatory (2011) Obesity and ethnicity. Association of Public Health
[15] Avenell et al (2004) Systematic review of the long term effects and economic consequences of treatments for obesity and implications for health improvement. Health Technology Assessment 8: 1-473
[16] Perez-Pastor EM, Metcalf BS, Hosking J, Jeffery AN, Voss LD and Wilkin TJ. Assortative weight gain in mother–daughter and father–son pairs: an emerging source of childhood obesity. Longitudinal study of trios (EarlyBird 43)
[17] NOO (2012) Child Obesity and Socioeconomic Status
[18] NOO (2011) Obesity and Ethnicity

People living on a low income,

- Among women the proportion classified as overweight or obese varies with socioeconomic status (SES)17
- A higher percentage of women in the lower SES groups (29.1%) are overweight and obese, compared to women in the highest SES group (18.7%)

Older people

- Increasing age is associated with increasing prevalence in obesity up to the age of 64 years, when a decline in the prevalence begins.
- There is also a consistent trend, that the older you are the less physical activity you participate in.

Pregnancy

- Women who are overweight or obese before they conceive have an increased risk of complications during pregnancy and birth. This poses health risks for the mother and baby.
- There is also evidence that maternal obesity is related to health inequalities, particularly socio-economic deprivation, inequalities within ethnic groups and poor access to maternity services.
- Maternal BMI status is also shown to relate to health inequalities, particularly for women who live in the areas of the most deprivation who are almost two and a half times more likely to be obese at the start of pregnancy than women who live in areas of least deprivation.[19]

People with a mental health condition

- There are bi-directional associations between mental health problems and obesity, with levels of obesity, gender, age and socioeconomic status being key risk factors[20]
- Those people with a diagnosis of schizophrenia or bipolar disorder have been identified as being at increased risk of greater levels of obesity and associated conditions, such as heart disease and diabetes.[21]

People with learning disabilities

- Literature reports that there is increased prevalence of obesity and overweight among people with learning disabilities.[22]

7.0 What is effective in tacking obesity

The evidence base on effective action to tackle obesity remains weak, and skewed towards individual level downstream approaches (trying to manage the consequences of obesity rather than more upstream approaches, which attempt to solve the real problems underpinning obesity). This is largely down to the existing evidence base failing to take adequate account of the complex nature of the obesity system. Addressing obesity necessitates the need to establish new social norms around eating and physical activity and, given the complex interplay of determinants most experts agree that a 'whole system

[19] NICE (2008) Improving the nutrition of pregnancy and breastfeeding mothers and children in low-income households. March 2008, NICE.
[20] NOO (2011) Obesity and Mental Health
[21] Department of Health (2006) Choosing Health: Supporting the physical health needs of people with severe mental illness. DH: London
[22] Nocon, A. (2006) Background evidence for the DRC's formal investigation into health inequalities experienced by people with learning disabilities or mental health problems. Disability Rights Commission

approach' is needed. These approaches require the involvement of all organisations from across local systems that tackle the determinants for obesity.

A publication by Public Health England in 2019 highlighted the important role that local authorities have in leading communities and local partners to tackle obesity, including through working with local NHS organisations and integrated care systems. The document sets out the need for areas to utilise systems science whereby its recognised that there is no single solution to obesity and that there is a need for local stakeholders, including communities, to come together, share an understanding of the reality of obesity and consider how the local system is operating and where there are the greatest opportunities for change.

A wealth of guidance has been produced by NICE based on evidence to support the prevention and treatment of obesity across the life course (see appendix 3). Much of the evidence to support overweight children and adults highlights the importance of multi-component approaches that tackle diet, physical activity and behaviour change. Whilst weight management programme remain important in tackling obesity, evidence is increasingly showing that action is needed across all levels of society.

When looking to develop a whole systems approach to obesity it is important to consider the role of different organisations in influencing the determinants of health and how we can influence individual behaviour change. The COM-B Behaviour change wheel (figure 4) provides a useful framework to assist national and local policy makers, as well as stakeholders, to understand the role they can play in influencing people's behaviour.

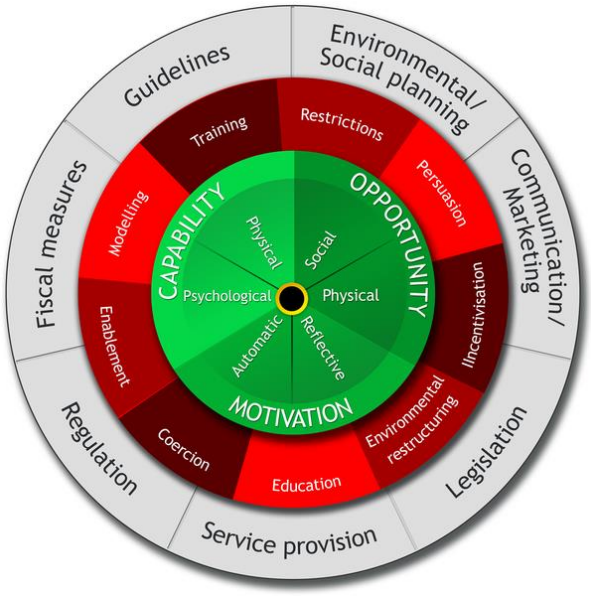


Figure 4 Behaviour change wheel

The COM-B model of behaviour is widely used to identify what needs to change in order for a behaviour change intervention to be effective**.** For example, at a national level regulatory measures such as introducing the soft drinks industry levy can be effective in reducing sugar consumption through persuasion[23].

Approaches used to influence individual behaviour generally involve the provision of information (education), motivational messages or empowering individuals to make healthy

[23] 'Best buys' and other recommended interventions for the prevention and control of noncommunicable diseases. Geneva: World Health Organization; 2017.

choices. Individual approaches need to be balanced alongside wider interventions that help to make healthier choices easier e.g. encouraging people to cycle to work is of limited value of there are no cycle paths on route (environmental restructuring). A balance has to be found for prevention of obesity at population level, whilst helping those who are already at risk of serious health consequences due their weight.

8.0 Current provision across Herefordshire

Given the complex nature of obesity. It is difficult for this report to outline all services, programmes and initiatives that directly or indirectly have an impact on our body weight. The next section summaries the key interventions in place across the county and gaps in provision.

Within the UK, a four-tiered approach is commonly adopted to achieve and maintain a healthy weight for children and adults - the obesity care pathway. As the severity of excess weight increases, a higher tier of intervention is required and advocated. These tiers are summarised below:

- Tier 1 - Universal based prevention and early intervention
- Tier 2 - Self-help, community and primary care initiatives
- Tier 3 - Specialist services for individuals who makes no progress at Tier 2 or who has an urgent health need to lose weight
- Tier 4 – Surgery

Commissioning responsibilities for weight management are unclear given the recent move toward integrated care systems where partnerships of organisations are now coming together to plan and deliver joined up health and care services for their local populations.

Historically, local authorities have had primary commissioning responsibility for tiers 1 and 2, including population level interventions to encourage healthy eating and physical activity, as well as lifestyle related weight management services. Integrated Care Boards (ICB's) have primary commissioning responsibility for tier 3, clinician-led specialist multidisciplinary teams and tier 4 services, including bariatric surgery.

With the introduction of the NHS Long Term Plan, a number of nationally prescribed interventions have been introduced that provide weight management support across the obesity care pathway including the National Diabetes Prevention Programme, the NHS Digital Weight Management Programme and an enhanced weight management specification for primary care (see section 8.22).

Combining a tiered approach with a lifecourse approach we are able illustrate the range of preventive and treatment interventions across Herefordshire (see Appendix 1).

8.1 Tier 1 – Universal Prevention and Early Intervention Programmes

Tier 1 services are described as "activities to help prevent everyone, regardless of their weight, from becoming overweight or obese" (NICE ph47). NICE (2012) recommend a similar model described as a 'sustainable community-wide approach' to obesity prevention that involves a set of integrated services and actions delivered by the many organisations, community services and networks that make up the local system These universal services help raise awareness of the importance of maintaining a healthy weight and develop and promote services, facilities, environments and policies that enable children, young people and their families to eat more healthily and be more physically active.

Tier 1 universal interventions (prevention and reinforcement of healthy eating and physical activity messages), which includes public health and national campaigns, providing brief advice. Tier 1 is delivered by local and regional public health teams, together with the identification and advice, often carried out in a primary care setting, by healthcare professionals such as GPs, nurses, health visitors, school nurses etc. but together with support from pharmacists, local leisure providers and allied organisations.

8.11 Tier 1 – Children

Given that universal provision to ensure children and young people maintain a healthy weight involves an expansive list of services and activities due to numerous determinants that shape our behaviour which are summarised below:

- Health Visiting Service / Healthy Child Programme
- Public Health Nursing Service
- Breastfeeding initiatives
- Children centres
- Personal Social and Health Education (PSHE) in schools
- Solihull Approach –parental support, information and advice on bringing up children and young people
- PE and sport premium for schools (Schools with 16 or fewer eligible pupils receive £1,000 per pupil. Schools with 17 or more eligible pupils receive £16,000 and an additional payment of £10 per pupil)
- Early years settings

The Public Health Nursing service (health visitors and school nurses) which is commissioned by the council and provided by Wye Valley Trust, provides the primary mechanism to promote good health from pregnancy and the first 5-19 years of life.

The programme focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. This includes advice and support on a number of areas that promote healthy growth including breastfeeding, weaning, physical activity and good nutrition. This service delivers the national child measurement programme (NCMP).

8.12 Tier 1 – Adults

There are a plethora of services and activities that exist across Herefordshire aimed at supporting adults to maintain and achieve a healthy weight. Many of these are provided or commissioned by local authorities, voluntary and the private sector. Some of these include;

- Health walks and other recreational activities
- Leisure Centres
- Sport Clubs
- Active travel

The council currently offers a Making Every Contact Count (MECC) e-learning course. This course is freely available and equips participants with the knowledge and understanding on how to deliver basic health and wellbeing advice and information to people they may come into contact with, who might benefit from making a change to a healthier lifestyle.

General advice, support and signposting to healthy weight initiatives can be found on the council's Talk Community website that is widely promoted across the county

8.2 Tier 2

Tier 2 represents local community weight management services that provide community-based diet, nutrition and behaviour change advice, normally in a group settings and for people with a BMI greater than 30.

8.21 Tier 2 - Children

Herefordshire Council provide limited child weight management services and is therefore a gap within our child weight management pathway. The National Child Measurement Programme (NCMP) provides high-quality, reliable data on child overweight and obesity levels and trends. Letters are sent by Wye Valley Trust to parents of children who are measured and offered some support by the School Nursing Team. However uptake of this service by parents is low. Some further support is provided by Talk Community health trainers if requested by parents, but this primarily addresses parental/adult behaviours, rather than recommendations contained within national guidance on child weight management programmes[24]

Public health is working with the integrated care board (ICB) and primary care network areas (PCN) areas to develop pilot family weight management and wellbeing projects for 2022-2024.

8.22 Tier 2 - Adults

Herefordshire Council does not currently commission a generic adult weight management Tier 2 service and is therefore a gap within our adult weight management pathway. However, the council currently provides an in-house Healthy Mums programme that supports 'new mums' over 12-weeks focusing on behaviour change. This programme was initially funded with a national grant from the Office for Health Improvement and Disparities (OHID). However, the Government announced in April 2022 that this funding stream would end early due to national budgetary restraints. The Council have currently committed to maintain this provision until March 2023. To date, 11 courses have been delivered across the county with further courses to start during September.

A generic adult weight management Tier 2 programme based on the Healthy Mums approach is being delivered in one PCN area on a trial basis until March 2023.

Whilst not set up as a Tier 2 weight management service, the Council provides a Health Trainer service through Talk Community and funded through the public health grant. The service sees between 200-300 adults each year (excluding those referred for stop smoking) supporting people with healthy eating, being more active and looking after their mental wellbeing. In addition, a referral pathway is in place for any pregnant women with a BMI over 30 for the service to support keeping healthy in pregnancy.

Whilst not all referrals into the service are solely for weight management purposes, data from 2021 showed an average reduction in body weight per service user of 3.86%, which is comparable with other community weight management programmes[25]. Whilst losing relatively small amounts of weight will likely lead to health benefits, evidence suggests that a weight loss of 5% body weight should be the goal for Tier 2 services to lead to clinical benefits. Recent evidence has shown that people with obesity may be more likely to lose

[24] Overview | Weight management: lifestyle services for overweight or obese children and young people | Guidance | NICE
[25] 4 Considerations | Weight management: lifestyle services for overweight or obese adults | Guidance | NICE

weight if they attend group sessions for weight loss programmes, rather than having one-to-one support[26].

A range of proxy indicators are collected and monitored as part of the health trainers' service. Figure 5 shows differences in service user's physical activity levels at the beginning and the end of the intervention. This is also mirrored in the intake of the service user's fruit and vegetables which reflect positive changes in dietary behaviour (see figure 6. The service does collect data on longer term behaviour change outcomes although this is limited due to lack of follow-up.

Figure 7 shows the uptake of the health trainer service by deprivation with a proportion of referrals from the most deprived areas. Feedback from the Health Trainers service can be found in appendix 4

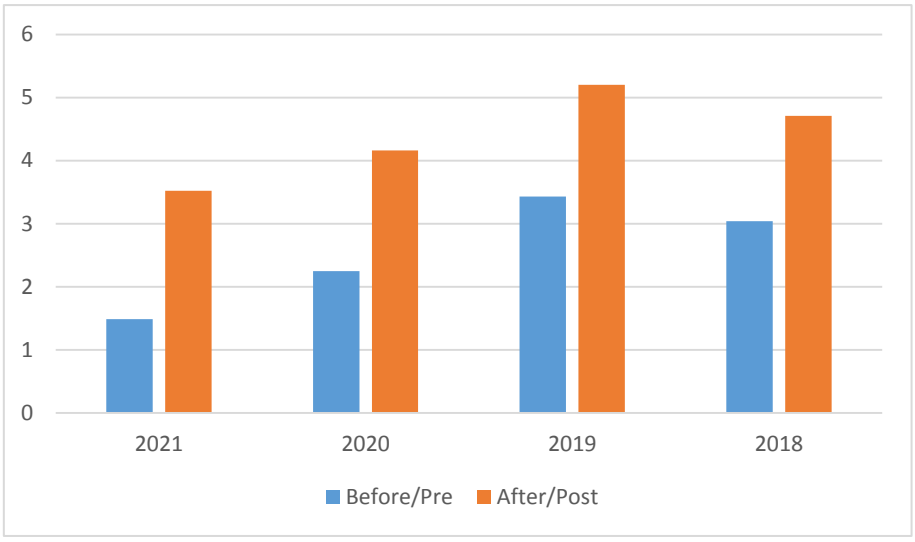


Figure 5 Average Number of Moderate Exercise Sessions of 30mins per week before and after intervention for referrals into the Health Trainer Service

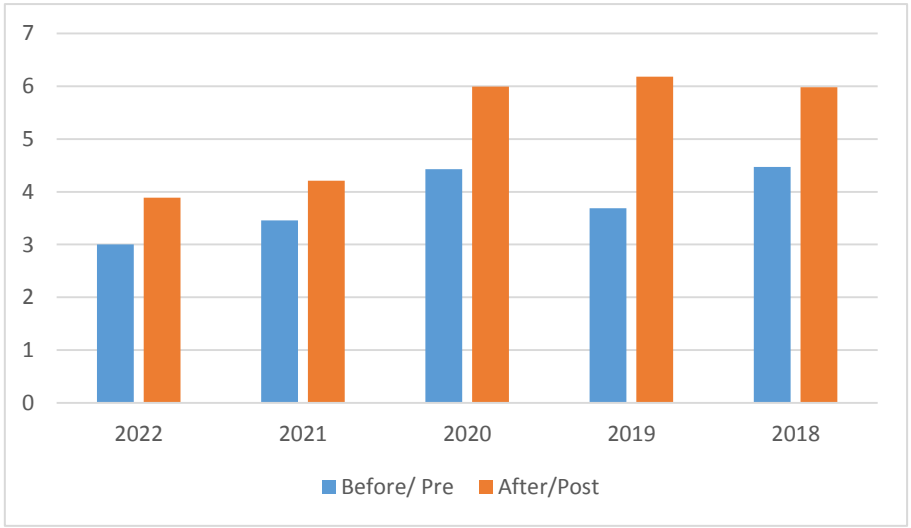


Figure 6 Average Fruit and Veg Per Day for referrals in to the Health Trainer Service

[26] Group versus one-to-one multi-component lifestyle interventions for weight management: a systematic review and meta-analysis of randomised controlled trials - Abbott - 2021 - Journal of Human Nutrition and Dietetics - Wiley Online Library

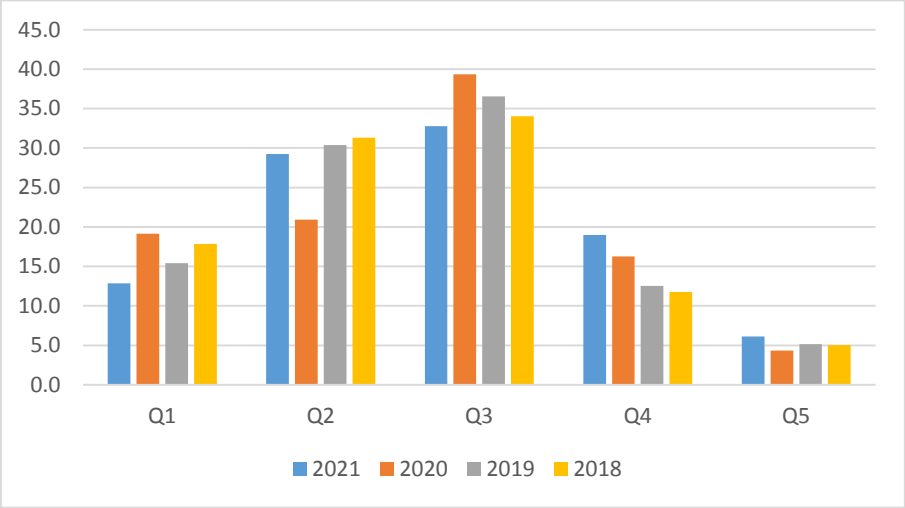


Figure 7 Proportion of referrals to the Health Trainers Service based on deprivation quintile (Q1 = most deprived, Q5 least deprived

Since 2015, the local NHS has commissioned a Diabetes Prevention Programme (NDPP) through a national procurement framework. Whilst the primary aim of the service is to provide behaviour change support to individuals with impaired glucose tolerance (Pre-diabetes), many of these individual will likely be above a healthy weight. The service is provided by 'Living Well Taking Controls' and offers both a face to face and digital offer. Further analysis needs to be undertaken but data for Herefordshire and Worcestershire indicates that 5340 patients have been referred into the service. Data suggests that of those patients who complete 5 sessions, they achieve an average weight loss of 3.16% body weight, those who complete 9 session achieve 5.10% reduction in body weight and those who complete 13 weeks achieve 6% reduction in body weight. No data are currently available on longer term outcomes.

In 2021, NHS England commissioned a national Digital Weight Management Programme that provides online support for individuals with who also have a diagnosis of diabetes, hypertension or both. Further data on the uptake and outcomes of this service is expected in October 2023.

Following the publication of the 2020 government policy document Tackling obesity, a national enhanced service for GP Practices was launched in 2021. This recognised that there was a need to increase the frequency of interventions for obesity in general practice care with a focus on improving referral pathways into weight management services in every local health care system. The enhanced specification rewards GP Practices for identifying patients living with obesity and signposting them to the most appropriate intervention. All practices in Herefordshire have signed up to the enhanced service.

8.3 Tier 3

Tier 3 comprises specialist weight management clinics that provide non-surgical intensive medical management with an MDT approach that consists of bariatric physicians or GPs with specialist interest, obesity specialist nurses, specialist dietitians and clinical psychologists to identify and manage psychological barriers to weight loss.

8.31 Tier 3 Children

There are no dedicated tier 3 weight management services in Herefordshire for children.

8.32 Tier 3 Adults

Herefordshire does not currently have a bespoke Tier 3 service with the referral pathway to the Gloucestershire Hospitals NHS Foundation Trust, based at Gloucester Royal Hospital. The service offer includes both face to face and virtual support, as well as 1:1 and group sessions. The location of services may present accessibility issues, particularly for those who have poor mobility.

8.4 Tier 4

Tier 4 accounts for bariatric surgery performed in secondary care with pre-operative assessment and post-operative care and support.

8.41 Tier 4 – Children

Surgical intervention is not generally recommended in children or young people. However, bariatric surgery may be considered for young people only in exceptional circumstances, and if they have achieved or nearly achieved physiological maturity. A full medical evaluation, including genetic screening or assessment should be performed before surgery to exclude rare, treatable causes of obesity.[27]

8.42 Tier 4 - Adults

Following tier 3, tier 4 services for Herefordshire patients are provided by Gloucestershire Hospitals NHS Foundation Trust and based in Gloucester Royal Hospital. Multi-disciplinary approaches are taken with patients support by surgeons, psychologists and dietitians, for pre-operative care and two years of follow up post-surgery.

9.0 Addressing the key determinants across Herefordshire

9.1 Food and Nutrition

Our consumption is driven by food systems (e.g. how food is grown, made and distributed); the community we live in; our individual behaviours and drivers of these behaviours; and economic factors. The food system has changed both locally and nationally, with increased availability of cheaper processed foods which are often high in fat, sugar and salt and consumption of food cooked outside the home. The quality of an individual's diet can therefore be affected by poverty and the causes of poverty; low or lack of income, competing expenditures (such as heating), access to food (including geography) and the food environment, education, family life and food skills of individuals, families and communities.

Improving the food system and diets often has synergistic and broader impacts on wellbeing through wider determinants of health. For example, changes in diet to include greater consumption of healthier foods, and lower consumption of unhealthy foods, would generally improve environmental sustainability, whilst community initiatives to increase skill sharing or local growing schemes can positively impact communities for example through reducing loneliness and improving connectedness.

Evidence has indicated that throughout the pandemic there was a shift towards modified eating behaviours, characterised by an increased snack frequency and a preference for

[27] NICE (2014) Obesity: identification, assessment and management CG 189

sweets and ultra-processed food rather than fruits, vegetables, and fresh food. Additionally, an increased alcohol consumption has also been found[28]. Emerging evidence suggests that children's dietary habits changed with one study indicating that the average intake of fruit in 9-12 years fell from just over one portion a day to half a portion a day[29].

In December 2021 the Health and Wellbeing Board endorsed a county-wide approach to becoming a Sustainable Food Place (SFP), with a Food Vision for Herefordshire developed by Herefordshire Food Alliance. The approach recognised that that food plays a key role in economic, environmental and social challenges. This includes obesity, diet related ill health, food poverty, waste and climate change. Food is a key driver of health inequalities. COVID-19 has further shown the vulnerabilities of the food system.

SFP provide a well developed and tested model on which to build our work to ensure a healthier and more sustainable food environment for all in Herefordshire. The SFP framework for strategy and action plan is structured around six key issues:

1. Taking a strategic and collaborative approach to good food governance and action
2. Building public awareness, active food citizenship and a local good food movement
3. Tackling food poverty, diet related ill-health and access to affordable healthy food
4. Creating a vibrant, prosperous and diverse sustainable food economy
5. Transforming catering and food procurement and revitalizing local and sustainable food supply chains
6. Tackling the climate and nature emergency through sustainable food and farming and an end to food waste

With regard to food redistribution specifically, the following key actions are currently being delivered in the county;

- Food redistribution working group created from Food Alliance
- Talk Community healthy lifestyle trainer service and waste team collaborative activity, use of excess food, meal planning, recipe ideas, campaign activity
- Grant recently awarded to Ethos to develop a project focusing on surplus food redistribution across the county,
- Food Alliance partner activity - Food banks, Ross community gardens, Herefordshire Helpers
- Herefordshire Council waste team project area focus
- Healthy Lifestyle Trainers are attending Food shares across the county offering advice and support on cooking and eating healthily.

In addition, the council is currently participating in a national school food compliance project in collaboration with The Food Standards Agency and Department of Education.

9.2 Diet and cost of living

With the cost of living crisis there is concern that this may negatively impact on people's diet. Evidence from previous recessions has found that expenditure and calorie consumption in the home fell during the economic downturn of 2008-12, relative to its 2005-07 average. Research conducted by the IFS found that households substituted towards calorie dense items (i.e. from fruit and vegetables towards processed foods). Pensioners, single-parent households and households with young children experienced the largest decline in nutritional quality. However, subsequent analysis, accounting for meals eaten

[28] Eating Behaviour Changes during the COVID-19 Pandemic: A Systematic Review of Longitudinal Studies - PMC (nih.gov)
[29] Defeyter, G. and Mann, E. 2020. The Free School Meal Voucher Scheme: What are children actually eating and drinking? ,

outside of the home, suggests that overall diets improved during the recession**.** IFS (2015).[30]

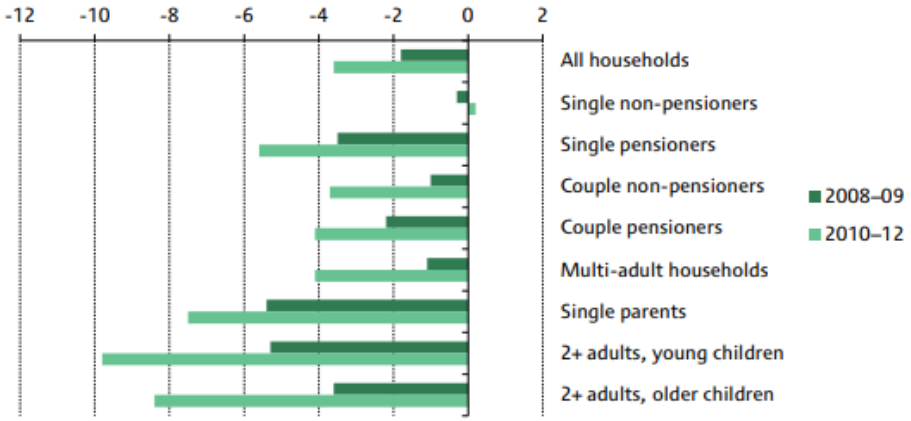


Figure 8 % change in calories purchased, from 2005-07 to 2008-09 and 2010-12

Whilst there is no easy way to count the number of people living in food poverty, in Herefordshire, as in other areas, we have seen increasing numbers of people receiving support from food banks. In 2021, there were 2792 vouchers redeemed at the two main foodbanks at Hereford and Leominster supporting 3784 adults and 2248 children. For the current year, as of August 2022, the numbers were 2102 vouchers supporting 2775 adults and 1398 children. Foodbanks have recently reported their concern that while there has been an increase in demand, there has at the same time been a reduction in food donations. This has meant that their stocks are running low and they are having to spend more money than usual on buying food. A number of Food banks are arranging "food drives" with their local supermarkets, which has raised their profile. The council continue to meet monthly with foodbanks.

In addition to the more formal foodbanks there are also other providers of food through food share such as the St Martins Foodshare in South Wye, Leominster and Kingstone, as well as other local food parcel providers / food larders particularly in Hereford – the Living Room and Putson Baptist Church. Foodbanks work closely with their local supermarkets and other local providers including farmers to use surplus fresh produce.

Holiday Activities Fund (HAF)

The 'Here for Herefordshire Holidays' programme is funded by the Department for Education and provides free activities and a meal to children and young people that are eligible for free school meals. Children and young people can access 16 hours of activities throughout the Easter and Christmas holidays and 64 hours of activities throughout the summer holidays.

30 activity providers are currently running sessions across the county in 2022 with activities on offer such as horse-riding, pottery, drama, dance, outdoor activities, aerial & circus skills, music workshops and Forest school. HALO were able to offer free family activities and sessions for children over the age of 13 to attend independently. The final numbers for this summer have not been completed yet as they are in the final week of the programme, however the number of children booked on to activities is likely to exceed over 1100 and attendance looks as though it has been much better than last summer's HAF programme.

[30] WP201529.pdf (ifs.org.uk)

Last year the Council had just over 950 children book on to activities, with 780 attending at least one activity. There has been an increase in the number of children 5 – 15 years eligible for FSM, last year it was approximately 3600 this year it is approximately 4000.

9.3 Physical Activity

Physical inactivity is the fourth leading risk factor for global mortality accounting for 6% of deaths globally. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer and with improved mental health. For those adults who are already overweight or obese, physical activity brings important reductions in health risks – the more activity they do, the lower their overall risk of mortality and morbidity. Physical activity is important for children and young people's healthy growth and development as well as helping to prevent a range of long-term medical conditions, including obesity.

9.31 Herefordshire's Physical Activity Strategy

Herefordshire's Physical Activity Strategy (2021-26) was ratified by the Health and Wellbeing Board in March 2022. The strategy sets out a goal of every person having the opportunity to: 'get moving, be active, feel better, keep well and enjoy healthier lives as part of everyday life in their local community'. Work undertaken to date to progress delivery of the strategy includes:

- The establishment of a physical activity multi-agency steering group to oversee delivery of the strategy
- Collaborative communications plan under development
- Piloting physios based in community settings started
- Collaborating with partners to target resources more effectively

9.32 Get Active Programme

As part of the Covid-19 economic and recovery plan, Herefordshire Council invested £850,000 Government Grant funding to an initiative called Get Active. The aim of *Get Active* was to increase opportunities for individuals of all ages to become more active and experience new opportunities through culture and leisure facilities.

The programme's focus was on supporting physical activity, in particular enabling inactive people to become more physically active through a combination of support to address barriers to participation and a diversification of opportunities to be more active, including improved infrastructure and access to green space.

The Programme includes seven elements directly delivered by a partner organisation or service:

1. Individual health assessments and healthy lifestyle support and guidance, delivered by Talk Community Health and Wellbeing Trainers
2. Active Families programme, delivered by Stride Active; 157 clients engaged, 11 schools involved.
3. Continuing Professional Development (CPD) for school PE leads to diversify opportunities for school children to be physically active, delivered by Stride Active; Training delivered to 20 staff on various activities
4. Free gym membership for 15-18 year olds, delivered by HALO Leisure; 1,708 individuals
5. Leisure events and taster activities, delivered by HALO Leisure;

6. Development of walking groups for adults, delivered by Active Herefordshire and Worcestershire; 3 new walks created
7. Delivery of 12-week physical activity taster opportunities for adults, delivered by Active Herefordshire and Worcestershire.

9.4 Build Environment

Planning authorities can influence the built environment to improve health and reduce the extent to which it promotes obesity[31]. In particular, there is growing evidence[32] that the number and density of fast food outlets adversely impacts on body weight with some local authorities[33] using their planning powers to restrict the numbers of fast food outlets in their areas. The council does not currently have a Health Impact Assessment (HIA) in place and work is underway to understand the opportunities for specific Supplementary Planning Documents to ensure new developments provide health enhancing environments that facilitate healthy behaviours.

9.41 Active Travel

A key priority for the council is 'to improve and extend active travel options across the council'. Evidence suggest that individuals switching to physically active forms of travel can have beneficial effects on body weight in addition to benefits for the environment[3435]

The Sustainability & Climate Team deliver and manage a range of schemes to increase Active Travel. Some of these are summarised below:

Cycling

- Bikeability provides cycle training to Primary school age children, Courses are delivered by Bike Right.
- Children's cycling activities – delivered in school holidays, from Balance bikes up
- Adult Cycle lessons – 1-2-1 sessions available to 16 + for starters, to build confidence or learn new routes or as a refresher
- Bike Loans – to support lessons and build confidence
- Beryl bikes – Low-cost easy access to travel for work and leisure
- E Beryl bikes – making cycling more accessible

Walking

- Walk to School – Promoting and supporting increased walking to school, delivered by Stride Active, delivering assemblies, lesson and walking challenges
- Get Walking – Virtual walking routes to support and encourage regular walking
- Led Nordic Walking - to encourage activity, build capability and confidence

Business

- Grant schemes for Business – bikes and parking provide access to active travel at work and encourages increased cycle to work
- Travel to Work Network- Provides members with travel information, supports travel planning

[31] Obesity and the environment: increasing physical activity and active travel (publishing.service.gov.uk)
[32] Weight gain in mid-childhood and its relationship with the fast food environment | Journal of Public Health | Oxford Academic (oup.com)
[33] Putting the brakes on fast food - evaluating the use of planning policy to support public health - ARC (nihr.ac.uk)
[34] Obesity and the environment: increasing physical activity and active travel (publishing.service.gov.uk)
[35] Associations of active travel with adiposity among children and socioeconomic differentials: a longitudinal study | BMJ Open

Information and support

- Travel planning in schools and businesses
- Park& Share and Park & Cycle – supports active commuting
- Signed walking and cycling routes – provide directions and time to destination
- Maps and route planning – building knowledge of the network, supports leisure

10.0 Finance

Whilst tackling obesity is a public health issue, it is recognised that many departments across the council (as well as external partners) have a key role in influencing the determinants that create environments that shape our dietary and physical activity behaviours. This therefore makes it challenging to understand the overall investment in obesity related services across the county with this regard

Public Health are best placed to drive the local leadership and strategies to promote healthy weight and are also responsible for commissioning weight management, although this is not at statutory requirement of the public health grant. A summary of current recurrent funding within the public health grant on obesity is as follows:

Intervention Service	Recurrent budget
Public Health Nursing	£2,504,500
Adult Weight Management Bespoke Adult Weight Management (Health Trainers)	£0 £260,000 (approx.)
Children Weight Management	£0
Active Travel Initiatives via Highways and Transport	£294,000

Table 2 High level of spend within the public health grant against obesity related activities

11.0 Conclusion and key areas for policy development

This report provides a high level summary of the services, activities and interventions that are in place to support people in maintaining and achieving a healthy weight. There are a number of areas where the Committee may wish to consider making recommendations to improve provision in Herefordshire, including:

1. Embed healthy weight as a strategic priority across local organisations and agencies by working with all key partners to develop a greater understanding of the causes of obesity and how best to deliver collective action through a whole system approach
2. Assess the impact of the current gaps in the county's weight management services in order to allocate sufficient resources as appropriate:
    - Tier 2 child and adult weight management services
    - Tier 3 child and adult weight management services – NHS/ICB priority
    - Tier 4 adult weight management service – NHS/ICB priority
3. Encourage health professionals and residents to identify ways in which patients can do more to help themselves through promotion of digital and self-help resources
4. Work with the planning department to develop and implement a Health Impact Assessment Tool to ensure health is considered in all planning decisions
5. Improve the quality of data on weight management services and obesity across the life course with a particular focus on long-term outcomes
6. Develop a training package around 'raising the issue of weight' for health practitioners and other front line workers to give them confidence to identify and elicit positive behaviour change in individuals

7. Build on the Sustainable Food Partnership to deliver collective action through a systems approach
8. Undertake further mapping of weight management services (and compliance with NICE Guidance) and raising awareness of the Weight Management to health practitioners across the county, including the service offer, eligibility criteria etc
9. Consider a consistent approach to the type of language and media used to communicate about obesity, tailoring language to the situation and co-producing communications with intended audiences

11.0 Background papers

Whole systems approach to obesity: A guide to support local approaches to promoting a healthy weight, Professor Paul Gately, Professor of Exercise and Obesity - Leeds Beckett University, Dr Duncan Radley, Senior Research Fellow - Leeds Beckett University.

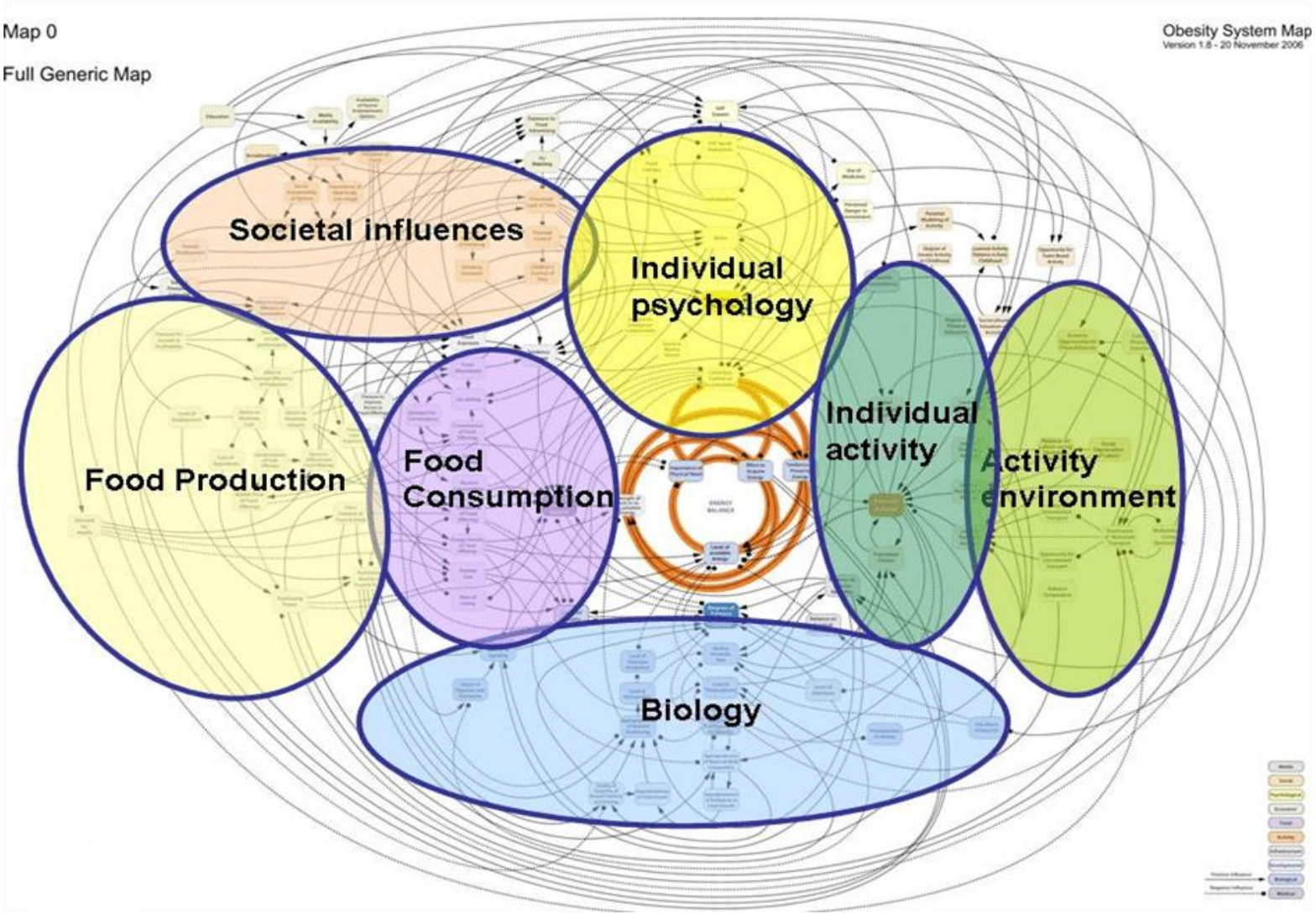
Tackling obesities: future choices - Tackling obesities: future choices - GOV.UK (www.gov.uk)

Spotlight review concerning dental health and childhood obesity, Herefordshire Council, September 2018.
https://councillors.herefordshire.gov.uk/documents/s50063205/Appendix%202%20-%20Spotlight%20review%20concerning%20dental%20health%20and%20childhood%20obesity%20task%20and%20finish%20group%20r.pdf

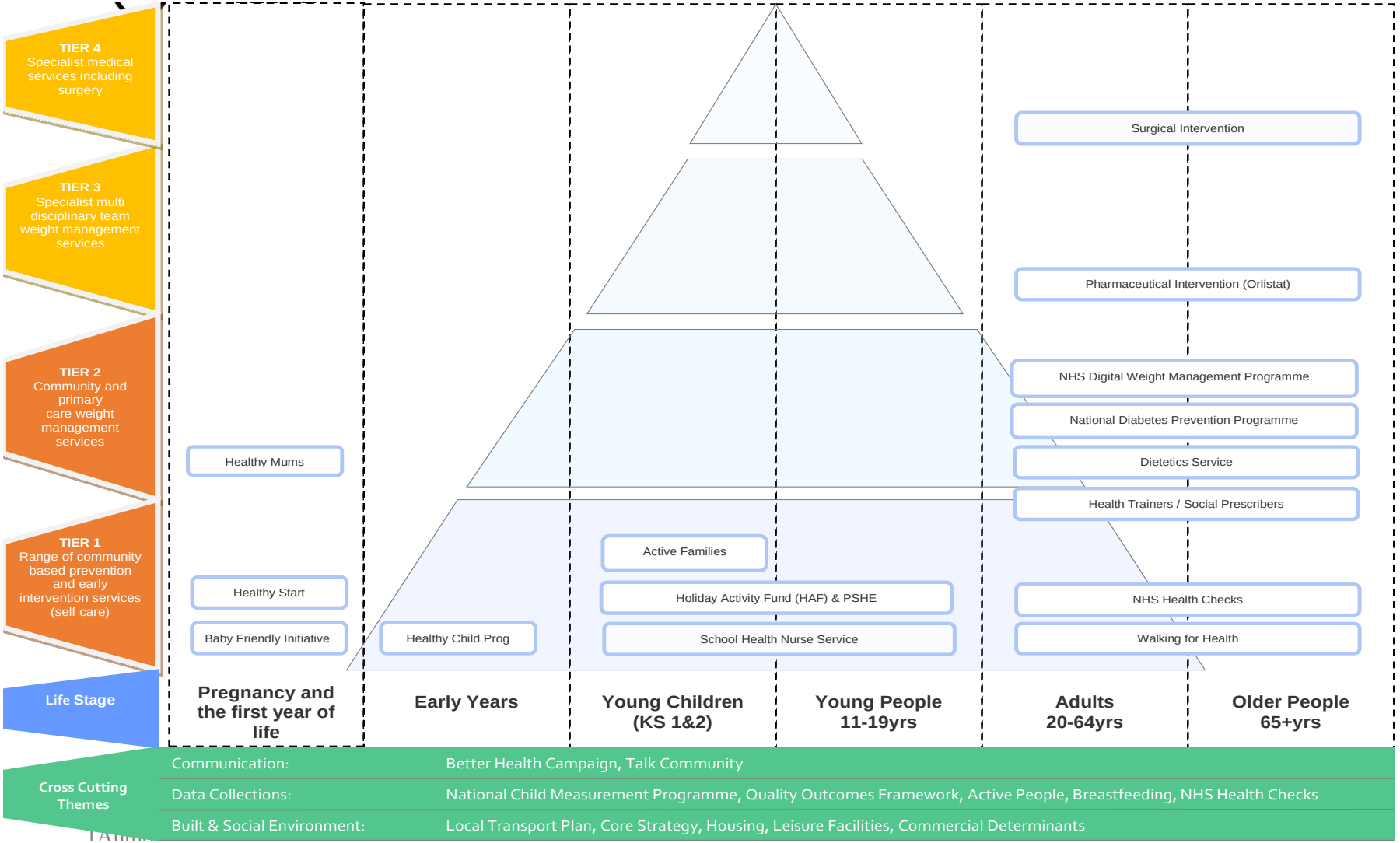
Herefordshire Health and Wellbeing Strategy, Priority 5:
For adults – long term conditions, lifestyles(alcohol, weight, active lifestyles, smoking prevention, mental health)

Requested for and on behalf of the Health Care and Wellbeing Scrutiny Committee	
	Councillor Elisa Swinglehurst – Chairperson HCWSC
	Michael Carr – Interim Statutory Scrutiny Officer **Michael.Carr@herefordshire.gov.uk** **Ben Baugh – Democratic Services Officer** **Ben.Baugh@herefordshire.gov.uk**
Date Requested:	**22nd August 2022**

Appendix 1


Map 0
Full Generic Map
Obesity System Map
Version 1.0 - 20 November 2006
Societal influences
Individual psychology
Food Production
Food Consumption
Individual activity
Activity environment
Biology

Appendix 2 – A pyramid pictorially reflecting the different level of healthy weight interventions from universal provision through to services to meet individual care needs



Appendix 3 – Summary of NICE Guidance related to obesity

NICE guidance	Recommendations
Pregnancy and Maternity	
Weight management before, during and after pregnancy [PH27] - July 2010 http://www.nice.org.uk/guidance/ph27	This is NICE's formal guidance on dietary interventions and physical activity interventions for weight management before, during and after pregnancy: • Weight management includes assessing and monitoring body weight, preventing someone from becoming overweight or obese, helping someone to achieve and maintain a healthy weight before, during and after pregnancy by eating healthily and being physically active and gradually losing weight after pregnancy • Effective weight-loss programmes address the reasons why someone might find it difficult to lose weight, are tailored to individual needs and choices, are sensitive to the person's weight concerns, are based on a balanced, healthy diet, encourage regular physical activity, expect people to lose no more than 0.5–1 kg (1–2 lb) a week, identify and address barriers to change. • Health professionals to use any opportunity to provide women with a BMI of 30 or more with information about the health benefits of losing weight before becoming pregnant. This should include information on the increased health risks their weight poses to themselves and would pose to their unborn child. • Health professionals should offer specific dietary advice in preparation for pregnancy, including the need to take daily folic acid supplements. • At the earliest opportunity, for example, during a pregnant woman's first visit to a health professional, discuss her eating habits and how physically active she is. Offer practical and tailored information. This includes advice on how to use Healthy Start vouchers. Use 6–8-week postnatal check to follow up. • Dieting during pregnancy is not recommended as it may harm the health of the unborn child

	• Offer women with a BMI of 30 or more after childbirth a structured weight-loss programme. If more appropriate, offer a referral to a dietitian or an appropriately trained health professional. • Encourage breastfeeding • Offer women with babies and children the opportunity to take part in a range of physical or recreational activities. This could include swimming, organised walks, cycling or dancing. Activities need to be affordable and available at times that are suitable • Ensure health professionals, healthcare assistants and support workers have the skills to advise on the health benefits of weight management and risks of being overweight or obese before, during and after pregnancy. Ensure they have the communication techniques needed to broach the subject of weight management in a sensitive manner.
Antenatal and postnatal mental health: clinical management and service guidance [CG192] - December 2014 http://www.nice.org.uk/guidance/cg192	This guideline covers recognising, assessing and treating mental health problems in women who are planning to have a baby, are pregnant, or have had a baby or been pregnant in the past year. It covers depression, anxiety disorders, eating disorders, drug- and alcohol-use disorders and severe mental illness. • Assessment and care planning in pregnancy and the postnatal period should include physical wellbeing (including weight, smoking, nutrition and activity level) and history of any physical health problem • Advise pregnant women taking antipsychotic medication about diet and monitor for excessive weight gain
Weight Management - Children and Young People	
Weight management: lifestyle services for overweight or obese children and young people NICE guidelines [PH47] - October 2013 https://www.nice.org.uk/guidance/ph47	This guidance makes recommendations on lifestyle weight management (sometimes called tier 2) services for overweight and obese children and young people aged under 18. These services are just one part of a comprehensive approach to preventing and treating obesity. • Ensure family-based, multi-component lifestyle weight management services for children and young people are available as part of a community-wide, multi-agency approach to promoting a healthy weight and preventing and managing obesity. They should be provided as part of a locally agreed obesity care or weight management pathway.

	• Ensure all lifestyle weight management programmes for overweight and obese children and young people are multi-component. They should focus on: o diet and healthy eating habits o physical activity o reducing the amount of time spent being sedentary o strategies for changing the behaviour of the child or young person and all close family members. • Ensure the following core components, developed with the input of a multidisciplinary are included: o Behaviour-change techniques to increase motivation and confidence in the ability to change. This includes strategies to help the family identify how changes can be implemented and sustained at home. o Positive parenting skills training, including problem-solving skills, to support changes in behaviour. o An emphasis on the importance of encouraging all family members to eat healthily and to be physically active, regardless of their weight. o A tailored plan to meet individual needs, appropriate to the child or young person's age, gender, ethnicity, cultural background, economic and family circumstances, any special needs and how obese or overweight they are. This should include helping them and their family to set goals, monitor progress against them and provide feedback (see recommendation 4). o Information and help to master skills in, for example, how to interpret nutritional labelling and how to modify culturally appropriate recipes on a budget. o Help to identify opportunities to become less sedentary and to build physical activity into their daily life (for example, by walking to school and through active play). o A range of physical activities (such as games, dancing and aerobics) that the children or young people enjoy and that can help them gradually become more active. o Information for family members who may not attend the programme itself to explain the programme's aims and objectives and how they can provide support.

	○ Ongoing support and follow-up for participants who have completed the programme. • Ensure all lifestyle weight management programmes are designed and developed with input from a multidisciplinary team and have taken into account the views of children, young people and their families. The team should include professionals who specialise in children, young people and weight management. • Local authorities should ensure an up-to-date list of local lifestyle weight management programmes for children and young people is maintained. This should form part of a list of services commissioned for the local obesity care or weight management pathway. It should be regularly disseminated, or accessible to organisations in the public, community and voluntary sectors.
Obesity in children and young people: prevention and lifestyle weight management programmes NICE quality standard [QS94] - July 2015 **https://www.nice.org.uk/guidance/QS94**	This quality standard covers a range of approaches at a population level to prevent children and young people aged under 18 years from becoming overweight or obese. It includes interventions for lifestyle weight management. Statement 1. Children and young people, and their parents or carers, using vending machines in local authority and NHS venues can buy healthy food and drink options. Statement 2. Children and young people, and their parents or carers, see details of nutritional information on menus at local authority and NHS venues. Statement 3. Children and young people, and their parents or carers, see healthy food and drink choices displayed prominently in local authority and NHS venues. Statement 4. Children and young people, and their parents or carers, have access to a publicly available up-to-date list of local lifestyle weight management programmes. Statement 5. Children and young people identified as being overweight or obese, and their parents or carers as appropriate, are given information about local lifestyle weight management programmes.

	Statement 6. Family members or carers of children and young people are invited to attend lifestyle weight management programmes, regardless of their weight. Statement 7. Children and young people, and their parents or carers, can access data on attendance, outcomes and the views of participants and staff from lifestyle weight management programmes. Statement 8. (placeholder) Reducing sedentary behaviour.
Weight Management CYP & Adults	
Obesity: clinical assessment and management NICE quality standard - [QS127] August 2016 **https://www.nice.org.uk/guidance/QS127**	This quality standard covers the clinical assessment and management of obesity in children, young people and adults. This includes those with established comorbidities and those with risk factors for other medical conditions. Statement 1. People are informed of their BMI when it is calculated and advised about any associated health risks. Statement 2. Adults with a BMI of 30 or more for whom tier 2 interventions have been unsuccessful have a discussion about the choice of alternative interventions for weight management, including tier 3 services. Statement 3. Children and young people who are overweight or obese and have significant comorbidities or complex needs are referred to a paediatrician with a special interest in obesity. Statement 4. Adults with a BMI of 35 or more who have been diagnosed with type 2 diabetes within the past 10 years are offered an expedited referral for bariatric surgery assessment. Statement 5. Adults with a BMI above 50 are offered a referral for bariatric surgery assessment. Statement 6. People who have had bariatric surgery have a postoperative follow-up care package within the bariatric surgery service for a minimum of 2 years.

	Statement 7. People discharged from bariatric surgery service follow-up are offered monitoring of nutritional status at least once a year as part of a shared-care model of management.

Obesity: identification, assessment and management
[CG189]- November 2014
http://www.nice.org.uk/guidance/cg189
	This guideline addresses three main areas: follow‑up care packages after bariatric surgery; the role of bariatric surgery in the management of recent-onset type 2 diabetes; and very-low-calorie diets including their effectiveness, and safety and effective management strategies for maintaining weight loss after such diets.
	
	• Measures of overweight and obesity
	  ○ Use BMI as a practical estimate of adiposity in adults. Interpret BMI with caution because it is not a direct measure of adiposity.
	  ○ Interpret BMI with caution in highly muscular adults as it may be a less accurate measure of adiposity in this group. Some other population groups, such as people of Asian family origin and older people, have comorbidity risk factors that are of concern at different BMIs (lower for adults of an Asian family origin and higher for older people
	  ○ Think about using waist circumference, in addition to BMI, in people with a BMI less than 35 kg/m2
	  ○ For children use BMI (adjusted for age and gender) as a practical estimate of adiposity in children and young people. Interpret BMI with caution because it is not a direct measure of adiposity. Waist circumference is not recommended as a routine measure.
	• Equip specialist settings for treating people who are severely obese with, for example, special seating and adequate weighing and monitoring equipment, larger scanners & beds in hospitals
	• Tailor the components of the planned weight management programme to the person's preferences, initial fitness, health status and lifestyle. Multicomponent interventions (physical activity / diet / behaviour change) are the treatment of choice.

	• Ensure that interventions for children who are overweight or have obesity address lifestyle within the family and in social settings • Offer regular, non-discriminatory long-term follow-up by a trained professional for adults and children • Use clinical judgement to decide when to measure a person's height and weight. Opportunities include registration with a general practice, consultation for related conditions (such as type 2 diabetes and cardiovascular disease) and other routine health checks. • The level of intervention should be higher for patients with comorbidities / high risk groups – levels of intervention to start with general advice on healthy weight and lifestyle at level 1 – at level 4 interventions should include diet and physical activity; consider drugs; consider surgery • Recognise that surprise, anger, denial or disbelief about their health situation may diminish people's ability or willingness to change. Stress that obesity is a clinical term with specific health implications, rather than a question of how people look. Praise successes in losing weight however small • Consider referral to an appropriate specialist for children who are overweight or obese and have significant comorbidities or complex needs (for example, learning disabilities or other additional support needs). • Give people who are overweight or obese, and their families and/or carers, relevant information on treatments / risks / self-care / support from the VCS • Encourage adults & children to increase their level of physical activity even if they do not lose weight as a result • Consider pharmacological treatment only after dietary, exercise and behavioural approaches have been started and evaluated (drug treatment not recommended for children under 12) • Bariatric surgery is a treatment option for people with obesity if they have a BMI of 40 kg/m2 or more, or between 35 kg/m2 and 40 kg/m2 and other significant disease and where all appropriate non-surgical measures have been tried but the person has not achieved or maintained adequate, clinically beneficial weight loss. • Bariatric surgery is the option of choice (instead of lifestyle interventions or drug treatment) for adults with a BMI of more than 50 kg/m2 when other interventions have not been effective.

	• Surgery for obesity should be undertaken only by a multidisciplinary team that can provide appropriate pre-operative and post-operative support, including psychological – minimum of 2 years follow-up care. Following that, annual monitoring of nutritional status and appropriate supplementation according to need • Surgical intervention is not generally recommended in children or young people. Bariatric surgery may be considered for young people only in exceptional circumstances, and if they have achieved or nearly achieved physiological maturity. • Offer an expedited assessment for bariatric surgery to people with a BMI of 35 or over who have recent-onset type 2 diabetes
Weight Management Adults	
Obesity in adults: prevention and lifestyle weight management programmes NICE quality standard [QS111] - January 2016 **https://www.nice.org.uk/guidance/QS111**	This quality standard covers ways of preventing adults (aged 18 and over) from becoming overweight or obese and the provision of lifestyle weight management programmes for adults who are overweight or obese. Although local definitions vary, these programmes are usually tier 2 interventions that may include weight management programmes, courses or clubs, and form 1 part of a comprehensive approach to preventing and treating obesity. This quality standard does not cover specialist management (tier 3 interventions) or bariatric surgery (tier 4 intervention). Statement 1. Adults using vending machines in local authority and NHS venues can buy healthy food and drink options. Statement 2. Adults see details of nutritional information on menus at local authority and NHS venues. Statement 3. Adults see healthy food and drink choices displayed prominently in local authority and NHS venues. Statement 4. Adults have access to a publicly available, up-to-date list of local lifestyle weight management programmes.

	Statement 5. Adults can access data on attendance, outcomes and views of participants and staff from locally commissioned lifestyle weight management programmes. Statement 6. Adults identified as being overweight or obese are given information about local lifestyle weight management programmes. Statement 7. Adults identified as overweight or obese, with comorbidities are offered a referral to a lifestyle weight management programme. Statement 8. Adults about to complete a lifestyle weight management programme agree a plan to prevent weight regain.
Weight management: lifestyle services for overweight or obese adults [PH53] - May 2014 http://www.nice.org.uk/guidance/ph53/chapter/1-recommendations	This guideline makes recommendations on the provision of effective multi-component lifestyle weight management services for adults who are overweight or obese (aged 18 and over). It covers weight management programmes, courses, clubs or groups that aim to change someone's behaviour to reduce their energy intake and encourage them to be physically active. The aim is to help meet a range of public health goals. These include helping reduce the risk of the main diseases associated with obesity, for example: coronary heart disease, stroke, hypertension, osteoarthritis, type 2 diabetes and various cancers (endometrial, breast, kidney and colon). • Adopt an integrated approach: Ensure there is an integrated approach to preventing and managing obesity and its associated conditions. Systems should be in place to allow people to be referred to, or receive support from (or across) the different service tiers of an obesity pathway. All the options in the local obesity pathway should be made clear to both professionals and the public. • Ensure services cause no harm and treat people with respect • Be aware of the effort needed to lose weight and harm caused by stigma • Ensure the tone and content of all communications is respectful and non-judgemental • Raise awareness of local weight management issues and services with commissioners, professionals and the public • Commission services that are effective address both weight loss and maintaining weight loss ○ Multi-component: diet, activity, behaviour

	○ Multidisciplinary: dieticians, psychologists and physical activity instructors ○ Focus on life-long change ○ For funded referrals, note that: ▪ programmes may particularly benefit adults who are obese (that is, with a BMI over 30 kg/m2, or lower for those from black and minority ethnic groups) or with other risk factors (comorbidities such as type 2 diabetes) ▪ where there is capacity, access for adults who are overweight should not be restricted (that is, for people with a BMI between 25 to 30 kg/m2, or lower for those from black and minority ethnic groups) or with other risk factors (comorbidities such as type 2 diabetes) ▪ there should be no upper BMI or upper age limit for referral. • Address the expectations and information needs of adults thinking about joining a lifestyle weight management programme ○ Discuss the importance and wider benefits of adults who are overweight or obese making gradual, long-term changes to their dietary habits and physical activity levels. ○ Discuss realistic weight-loss goals. People should be aware that: The more weight they lose, the greater the health benefits, particularly if someone loses more than 5% of their body weight and maintains this for life. ○ On average, people attending a lifestyle weight management programme lose around 3% of their body weight, but this varies a lot. ○ Preventing future weight gain and maintaining a lower weight trajectory leads to health benefits. • Provide national sources of information • Provide training and continuing professional development on lifestyle weight management for health and social care professionals • Monitor and evaluate progress and effectiveness

BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups [PH46] - July 2013 http://www.nice.org.uk/guidance/ph46/chapter/1-Recommendations	This guidance aimed to determine whether lower cut-off points should be used for black, Asian and other minority ethnic groups in the UK as a trigger for lifestyle interventions to prevent conditions such as diabetes, myocardial infarction or stroke. • Use lower thresholds to trigger action to prevent type 2 diabetes among Asian (South Asian and Chinese) population (23 kg/m2 to indicate increased risk and 27.5 kg/m2 to indicate high risk) • Extend the use of lower BMI thresholds to trigger action to prevent type 2 diabetes among black African and African-Caribbean populations • Raise awareness of practitioners and within the BME community that there is an increased risk of chronic health conditions at a lower BMI
Behaviour Change	
Maintaining a healthy weight and preventing excess weight gain among adults and children [NG7] - March 2015 http://www.nice.org.uk/guidance/NG7/chapter/1-recommendations	This guideline makes recommendations on behaviours that may help people maintain a healthy weight or prevent excess weight gain: • Advice for parents and carers to encourage physical activity and appropriate dietary habits in adults and children and: • Identify perceptions, habits or situations that may undermine efforts to maintain a healthy weight or prevent excess weight gain in the long term, and offer practical examples of helpful alternatives. These may include: drinking water instead of drinks containing free sugars while being physically active, not overestimating how much physical activity is being done, avoiding overeating after being physically active • Increase regular walking, particularly brisk walking, or cycling as a form of active travel (to school, work or other local destinations) • Encourage adults to limit alcohol consumption • Help children and encourage young people to get enough sleep • Encourage self-monitoring of weight and amount of physical activity • Communicate benefits of a healthy weight, and of gradual improvements in physical activity and diet • Tailor messages for specific groups

Behaviour change: individual approaches [PH49] - January 2014 http://www.nice.org.uk/guidance/ph49/chapter/1-recommendations	This guidance makes recommendations on individual-level behaviour change interventions aimed at changing the behaviours that can damage people's health. It includes a range of approaches for people aged 16 and over, from single interventions delivered as the opportunity arises to planned, high intensity interventions that may take place over a number of sessions. • Develop a local behaviour change strategy • Ensure organisational strategy, policy, resources and training all support behaviour change • Commission high-quality behaviour change interventions that take local need into account • Use proven behavioural change techniques • Commission suitable training for all health and social care professionals and others involved in helping to change people's behaviour • Monitor and evaluate programme success - ensure behaviour change is maintained for at least a year
Physical Activity	
Physical activity and the environment - [PH8] January 2008 http://www.nice.org.uk/guidance/ph8	This guidance offers the first evidence-based recommendations on how to improve the physical environment to encourage physical activity. It is for NHS and other professionals who have responsibility for the built or natural environment. • Involve all local communities and experts at all stages of the development to ensure the potential for physical activity is maximised. • Ensure planning applications for new housing developments / new workplaces always prioritise the need for people (including those whose mobility is impaired) to be physically active as a routine part of their daily life. • Ensure local facilities and services, workplaces, homes and school are easily accessible on foot, by bicycle and by other modes of transport involving physical activity. • Ensure children can participate in physically active play in and outside of school grounds • Ensure pedestrians, cyclists and users of other modes of transport that involve physical activity are given the highest priority when developing or maintaining streets and roads. (This includes people whose mobility is impaired.)

	• During building design or refurbishment, ensure staircases are designed and positioned to encourage people to use them
Physical activity: for NHS staff, patients and carers NICE quality standard [QS84] March 2015 **https://www.nice.org.uk/guidance/QS84**	This quality standard covers encouraging physical activity in people of all ages who are in contact with the NHS, including staff, patients and carers. It does not cover encouraging physical activity for particular conditions. Statement 1. Adults having their NHS Health Check are given brief advice about how to be more physically active. Statement 2. Parents or carers of children are given advice about physical activity during their child's Healthy Child Programme 2-year review. Statement 3. Parents or carers of children are given advice about physical activity as part of the National Child Measurement Programme (NCMP). Statement 4. NHS organisations have an organisation-wide, multi-component programme to encourage and support employees to be more physically active.
Physical activity: walking and cycling NICE guidelines [PH41] - November 2012 **https://www.nice.org.uk/guidance/ph41/chapter/1-recommendations**	This guidance aims to set out how people can be encouraged to increase the amount they walk or cycle for travel or recreation purposes. • Ensure a senior member of the public health team is responsible for promoting walking and cycling. • Ensure the joint strategic needs assessment, the joint health and wellbeing strategy and other local needs assessments and strategies take into account opportunities to increase walking and cycling. • Ensure walking and cycling are considered, alongside other interventions, when working to achieve specific health outcomes in relation to the local population (such as a reduction in the risk of cardiovascular disease, cancer, obesity and diabetes, or the promotion of mental wellbeing[• Ensure local, high-level strategic policies and plans (esp local authorities) support and encourage both walking and cycling. This includes a commitment to invest sufficient

	resources to ensure more walking and cycling – and recognition that this will benefit individuals and the wider community. • Help those interested in changing their travel behaviour to make small, daily changes by commissioning personalised travel planning programmes. • Address infrastructure and planning issues that may discourage people from wanting to cycle or walk, for example, motor traffic volume and speed, lack of convenient road crossings, poorly maintained footways and cycle paths or lack of dropped kerbs, • Develop strategies in consultation with staff (and other relevant stakeholders, for example, students in universities and colleges) to promote walking and cycling in and around the workplace •
Physical activity: brief advice for adults in primary care NICE guidelines [PH44] Published date: May 2013 **https://www.nice.org.uk/guidance/ph44**	The guideline is for commissioners of health services and anyone working in primary care whose remit includes offering lifestyle advice. Examples include: exercise professionals, GPs, health trainers, health visitors, mental health professionals, midwives, pharmacists, practice nurses, physiotherapists. • Identify adults who are not currently meeting the UK physical activity guidelines • Advise adults who have been assessed as being inactive to do more physical activity, with the aim of achieving the UK physical activity guidelines. Emphasise the benefits of physical activity. • Provide information about local opportunities to be physically active for people with a range of abilities, preferences and needs. • When commissioning services to prevent or treat conditions such as cardiovascular disease, type 2 diabetes and stroke or to improve mental health, ensure brief advice on physical activity is incorporated into the care pathway. • Ensure brief advice on physical activity is incorporated into services for groups that are particularly likely to be inactive. This includes people aged 65 years and over, people with a disability and people from certain minority ethnic groups. • Ensure systems such as Read Codes are being used to identify opportunities to assess people's physical activity levels and deliver brief advice. • Ensure resources (for example, standard documents a • Provide information and training for primary care practitioners to do the above

Communities	

Obesity: working with local communities- [PH42] November 2012
http://www.nice.org.uk/guidance/ph42
	This guidance aims to support effective, sustainable and community-wide action to prevent overweight and obesity in adults and overweight and obesity in children. It sets out how local communities, with support from local organisations and networks, can achieve this.
	
	Guiding principles
	• Community Engagement
	• Behaviour Change
	• Cultural appropriateness (to take account of the community's cultural or religious beliefs and language and literacy skills)
	Recommendations
	• Develop a sustainable, community-wide, multi-agency, approach
	• Support leadership at all levels to tackle obesity
	  ○ Work with local champions
	  ○ Fund small-scale community led projects
	• Effective communications
	• Involve the community, local businesses and social enterprises- integrated approach in identifying their priorities in relation to weight issues, co-produce action
	• Local authorities and the NHS can be exemplars of good practice (help staff / service users and wider community to achieve a healthy weight)
	• Monitor and evaluate appropriately
	• Embed organisational development and training

Preventing obesity and helping people to manage their weight NICE advice [LGB9] Published date: May 2013 https://www.nice.org.uk/advice/lgb9	This briefing summarises NICE's recommendations for local authorities and partner organisations on preventing people becoming overweight and obese and helping them to manage their weight. **Basic principles** • Obesity is a complex problem for which there is no simple solution. It cannot be addressed through single interventions undertaken in isolation.

	• NICE recommendations on preventing obesity and helping people to manage their weight should be undertaken in parallel, wherever possible. They should also:
	  ○ be implemented as part of a broad approach, which involves a variety of organisations, community services and networks operating at a range of levels
	  ○ be implemented as part of integrated programmes that address the whole population, but also address local health inequalities, for example, within specific neighbourhoods
	  ○ be underpinned by a robust, community-wide approach that includes monitoring and evaluation
	  ○ comprise specific actions commissioned to meet local needs and priorities, for example, to encourage healthy eating and physical activity and to develop community programmes to combat obesity.
	
	<u>Specific actions to meet local needs</u>
	
	Encouraging healthy eating
	• Make people aware of their eligibility for welfare benefits and other schemes that supplement the family food budget.
	• Use existing powers to control the number of take-aways and other food outlets in a given area, particularly near schools.
	• Local authority and NHS commissioners could make a difference by ensuring healthier choices are included in catering contracts and are promoted through pricing and educational initiatives.
	
	Encouraging physical activity
	• Work in partnership to create and manage more safe spaces for incidental and planned physical activity, addressing any concerns about safety, crime and inclusion. Audit and amend bye laws that prohibit games. For details see public open spaces and children and young people on NICE's 'Physical activity' pathway.
	• Plan local facilities and services to ensure they are accessible on foot or by bicycle. For details see environment and physical activity on NICE's 'Physical activity' pathway.
	• Ensure leisure services are affordable, culturally acceptable and accessible by public transport or by safe 'active travel' routes. Ensure provision is made for women who wish

	to breastfeed. For details see local strategy, policy and commissioning for physical activity and women before, during and after pregnancy on NICE's 'Physical activity' pathway. • Consider pedestrians and cyclists when designing, developing or maintaining streets or roads, for example, by introducing traffic calming measures. **Developing community programmes to combat obesity** • Ensure obesity prevention programmes are highly visible and easily recognisable. Consider adapting a widely known brand for use locally (such as the Department of Health's Change4Life). For details see branding on NICE's 'Obesity: working with local communities' pathway. • Consider the type of language and media used to communicate about obesity, tailoring language to the situation or intended audience. Ensure messages are consistent and clear. For details see language on NICE's 'Obesity: working with local communities' pathway and conveying healthy lifestyle messages to the local community on NICE's 'Preventing type 2 diabetes' pathway. • Address local people's concerns about issues such as the cost of eating more healthily or being more physically active and the perceived dangers of children playing outside. For details see recommendations for local authorities about community programmes to improve diet on NICE's 'Diet' pathway. • Train lay or peer workers from black and minority ethnic communities and lower socioeconomic groups to promote physical activity and healthy eating. • **Commissioning community weight management programmes** • Commission lifestyle weight management services from either NHS or non-NHS providers. Ensure they meet the needs of high risk groups . For details see using community resources and lay and peer workers to tailor interventions and target communities at high risk of type 2 diabetes on NICE's 'Preventing type 2 diabetes' pathway. • Ensure lifestyle weight management services meet current best practice guidance. • Work in partnership with NHS colleagues, leisure services and providers of weight management services to support women who wish to lose weight after childbirth.

	Ensuring local authorities and their NHS partners are exemplary employers • Set an example by ensuring on-site catering offers healthier choices. • Encourage physical activity by improving the décor and signposting of stairs, and by providing showers and secure cycle parking to encourage active travel. • Offer lifestyle weight management services for overweight or obese staff who would like support to manage their weight. **Involving local businesses and social enterprises** • Encourage local organisations and businesses to recognise their corporate social responsibilities in relation to health and wellbeing. For example, they should ensure the range and content of the food and drink sold does not create an incentive to over-eat and gives people the opportunity to eat healthily. • For details see involving local businesses and social enterprises on NICE's 'Obesity: working with local communities' pathway. • Encourage local organisations to provide information, such as the calorie content of meals, on menus. For details see promoting a healthy diet – local action on NICE's 'Preventing type 2 diabetes' pathway. • Encourage venues frequented by children and young people to resist sponsorship and product placement from companies associated with foods high in fat, sugar and salt. **<u>Community-wide actions to prevent obesity</u>** **Developing a sustainable, community-wide approach** • Adopt a coherent multi-agency approach. Ensure activities on obesity are integrated within the joint health and wellbeing strategy, the joint strategic needs assessment (JSNA) and broader regeneration and environmental strategies. • Make action on obesity prevention and management a strategic priority and align it with other disease-specific prevention strategies. • Work in partnership. This includes working with local clinical commissioning groups. **Providing and supporting leadership** • Ensure the needs and priorities of the local community, as outlined by the JSNA, are understood by all those who may take action on obesity.

	• Ensure elected members are briefed on the local picture and help them ensure obesity prevention is integrated within all council strategies and plans. • Ensure all management, staff and partners working with local communities are aware of the importance of preventing and managing obesity. • Support senior and middle management and frontline staff of partnerships involved in local action on obesity. • Provide opportunities for partners to meet to share learning and to enhance cooperation and joint working. • Identify and work with 'champions' within local authorities, NHS groups and public, private, community and voluntary sector bodies. **Coordinating local action** Ensure the public health team includes: • a director of public health or lead public health consultant who, as part of their role, provides strategic direction on obesity • a senior coordinator with expertise in obesity prevention and community engagement and with dedicated time to oversee the local programme • community 'health champions' and others who work directly with the community. **Involving the community** • Work with local people, groups and organisations to decide what action to take. • Use community engagement and capacity-building methods to identify networks of local people, champions and advocates who can help. • Work with local clinical commissioning groups to ensure GP practices are aware of local obesity prevention and treatment initiatives. • Council leaders and elected members should raise the profile of obesity prevention initiatives through informal and formal meetings with local people. **Integrated commissioning**

	• Foster an integrated approach to commissioning which supports a long-term (beyond 5 years) health and wellbeing strategy It should involve a variety of organisations, community services and networks operating at a range of levels • Focus on the most effective 'packages' of interventions to meet local needs. This includes awareness-raising and environmental interventions that support changes in behaviour and lifestyle weight management services for adults, children and families. • Allocate resources to local community engagement activities and to innovative approaches which are likely to be effective and which have the support of the local community. • Ensure flexibility in contracts to allow programmes or services to be adapted and improved. Consider extending effective programmes and services, or commissioning effective small-scale projects or prototypes. **Monitoring and evaluation** • Ensure all strategies, policies and activities that may impact on obesity are monitored in a proportionate manner. This includes taking into account their impact on inequalities. • Build monitoring into all contracts and simple tests used to assess value for money. • Set aside sufficient time and resources to thoroughly evaluate new or innovative pieces of work (for example, 10% of project budgets). • Ensure the results of monitoring and evaluation are easy to use and made available to all those who could benefit. **Scrutiny and accountability** Health overview and scrutiny committees and others with a scrutiny responsibility should assess local action on preventing obesity. This includes: • assessing the priority given to obesity • ensuring the local community's views have been taken into account • ensuring local obesity strategies have been implemented by local health and wellbeing boards. **Organisational development and training** • Ensure all partners have an opportunity to increase their awareness of, and develop their skills in, obesity prevention.

	• Ensure all relevant professionals are trained to be aware of the health risks of being overweight and obese and the benefits of preventing and managing obesity. • Ensure all relevant staff who are not specialists in weight management or behaviour change can give people details of local services that can help them maintain a healthy weight.For examples, see training and development on NICE's 'Obesity: working with local communities' pathway. • Ensure the links between nutrition and health are an integral part of training for catering managers.

Appendix 3 – Quotes from the Health Trainer Service

- Sarah's client - "You've [Sarah] been the nudge that I needed to help change my lifestyle, not the doctor… You've convinced me of the benefits of change and I'm glad I've taken that first step."

He is half way through the programme now and his mind-set has already changed and he's on board with changes taking months not weeks. He is trying new varieties of foods now, he's got more energy to do things, no longer needs his shoehorn to put his trainers on in the morning plus he's now teaching his sister-in-law all about food labels.

- "I have really taken on board what you have been saying. Differently to going to the doctors or my diabetic nurse, I like that we are able to have a conversation surrounding my challenges with weight-loss. I find this approach far more beneficial as weight loss for me has always been more than 'eating too much' – something which I can comfortably say I have addressed and continuing to address".

- The client had an operation around 4 months ago and as a result has since suffered diabetes insipidus. During our sessions she had mentioned about the bloat feeling around her waist and just generally feeling low and unwell. As the client usually gets on the scales bare foot, I noticed considerable swelling in her feet, compared to when the client first started, along with weight gain client. Her food diary the previous week did not justify the weight gain and with this I asked the client to please contact the surgery and explain the above. The client consequently contacted her consultant, who immediately changed her medication and brought her appointment forward to august instead of October. She says she is feeling the best she had and the consultant was pleased she had contact him. She was very thankful for advice given.

1.

- 'Thank you for your continue encouragement. I am feeling much more positive about my health and now I've also started seeing an osteopath to sort out my trapped nerve in my neck. My energy levels have improved and I'm even losing weight. I'm trying to go to the toning suit 3 times a week. Thank you once again, even though we have only met 3 times, it has had such a positive impact. Even my wife is surprised and hugely impressed with the difference!'

Appendix 4 – Quotes for Healthy Mums Programme

“At the start of the program I was feeling deflated and uncomfortable in my skin. I had very little energy and low mood. I just wanted to get back to feeling like myself.”

“With the help of the Healthy Mums program I have been able to exercise in a friendly, non-judgemental environment, where I have not felt self-conscious about my appearance.”

“The trainers Sarah, Zoe and Becky have helped me to identify the reasons why I wasn’t losing weight as quickly as I would have liked, and they have helped me understand how to have a healthy relationship with food. I don’t feel as though I am denying myself foods I enjoy, but rather I am having them in moderation and finding healthier alternatives that I previously wouldn’t have found appealing.”

“I now feel physically and mentally healthier and more optimistic about my weight loss journey. I would strongly recommend this course to fellow mums wanting that support. I have had great fun and would happily take part again if given the chance. Thank you Ladies!”

Herefordshire Council

Title of report: Stroke Services

Meeting: **Health, Care and Wellbeing Scrutiny Committee**

Meeting date: **23rd September 2022**

Report by: **The Statutory Scrutiny Officer**

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose:

The report attached at Appendix A provides an update on NHS Herefordshire and Worcestershire ICS on stroke services across Herefordshire and Worcestershire. This includes a paper on Improving Stroke (including TIA) Services across Herefordshire and Worcestershire, September 2022. The committee is asked to consider and comment on the information provided and seek assurance that the wider public engagement undertaken on this will be focused on delivering the required improvement further inform possible solutions.

Recommendation(s)

That the committee is assured that the wider public engagement undertaken on improving stroke services across Herefordshire and Worcestershire will be focused on delivering the required improvement further inform possible solutions.

Alternative options

1. The alternative is for the committee not to consider issues for stroke services across Herefordshire and Worcestershire and the wider public engagement on improving stroke services across Herefordshire and Worcestershire, which would provide less opportunity for local accountability and engagement with the committee on this important issue.

Key considerations

2. Key considerations for the committee to consider are the key issues and challenges for stroke services across Herefordshire and Worcestershire, as outlined in the report and the extent to

which stakeholder consultation will be designed in a way to help drive the improvement of stroke services for residents. The committee is asked to consider and comment on the information provided and seek assurance that the wider public engagement undertaken on this will be focused on delivering the required improvement further inform possible solutions.

3. Scrutiny committees have statutory powers to make recommendations to the Executive, as appropriate, and the Cabinet has a statutory duty to respond to scrutiny recommendations. They may also make reports and recommendations to external decision making bodies, including NHS bodies, which also have a statutory duty to respond (to provide an Executive Response).

4. Once an Executive Response has been agreed, the scrutiny committee shall receive a report to receive the response and the committee may review implementation of the executive's decisions after such a period as these may reasonably be implemented (review date).

Community Impact

5. In accordance with the adopted code of corporate governance, the council is committed to promoting a positive working culture that accepts, and encourages constructive challenge, and recognises that a culture and structure for scrutiny are key elements for accountable decision making, policy development and review. Topics selected for scrutiny should have regard to what matters to residents.

Environmental Impact

6. This is an information report and no there are no direct environmental impacts.

Equality Duty

7. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

8. A public authority must, in the exercise of its functions, have due regard to the need to –

    a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
    b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
    c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

9. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.

Resource Implications

10. There are no resource implications arising from this report, however, resource implications should be addressed in the consideration of this issue by the committee and in consideration of any scrutiny recommendations that may be envisaged as a result of the committee's consideration.

Legal Implications

11. The council is required to deliver a scrutiny function. The development of a work programme which is focused and reflects those priorities facing Herefordshire will assist the committee and the council to deliver a scrutiny function.

12. The Scrutiny Rules in Part 4 Section 5 of the council's constitution provide for the setting of a work programme, the reporting of recommendations to Cabinet and the establishment of task and finish groups within the committee's agreed work programme.

13. There are no specific legal implications arising from this report.

Risk management

Risk / opportunity	Mitigation
There is a reputational risk to the council if the scrutiny function does not operate effectively.	The arrangements for the development of the work programme should help mitigate this risk.

Consultees

The Chair of the Health, Care and Wellbeing Scrutiny Committee.

Appendices

Appendix A Stroke Services paper by the Director of Communications and Engagement (NHS Herefordshire and Worcestershire Integrated Care Board

Appendix 1 – Improving stroke services across Herefordshire and Worcestershire – Issues Paper

Background papers

None identified**.**

Herefordshire and Worcestershire Integrated Care System

NHS Herefordshire and Worcestershire

Health, Care and Wellbeing Scrutiny Committee

23 September 2022

Stroke Services

Summary

1. The Health, Care and Wellbeing Scrutiny Committee is to receive an overview of Stroke Services in Herefordshire.

2. Representatives from Herefordshire and Worcestershire Integrated Care System have been invited to the meeting.

Background

3. Stroke is a serious, life-threatening condition. It is the leading cause of death and disability in the UK with around 32,000 stroke related deaths in England every year. Around, one in six people will have a stroke during their lifetime, and it is estimated that around 30% of people who have a stroke will go on to experience another at some point.[1]

4. With speedy access 7 days a week to the right specialist treatment, care and support, people can go on to live full and independent lives. We have ambitions to ensure we deliver both now and in the future high-quality stroke and TIA (transient ischaemic attack or 'mini stroke') services across Herefordshire and Worcestershire.

5. To achieve this, we are looking at the way stroke and TIA services are organised and run in our area, so that everyone who accesses services in Herefordshire and Worcestershire will have the best opportunity to survive and thrive after stroke.

6. To help described the way stroke services are delivered across Herefordshire and Worcestershire and highlight the challenges we face in delivering a sustainable service, an Issues Paper (Appendix 1) has been produced. This Issues Paper also sets out a number of potential solutions and describes the next steps of public engagement that will be carried out to further inform those models.

[1] www.gov.uk

Issues for the Committee to Consider

Current service arrangement

7. In Herefordshire and Worcestershire, stroke services are provided by Worcestershire Acute Hospitals NHS Trust, Wye Valley NHS Trust and Herefordshire and Worcestershire Health and Care NHS Trust:

- Worcestershire Acute Hospitals NHS Trust (WAHT) – provides Hyper Acute and Acute Stroke Services and TIA clinics at the Worcestershire Royal Hospital;
- Wye Valley NHS Trust (WVT) – provides of Hyper Acute and Acute Stroke Services, TIA clinics, in-patient stroke specialist rehabilitation (all at Hereford County Hospital) and the Community Stroke Service (including Early Supported Discharge) countywide;
- Herefordshire and Worcestershire Health and Care NHS Trust (HWHCT) – provider of Community in-patient stroke specialist rehabilitation at Evesham Community Hospital and Community Stroke Service (including Early Supported Discharge) countywide;
- Residents of Powys receive a wide range of services close to home from Powys Teaching Health Board (PTHB), including in-patient stroke specialist rehabilitation at Breconshire War Memorial Hospital and community stroke services (including Early Supported Discharge).

8. The Stroke Association is also commissioned as part of the Worcestershire stroke rehabilitation offer to patients and provides communication and holistic support to stroke survivors and their carers.

9. In 2021-22, approximately 70% of people in Worcestershire who had a stroke were admitted to Worcestershire Royal Hospital (WRH). Around 96% of people in Herefordshire and c. 35% people in Powys who had a stroke were admitted to Hereford County Hospital (HCH).

10. Patients from Herefordshire and Worcestershire also accessed acute stroke services outside of the area including University Hospitals Birmingham NHS Trust[2] (Worcestershire and Herefordshire patients) (4.4%), Gloucestershire Hospitals NHS Foundation Trust (1.1%) and Dudley Group of Hospitals NHS Trust (2.1%).

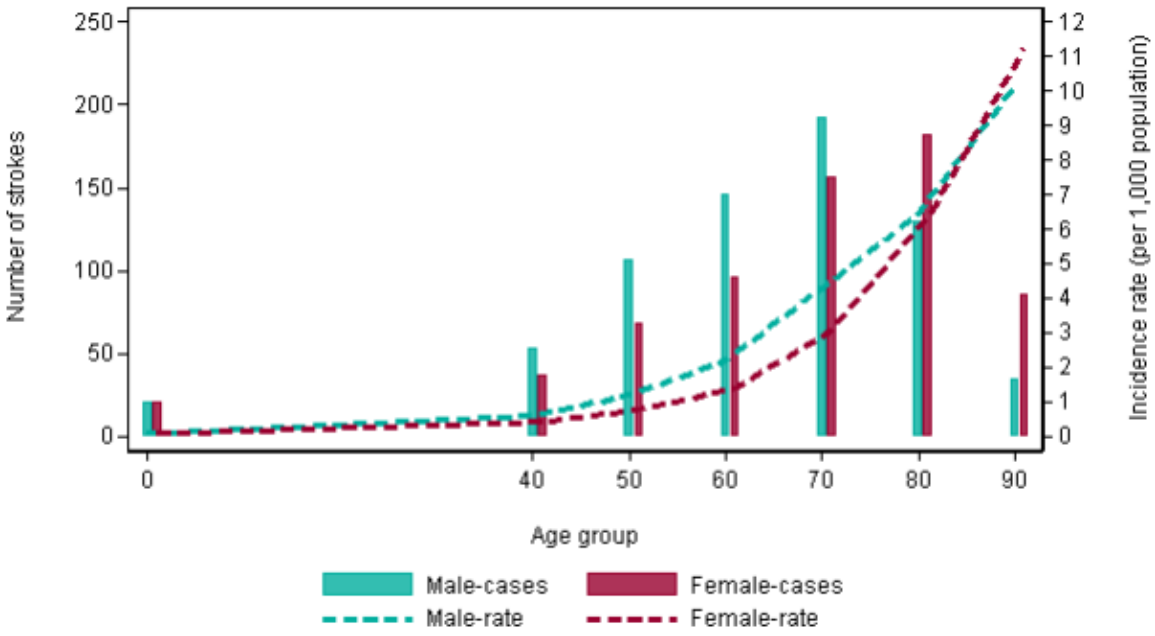
11. The majority of stroke patients admitted to Worcestershire Royal Hospital and Hereford County Hospital are from Herefordshire and Worcestershire (WRH 92.6% and HCH 92.8%), with a small number of admissions to HCH from patients outside of the county boundaries, including Powys (56 average admissions to HCH per year).

[2] University Hospitals Birmingham NHS FT is the designated Comprehensive Stroke Centre for Herefordshire and Worcestershire providing access to thrombectomy.

A case for change

12. More people are at risk of having a stroke because our population is growing, getting older and living with more long-term health conditions. The graph below shows how the incidence of stroke increases as we get older for the reasons outlined above, most significantly after the age of 60 years.

Diagram 1: Number of strokes and age-specific rates per 1,000 population, by gender, 2016 (Stroke Incident Briefing Document 2018).



13. Our healthcare teams work hard to provide high quality care to stroke and TIA patients at every stage of the pathway to ensure the best possible clinical outcome for that patient.

14. Across Herefordshire and Worcestershire there are however several challenges in doing this, especially at stages two and three of the stroke pathway (emergency treatment and ongoing acute hospital treatment and care), including the ability to recruit the staff with the specialist stroke skills required to ensure timely assessment, investigation and treatment of patients with a suspected stroke over 7-day services. By considering re-organising our services we can give everyone the best opportunity to survive and thrive after a stroke. Advantages of re-organising our services include:

- We could save more lives and help more people live well after stroke. The evidence shows that prompt access to assessment, investigation and time critical treatments followed by admission to a dedicated, centralised stroke unit (as mentioned in the NHS Long Term Plan and also known as a Hyper-Acute Stroke Unit or HASU), improves outcomes for people following a stroke, enabling them to go home quicker and go on living fuller lives.

- Everyone could have access to our specialist teams and treatments 24 hours a day, 7 days a week. This would happen regardless of where people live, or when they require treatment and care.

- We could meet the National Standards for Stroke Care. Increasingly, there are new and specialised treatments to reduce brain damage and disability after a stroke. These require highly skilled staff and the latest technology and services. As our expertise is currently spread over two sites, we're unable to offer 7-day access to this level of service at both hospital sites. The UK national audit programme grades our hospitals between B and D at the moment, with A being the best grade. We want to change this and improve the quality of care for everyone in our area

Developing potential solutions

15. To find solutions to our challenges, we have looked at a variety of ways we could address these. These have been considered with partners at the ICS Stroke Programme Board, the members of which include:

    - NHS Herefordshire and Worcestershire ICB
    - Worcestershire Acute Hospitals NHS Trust
    - Wye Valley NHS Trust
    - West Midlands Ambulance Service University NHS Foundation Trust
    - Welsh Ambulance Service NHS Trust
    - Powys Teaching Health Board
    - Herefordshire and Worcestershire Health and Care NHS Trust
    - Stroke Association
    - A patient representative
    - Healthwatch Herefordshire (observer)
    - Healthwatch Worcestershire (observer)
    - Powys Community Health Council (observer)

16. We have explored how we can meet the national guidelines across all organisations and sustain this level of service into the future. This work has been in development since 2017 but was paused in early 2020.The current potential solutions for Acute and Hyper-Acute stroke services are:

Potential Solution	Hyper Acute Stroke Unit (HASU)	Acute Stroke Unit (ASU)
1 – no change to current service	7-day units on two sites - Hereford County Hospital (HCH) and Worcestershire Royal Hospital (WRH). Not 24/7 specialist stroke consultant cover.	7-day units on two sites - Hereford County Hospital (HCH) and Worcestershire Royal Hospital (WRH). Not 24/7 specialist stroke consultant cover.
2	7-day unit at one site.	7-day units at two sites.
3	No HASU unit on HCH or WRH sites – HASU site outside of Herefordshire and Worcestershire.	No ASU unit on HCH or WRH sites – ASU site outside of Herefordshire and Worcestershire.
4	24/7day unit on one site with stroke specialist consultant cover - potentially WRH	24/7day unit on one site with stroke specialist consultant cover - potentially WRH

17. An options appraisal has been conducted on the above options, with potential solution number 4 being the preferred clinical model (which would see the single site being Worcestershire Royal Hospital).

Next steps

18. We want to reflect on stroke services, and the journey so far, and ask patients and stakeholders for their views. An engagement exercise will be carried out from 19 September to 11 November 2022 where we will seek feedback on the potential solutions and ask people whether there is anything that has been missed.

19. During this period of engagement, there will also be an online survey to collate feedback, and paper copies will also be made available. The Issues Paper will be available in Welsh and Easy Read, and other languages and formats will be available on request. A number of focus groups are planned within Herefordshire, Worcestershire and Powys. We will also be working with the voluntary and community sector to speak with stroke survivors and their carers to discuss their views on the issues and potential solutions.

20. As part of this reflection, we will also be reviewing key project documents such as the transport modelling, population modelling, workforce planning and the Equality Impact Assessment.

21. We will then work with people, communities, and stakeholders to reassess the options and how these are evaluated, which will include consideration of the location of services and the impact on other areas of the pathway including rehabilitation.

22. This work will be considered by the Stroke Programme Board before taking any potential solutions to the next stages of NHS governance and onwards through the service change process. This would include carrying out a full public consultation on any proposed changes ahead of a final decision being made.

Supporting Information

Appendix 1 – Improving stroke services across Herefordshire and Worcestershire – Issues Paper

Contact Points

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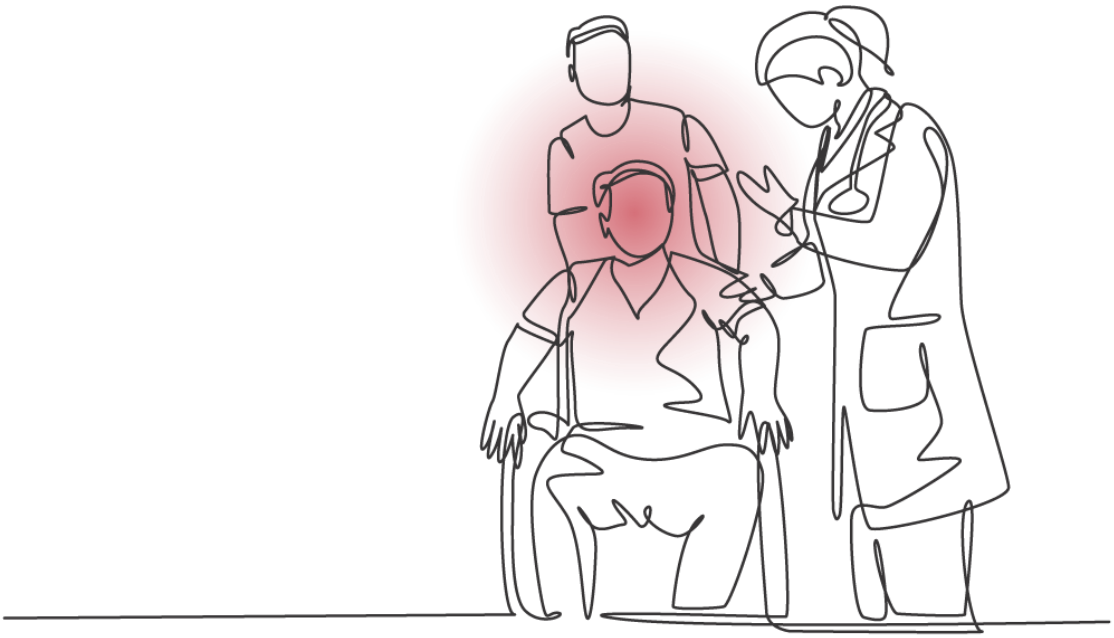
Appendix 1

Herefordshire and Worcestershire Integrated Care System

NHS Herefordshire and Worcestershire



Improving Stroke (including TIA) Services across Herefordshire and Worcestershire

Issues Paper September 2022

Introduction

The health and care leaders and clinicians across Herefordshire and Worcestershire responsible for planning care for our patients and communities, have come together to ensure we deliver the best quality stroke services for the people we serve.

We have worked together to develop our view of how these services could be delivered.

Stroke is a serious, life-threatening condition. It is the leading cause of death and disability in the UK with around 32,000 stroke related deaths in England every year. Around, one in six people will have a stroke during their lifetime, and it is estimated that around 30% of people who have a stroke will go on to experience another at some point.[1]

With the right specialist treatment, care and support, people can go on to live full and independent lives. We have ambitions to ensure we deliver both now and in the future high-quality stroke and TIA (transient ischaemic attack or 'mini stroke') services across Herefordshire and Worcestershire.

To achieve this, we are looking at the way stroke and TIA services are organised and run in our area, so that everyone who accesses services in Herefordshire and Worcestershire will have the best opportunity to survive and thrive after stroke.

This Issues Paper aims to describe the way stroke services are delivered across Herefordshire and Worcestershire and highlight the challenges we face in delivering a sustainable service.

Previous engagement has taken place and we would like to thank those who shared their experiences with us.

We began our journey to improve stroke services by engaging with patients and staff in 2018. As we move out of the COVID-19 pandemic we would like to continue this conversation. We would like to hear from you about the issues and challenges we face in delivering sustainable stroke and TIA services in line with national clinical standards, as well as potential solutions to these. This opportunity will help us to transform services and ensure high quality stroke and TIA services for the future.

This document is also summarised in a presentation which is available here https://www.hwics.org.uk/get-involved/involvement-opportunities/stroke-services

We would like to hear your views on this paper, and details on how to get in touch are at the end of this document, or please contact hw.engage@nhs.net

[1] www.gov.uk

Contents

Section	Page
Introduction	2
Glossary	4
Summary	6
Our system	7
What is a stroke?	8
How do we currently care for people who have had a stroke in our area?	9
Outlining a compelling case for change	12
Developing potential solutions	16
What have patients and the public told us so far?	22
What happens next?	22
Have your say	23
References	23

Diagrams

Diagram	Page
1 - Number of strokes and age-specific rates	12
2 - Stroke pathway	20
3 - Stroke pathway	20

Tables

Table	Page
1 - Five stages in the national stroke pathway	9
2 - Key standards	13
3 - Potential Solutions	18
4 - Pros and Cons	20

Glossary

Acute Stroke Unit (ASU) – for patients after 72 hours of admission. The ASU is an acute neurological ward providing specialist services for people who have had a new suspected stroke.

Atrial fibrillation - is **a heart condition that causes an irregular and often abnormally fast heart rate**.

Community Stroke Rehabilitation (CSR) - is an inter-disciplinary team made up of Nurses, Allied Health Professionals (Physiotherapists, Occupational Therapists, Speech and Language Therapists and Dietitians) and Rehabilitation Support Workers (RSW's) who provide community rehabilitation for patients in their own homes, residential homes and nursing homes.

Early supported discharge (ESD) - is an intervention for adults after a stroke that allows their care to be transferred from an inpatient environment to a community setting. It enables people to continue their rehabilitation therapy at home, with the same intensity and expertise that they would receive in hospital.

Integrated Care Board (ICB) –The ICB replaced the Clinical Commissioning Group (CCG) on 1 July 2022. The ICB leads the health element of the Herefordshire and Worcestershire Integrated Care System (ICS), which brings together the local NHS organisations, councils and the voluntary, community and faith sector to achieve better health outcomes for people who live and work in the two counties.

Integrated Care System (ICS) – An integrated care system (ICS) is when all organisations involved in health and care work together in different and more joined-up ways.

Hyper Acute Stroke Unit (HASU) - 0-72 hours after admission. The main focus of HASU is to closely monitor and stabilise the medical condition of a person newly diagnosed with a stroke.

Herefordshire and Worcestershire Health and Care NHS Trust (HWHACT) - HWHACT provide the community hospitals across Worcestershire and mental health services across Herefordshire and Worcestershire.

Powys Teaching Health Board (THB) – one of seven THBs across Wales. THBs are responsible for planning, commissioning and providing local health services to address local needs.

Thrombolysis - also known as thrombolytic therapy, is a treatment to dissolve dangerous clots in blood vessels, improve blood flow, and prevent damage to tissues and organs. For most people, thrombolysis needs to be given within four and a half hours of the stroke symptoms starting. In some circumstances, however, it could still be of benefit within six hours but the more time that passes, the less effective thrombolysis will be.

Thrombectomy - a treatment that physically removes a clot from the brain. It usually involves inserting a mesh device into an artery in the groin, moving it up to the brain,

and pulling the clot out. It only works with people where the blood clot is in a large artery. Like thrombolysis, it has to be carried out within hours of a stroke starting. Only a small proportion of stroke cases are eligible for thrombectomy, but it can have a big impact on those people by reducing disability. This procedure is only available at a certain number of stroke centres and the most local one to our area is at University Hospital Birmingham.

TIA - transient ischaemic attack or 'mini stroke'.

University Hospitals Birmingham NHS Foundation Trust (UHBFT) – delivers thrombectomy services to patients from Herefordshire and Worcestershire.

Worcestershire Acute Hospitals NHS Trust (WAHT) – runs Worcestershire Royal Hospital (WRH).

Wye Valley NHS Trust (WVT) – runs Herefordshire County Hospital (HCH), community hospitals and the community-based stroke specialist rehabilitation team across Herefordshire.

Welsh Ambulance Service NHS Trust (WAST) – Provider of Emergency Medical Services (EMS), NHS111 and Ambulance Care Services (formally known as Non-emergency Patient Transport) across Wales

West Midlands Ambulance Service University Foundation Trust (WMAS) – The West Midlands emergency ambulance service and NHS 111 provider.

Summary

Challenges in Herefordshire and Worcestershire

Herefordshire and Worcestershire Integrated Care System (ICS) (all health and care partners working together) provides health and care services to over 806,000 residents including some services for around 40,000 people living in Powys, a neighbouring county in Wales.

Our healthcare teams work hard to provide high quality care, and our ambition is to continue and sustain this into the future. Across Herefordshire and Worcestershire there are several challenges in providing this including workforce, specifically the recruitment of key clinical staff with the specialist stroke skills, and consequently our ability to be able to provide 7-day a week services. By considering re-organising our services we can give everyone the best opportunity to survive and thrive after a stroke.

Potential Solutions

Across the ICS we have been working with partners to consider the sustainability of stroke services. Several potential solutions or options have been considered. Our clinicians have identified a preferred way to deliver stroke services and that is to centralise hyper-acute and acute stroke services on one site as this will enable us to deliver a 7-day service in line with national clinical and quality standards, thereby ensuring we are able to meet the needs of patients by providing the best quality of care.

Have your say

We want to hear what you think about stroke services and the issues discussed in this paper. We will be engaging on this during September-October 2022.

After reading this paper we would like you to consider the following:

1. Do you think we have raised and explained all of the issues and challenges that may be associated with improving stroke services across Herefordshire and Worcestershire? If not, what do you think we have missed?
2. Have we considered all the potential solutions for improving stroke services? If not, what else should we consider?
3. When thinking about stroke services, is there anything we could be doing to support the prevention of stroke? If yes, please tell us what else we should consider.
4. Do you have any further feedback or comments?
5. Would you like to be involved in future stroke services engagement?

Our system

There are 42 Integrated Care Systems (ICSs) in England, ranging in population sizes from 500,000 to 3 million. Herefordshire and Worcestershire ICS is one of the smallest in the country, providing health and care services to over 806,000 residents including some services for around 40,000 people living in Powys, a neighbouring county in Wales.

Our system is sparsely populated, covering 1,500 square miles with significant rural areas, bringing challenges for travel and access to services for some citizens, as well as being a low wage economy and limited social mobility. This is in the context of a relatively high, and increasing, proportion of our population aged over 65, when compared with regional and national figures.

In addition, Powys is the most sparsely populated county in England and Wales, also with significant challenges for travel and accessing services, and a population profile that is older than UK and Welsh averages.

We know that access to and outcomes from health and care services are not experienced equally across our population. Addressing this is core to our strategic priorities.

What is a stroke?

A stroke is a life-threatening medical condition that occurs when the blood supply to the brain is cut off, either from a clot or if a blood vessel in the brain bursts (also known as a haemorrhage).

Stroke is a life-changing event, and a leading cause of death and disability in the UK. It can affect people of all ages and has significant, long-term impacts. Stroke is a serious condition and is the fourth biggest killer in the UK.

In 2021-22, around 1,200 people in Herefordshire and Worcestershire, and a further 150 people in Powys, were admitted to hospital following a stroke. That's around three people each day. That number is set to rise as the population continues to grow, people live longer and the number of people living with long term conditions such as raised blood pressure, high cholesterol and diabetes increases.

Thanks to a combination of better prevention, and earlier and more advanced emergency treatment and care within 72 hours of having a stroke, many people are surviving and making a good recovery. There are also things we could do differently to give everyone in our area the best opportunity to survive and thrive after a stroke.

We not only want to support those who have a TIA or stroke, but also work to prevent people experiencing them. Around 90% of strokes are preventable[2] and the best way to help prevent a stroke is to eat a healthy diet, exercise regularly, and avoid smoking and drinking too much alcohol. These lifestyle changes can reduce the risk of developing problems like: arteries becoming clogged with fatty substances (atherosclerosis), heart conditions that cause irregular heartbeats (atrial fibrillation) and high blood pressure (hypertension).

As well as these lifestyle changes, medicines can be used to effectively treat certain conditions such as atrial fibrillation (AF) as people with AF are five times more likely to have a stroke. We are therefore working with our GP practices to reduce the number of people with undiagnosed AF and ensure they are effectively treated.

We continue to work with our health and social care partners around prevention and reducing the impact of inequalities on patient outcomes of stroke and TIA. This includes improving access to smoking cessation and weight management services, proactively identifying and treating conditions such as AF and high blood pressure in primary care, as well as optimisation of NHS Health Checks.

[2] www.stroke.org.uk

How do we currently care for people who have had a stroke in our area?

Table 1. Five stages in the national stroke pathway:

Stage	1 **Prevention**	2 **Emergency treatment**	3 **Ongoing acute hospital treatment and care**	4 **Inpatient rehabilitation**	5 **Community care and life after stroke**
Detail	Focuses on reducing factors that put people at risk of having a stroke, like high blood pressure.	For people with a suspected stroke or immediately after a stroke, where people have surgery if needed.	With specialist staff who are experts in stroke and supporting people until they are well enough to move to the next stage of care.	On a hospital site or in the community for those who need additional specialist treatment and rehabilitation.	Ongoing treatment and care can be provided at home (or a care home) and a variety of community-based local facilities, such as physio centres, gyms or community hubs, depending on the support required.
Services	Smoking cessation services (support and treatment). Weight management. Identification and management of AF, hypertension and Chronic Kidney Disease, in primary care.	Hyper Acute Stroke Unit (HASU) for the first 72 hours of care.	Acute Stroke Unit (ASU) for patients after 72 hours of admission.	In-patient stroke specialist rehabilitation unit, providing specialist stroke rehabilitation for patients unable to return to their normal place of residence.	Community Stroke Rehabilitation (CSR) is an inter-disciplinary team who provide community rehabilitation. This includes early supported discharge (ESD).

In Herefordshire and Worcestershire, stroke services are provided by Worcestershire Acute Hospitals NHS Trust, Wye Valley NHS Trust and Herefordshire and Worcestershire Health and Care NHS Trust:

- Worcestershire Acute Hospitals NHS Trust (WAHT) – provides Hyper Acute and Acute Stroke Services and TIA clinics at the Worcestershire Royal Hospital;

- Wye Valley NHS Trust (WVT) – provides of Hyper Acute and Acute Stroke Services, TIA clinics, in-patient stroke specialist rehabilitation (all at Herefordshire County Hospital) and the Community Stroke Service (including Early Supported Discharge) countywide;
- Herefordshire and Worcestershire Health and Care NHS Trust (HWHCT) – provider of Community in-patient stroke specialist rehabilitation at Evesham Community Hospital and Community Stroke Service (including Early Supported Discharge) countywide;
- Residents of Powys receive a wide range of services close to home from Powys Teaching Health Board (PTHB), including in-patient stroke specialist rehabilitation at Breconshire War Memorial Hospital and community stroke services (including Early Supported Discharge).

The Stroke Association is also commissioned as part of the Worcestershire stroke rehabilitation offer to patients and provides communication and holistic support to stroke survivors and their carers.

In 2021-22, approximately 70% of people in Worcestershire who had a stroke were admitted to Worcestershire Royal Hospital (WRH). Around 96% of people in Herefordshire and c. 35% people in Powys who had a stroke were admitted to Hereford County Hospital (HCH).

Patients from Herefordshire and Worcestershire also accessed acute stroke services outside of the area including University Hospitals Birmingham NHS Trust[3] (Worcestershire and Herefordshire patients) (4.4%), Gloucestershire Hospitals NHS Foundation Trust (1.1%) and Dudley Group of Hospitals NHS Trust (2.1%).

Patients from other parts of Powys will receive their acute stroke services from other neighbouring hospitals including The Shrewsbury and Telford Hospital NHS Trust, Bronglais Hospital (Hywel Dda University Health Board), Prince Charles Hospital (Cwm Taf Morgannwg University Health Board) and Morriston Hospital (Swansea Bay University Health Board).

The proposals in this engagement relate to the stroke pathway to hospitals in Herefordshire and Worcestershire and do not directly affect stroke pathways to other hospitals outside of the area.

The majority of stroke patients admitted to Worcestershire Royal Hospital and Hereford County Hospital are from Herefordshire and Worcestershire (WRH 92.6% and HCH 92.8%), with a small number of admissions to HCH from patients outside of the county boundaries, including Powys (56 average admissions to HCH per year).

When someone experiences a stroke or TIA, there are a number of clinicians and allied health professionals who may, at different times of the pathway, be involved in their diagnosis, treatment, rehabilitation and longer-term support. These can include:

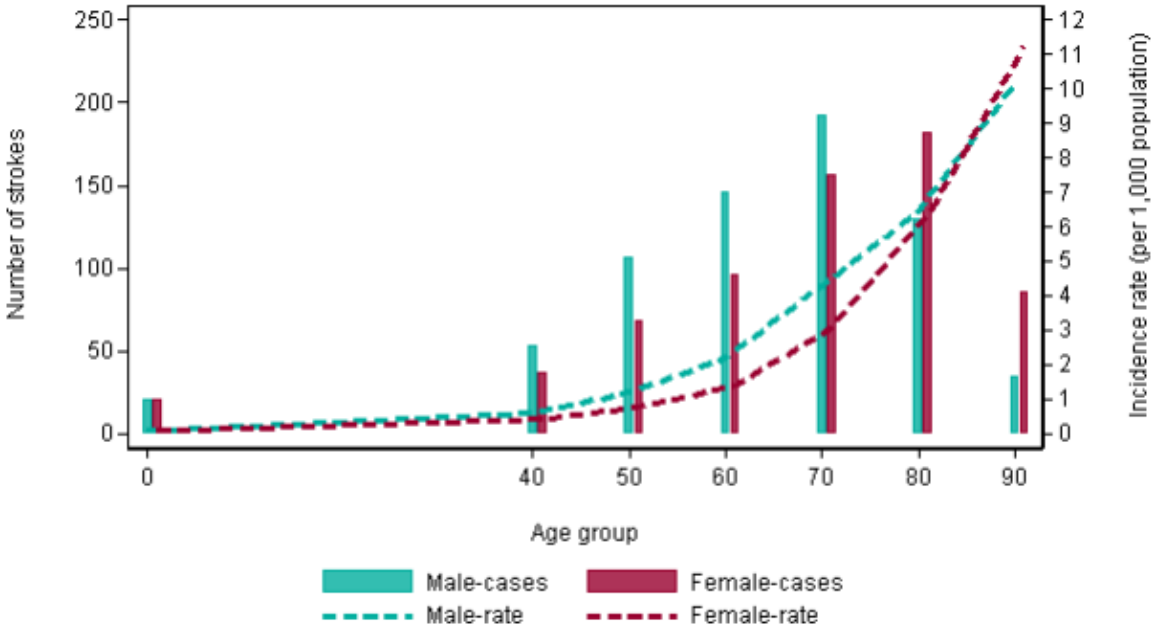
[3] University Hospitals Birmingham NHS FT is the designated Comprehensive Stroke Centre for Herefordshire and Worcestershire providing access to thrombectomy.

- GPs
- Paramedics
- Specialist stroke consultants
- Specialist stroke nurses
- Psychologists
- Physiotherapists
- Occupational therapists
- Speech and language therapists
- Dieticians
- Pharmacists
- Social workers

Outlining a compelling case for change

More people are at risk of having a stroke because our population is growing, getting older and living with more long-term health conditions. The graph below shows how the incidence of stroke increases as we get older for the reasons outlined above, most significantly after the age of 60 years.

Diagram 1: Number of strokes and age-specific rates per 1,000 population, by gender, 2016 (Stroke Incident Briefing Document 2018).



Our healthcare teams work hard to provide high quality care to stroke and TIA patients at every stage of the pathway to ensure the best possible clinical outcome for that patient. Across Herefordshire and Worcestershire there are however several challenges in doing this, especially at stages two and three of the stroke pathway (emergency treatment and ongoing acute hospital treatment and care), including the ability to recruit the staff with the specialist stroke skills required to ensure timely assessment, investigation and treatment of patients with a suspected stroke over 7-day services. By considering re-organising our services we can give everyone the best opportunity to survive and thrive after a stroke.

- **We could save more lives and help more people live well after stroke**. The evidence shows that prompt access to assessment, investigation and time critical treatments followed by admission to a dedicated, centralised stroke unit (as mentioned in the NHS Long Term Plan and also known as a Hyper-Acute Stroke Unit or HASU), improves outcomes for people following a stroke, enabling them to go home quicker and go on living fuller lives.
- **Everyone could have access to our specialist teams and treatments 24 hours a day, 7 days a week.** This would happen regardless of where people live, or when they require treatment and care.

- **We could meet the National Standards for Stroke Care.** Increasingly, there are new and specialised treatments to reduce brain damage and disability after a stroke. These require highly skilled staff and the latest technology and services. As our expertise is currently spread over two sites, we're unable to offer 7-day access to this level of service at both hospital sites. The UK national audit programme grades our hospitals between B and D at the moment, with A being the best grade. We want to change this and improve the quality of care for everyone in our area

Issues we think will be important to patients and their families in our area:

As part of this work, there are a number of other important considerations for our patients and their families and carers, these include:

- Ease and distance of travel: we have a wide geography and it can take a long time to travel across Herefordshire, Worcestershire and Powys. Public transport is not always available, and not everyone has access to their own vehicle. We also recognise that not everyone will have family and/or close relatives living near them and therefore may be reliant on other members of the community and/or services to enable them to travel to hospitals/other healthcare settings, and that families and carers will want to visit their loved ones in hospital.
- Impact on deprived communities: even if transport is available, not everyone can afford it. Wider factors of deprivation, for example, poor housing and education can also affect a person's health and wellbeing and contribute to the risk factors of stroke.
- Working with other health and social care systems: especially when a patient is discharged, or will receive rehabilitation services elsewhere, the communication with other health and social care services needs to be clear, timely and enable a smooth transition.

National guidelines and documents

As part of the wider National Health Service the services we provide in our area must meet national and regional guidelines to ensure we are offering the best clinical quality and safety for our patients. These include the 2016 National Clinical Guidelines for Stroke, Stroke NHS Toolkit, West Midlands Regional Service Specification, and the West Midlands Thrombectomy Clinical Guidelines (2019).

Table 2 below shows key standards from these documents, and our current service provision:

Standard	**Our service**
Thrombolysis within 60 minutes of admission (includes scanning time as per optimal stroke imaging pathway of CT within 20 mins and MRI within one hour (only for very mild strokes or where diagnosis is difficult).	We do not currently achieve this standard for all patients. There are a number of reasons for this including demand in our emergency departments, timely access to a stroke specialist to

	advise regarding diagnosis and treatment and access to CT/MRI.
24/7 access to thrombolysis.	This is in place at both hospital sites. During the day (Monday – Friday at HCH and Monday – Sunday at WRH) this is provided on site. Out of hours (weekday evenings, weekends and Bank Holidays), it is provided through the Southwest Thrombolysis Network[4].
24/7 access to thrombectomy	This is available at University Hospital Birmingham but is reliant on diagnosis and referral in Herefordshire and Worcestershire, and then transfer to UHB for treatment within the time window.
7-day services which includes twice daily ward rounds in HASU and once daily rounds in ASU.	This is currently being delivered at the WRH site. At HCH this is currently being delivered by locum staff over 5-days (Monday – Friday) with access to a consultant remotely (mornings only) at the weekend. To deliver sustainable 7-day services on two acute hospital sites, in line with national clinical and quality standards, a minimum of 12 stroke specialist consultants would be required. There is currently a national shortage of stroke consultants and most stroke units have vacant posts they are unable to fill. This includes both stroke units in Herefordshire and Worcestershire and given the recruitment issues outlined, it is unlikely that we will be able to recruit enough stroke consultants to maintain sustainable 7-day services across both sites.

[4] The Southwest Thrombolysis Network provides remote access to a stroke consultant to support thrombolysis decision-making. The consultant will remotely review the CT/MRI and advise regarding whether the patient is suitable for thrombolysis.

To summarise, the case for change for stroke and TIA services across the ICS can be outlined as follows:

- We do not have enough permanent stroke specialist consultants required to achieve the national clinical standards for stroke at either of the hyper acute and acute stroke units at Herefordshire County Hospital and Worcestershire Royal Hospital. To be compliant with 7-day national clinical and quality stroke standards, we would require a minimum of 12 consultants.
- We have been unable to recruit the number of stroke consultants required to deliver 7-day services across both sites, despite sustained and innovative efforts to do so. There is a national shortage of these roles and most acute stroke units across the country are currently carrying some vacancies resulting in an ongoing reliance on locum or agency staffing.
- We continue to rely on support from outside of Herefordshire and Worcestershire to ensure we have access to stroke specialist consultants over 7-days. Given the pressures on stroke services elsewhere, this is not sustainable and will require us to consider alternative and more sustainable service models to ensure access to services for our patients.

Though the service is currently being provided, it could be better for patients if we could ensure 7-day access to a stroke specialist consultant led service. This would enable us to do the following:

- Deliver more stroke specialist services within the ICS ourselves, thereby reducing our reliance on other areas to support us.
- Ensure we have local access to stroke specialist consultants to support other areas of the stroke pathway such as rehabilitation.
- Provide the opportunity to potentially develop the services we have locally for stroke and TIA, allowing us to embrace new technologies, treatments and interventions if we can create a sustainable and high-quality service for the ICS.
- Improve pathways between ourselves and stroke specialist centres that offer specialist treatments, thereby improving outcomes for our patients.

We believe there is a strong case for change to the way we deliver our hyper-acute and acute stroke services for the patients who need our services as outlined above.

Developing potential solutions

To find solutions to our challenges, we have looked at a variety of ways we could address these. These have been considered with partners at the ICS Stroke Programme Board, the members of which include:

- NHS Herefordshire and Worcestershire ICB
- Worcestershire Acute Hospitals NHS Trust
- Wye Valley NHS Trust
- West Midlands Ambulance Service University NHS Foundation Trust
- Welsh Ambulance Service NHS Trust
- Powys Teaching Health Board
- Herefordshire and Worcestershire Health and Care NHS Trust
- Stroke Association
- A patient representative
- Healthwatch Herefordshire (observer)
- Healthwatch Worcestershire (observer)
- Powys Community Health Council (observer)

We have explored how we can meet the national guidelines across all organisations and sustain this level of service into the future. This work has been in development since 2017 but was paused in early 2020.

The journey so far:

In 2018 we undertook an exercise to start to develop potential solutions to address the issues we have at stages 2 and 3 of the stroke pathway (see Table 1 on page 9 - emergency treatment and ongoing acute hospital treatment and care). These four ideas are described in Table 3 below.

Staff and patient feedback was gathered on their experiences of stroke services, and these potential solutions. Further modelling, workforce planning and travel assessments were conducted.

The above potential options were assessed against a set of high-level criteria including:

- Quality - Ability to offer services in line with clinical standards;
- Deliverability - Workforce required to deliver 7-day services;
- Accessibility - Local access to services, travel times, impact on carers/relatives, impact on cross border patients;
- Strategic fit - Inter-dependencies with other services for example diagnostics and other acute medical services.

In 2020 the global pandemic halted the development of this work as resources were directed into other areas. This has also altered how patients access some health services and technology has become an essential tool in improving access to and

delivery of health care services. Clinical work restarted in 2021/22 around improving stroke services across the two counties, focusing on potential solution 4 (one central location for Hyper Acute and Acute Stroke services). During this time, work has continued through the ICS Stroke Programme Board to maintain existing services and to improve service delivery where possible. This includes work around improving the pathways to accessing acute and stroke specialist rehabilitation services in line with national clinical standards. The ICS has invested to increase capacity in early supported stroke discharge services to enable more patients to receive their rehabilitation at home.

In the last two years, Integrated Stroke Delivery Networks and Regional Stroke Boards have also been established. These networks are in place to ensure high quality and accessible stroke services are delivered to people across the West Midlands. The networks themselves are also leading on a number of regional developments to support the modernisation of stroke services to improve outcomes for patients, including:

- Use of telemedicine and Artificial Intelligence (AI) to support remote decision-making for thrombolysis and thrombectomy;
- Standardisation of pre-alert pathways across the region, leading to improvements in the identification and management of suspected stroke patients;
- Use of video triaging in ambulances to enable hospital-based stroke specialists to visualise the patient and make decisions around the management of the patient;
- Standardisation of stroke rehabilitation ensuring all stroke patients have access to the services they require to enable them to optimise their rehabilitation potential;
- Workforce development of specialist stroke roles including consultant roles, specialist nurse and therapist roles and Advanced Care Practitioners.

We want to hear more views on this to ensure that we have considered all the issues and potential solutions.

Table 3: Potential solutions for Acute and Hyper-Acute stroke services

Potential Solution	Hyper Acute Stroke Unit (HASU)	Acute Stroke Unit (ASU)
1 – no change to current service	7-day units on two sites - Herefordshire County Hospital (HCH) and Worcestershire Royal Hospital (WRH). Not 24/7 specialist stroke consultant cover.	7-day units on two sites - Herefordshire County Hospital (HCH) and Worcestershire Royal Hospital (WRH). Not 24/7 specialist stroke consultant cover.
2	7-day unit at one site.	7-day units at two sites.
3	No HASU unit on HCH or WRH sites – HASU site outside of Herefordshire and Worcestershire.	No ASU unit on HCH or WRH sites – ASU site outside of Herefordshire and Worcestershire.
4	24/7day unit on one site with stroke specialist consultant cover - potentially WRH	24/7day unit on one site with stroke specialist consultant cover - potentially WRH

Potential solution 1 (no change, continuing the service as it is)

This was not considered to be sustainable longer term, largely because of the challenges we have had and continue to experience around recruitment to stroke consultant posts. With these ongoing difficulties we are unable to deliver robust and sustainable 7-day stroke specialist consultant led services across the ICS.

Potential solution 2

This solution was not developed any further as it scored lowest against the above criteria. This would not reduce our reliance on the number of stroke specialist consultants required to deliver 7-day services in line with national clinical and quality standards and did not offer an alternative to solution 1.

Potential solution 3

This solution was not developed any further as it scored lowest against the above criteria. Feedback received from the West Midlands Cardiovascular Strategic Clinical Network (WMCVCN) at the time did not consider this service model as viable for the following reasons:

- Insufficient HASU capacity outside of Herefordshire and Worcestershire - Note from West Midlands Cardiovascular Clinical Network (WMCVCN) Expert Advisory Group meeting held on 25/04/2017:

"A discussion followed to include UHB and UHCW who agreed that it was not viable due to capacity by either hospital".

- Excessive travel times for patients, particularly from Herefordshire and South Powys to UHBT/UHCW. Analysis of the travel times to the HASU and ASU sites outside of Herefordshire and Worcestershire confirmed this would potentially exclude a significant number of patients from being eligible for time critical interventions such as thrombolysis.

Potential solution 4

This potential solution would concentrate the Hyper Acute and Acute Stroke Unit on one site. This potentially identified as Worcestershire Royal Hospital, as part of existing plans to improve the emergency department, and development of a specialised intervention unit for cardiac and potentially stroke patients.

Patients with a suspected stroke will be taken to their closest hospital, which for the majority of patients from Powys and Herefordshire will be Herefordshire County Hospital. Here they will be triaged (assessed) by a stroke specialist, treated (if appropriate) and if a confirmed stroke, transferred and admitted directly to the Hyper Acute Stroke Unit at Worcestershire Royal Hospital. This ensures patients continue to have timely access to time critical assessment and interventions such as thrombolysis. In a small number of cases, some patients may be taken directly to the WRH site, if for example the patient is assessed by the ambulance service, in conjunction with the stroke team at Worcestershire Royal Hospital (WRH) that the patient is unlikely to benefit from time critical interventions such as thrombolysis and need to be admitted directly to a Hyper Acute Stroke Unit.

All other suspected strokes will be taken directly to the Worcestershire Royal Hospital (WRH) site and taken to a stroke assessment area for initial assessment, investigation and treatment.

On discharge, patients will receive their ongoing stroke specialist rehabilitation in their respective county. This includes in-patient rehabilitation at a designated in-patient unit or through the community stroke rehabilitation service, which offers specialist stroke rehabilitation in the patient's own home. A high-level potential solution and stroke pathway is shown below, in **Diagrams 3 and 4**:

Diagram 2: Stroke pathway - Herefordshire / Powys patients where Herefordshire County Hospital is the nearest imaging centre

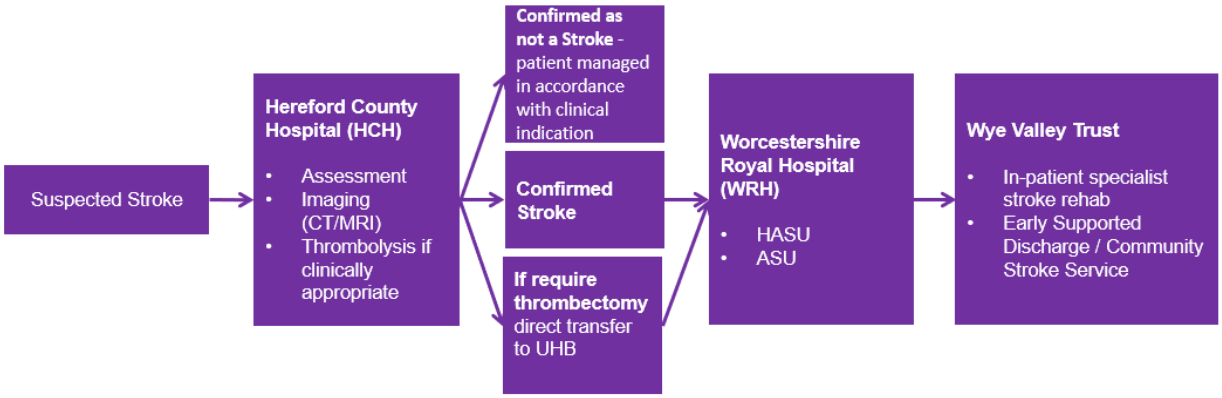
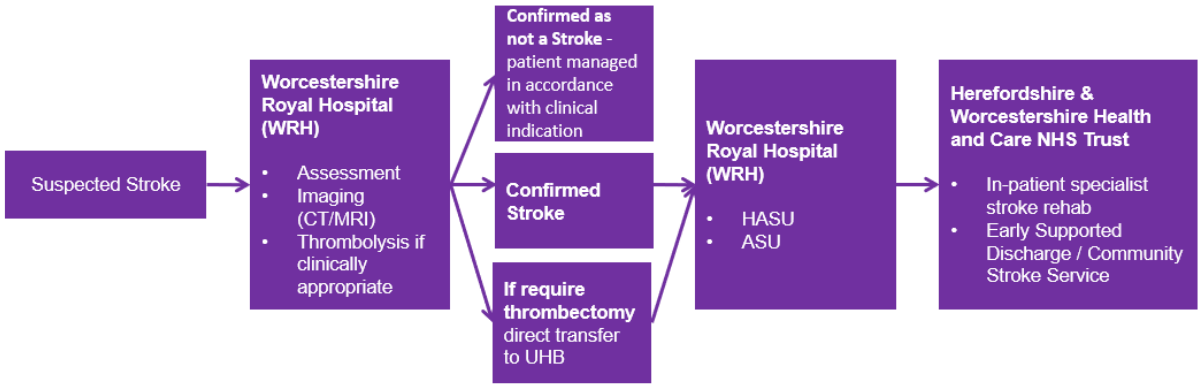


Diagram 3: Stroke pathway - Worcestershire and Herefordshire patients where Worcestershire Royal Hospital is the nearest imaging centre:



Some of the positive and negatives of this option are summarised below (**Table 4**):

Pros	Cons
Workforce will be concentrated in one unit rather than spread over two. To deliver 7-day services across both sites, we will require a minimum of 12 stroke consultants. There is currently a national shortage of these roles and most acute stroke units have vacant posts, making recruitment much more difficult for smaller units such as the ones in WRH and HCH.	Whilst initial assessment, investigation and treatment of patients will be undertaken at their closest imaging centre (i.e. HCH), patients from Powys and Herefordshire who are confirmed as a stroke will receive their ongoing acute specialist stroke care at a unit further away from their homes than currently, with an impact on travel for their relatives and carers.
Consolidation and development of the workforce on one site will enable us to deliver 7-day services including out of	Workplace location may need to change or flex

hours cover, ensuring 24-hour access to local stroke specialists. This model also has the potential to develop the treatments and services we can offer our patients.	
Removes the need for an out of hours arrangement for accessing a stroke specialist remotely to support thrombolysis/thrombectomy decision as this would be provided locally through the consolidated workforce.	Need for secondary journey for Powys and Herefordshire patients initially taken to HCH, so they can receive specialist stroke care at WRH. In some cases it may be clinically appropriate for the patient to be directly taken to WRH.
Continued access to local assessment, investigation, and time critical interventions, with access to remote/on-site stroke specialist support.	Longer journey time for Powys and Herefordshire patients to return home following acute management of their stroke at WRH.
Stroke specialist rehabilitation (in-patient and home based) and access to TIA/Follow-up clinics will continue to be delivered as close to home as possible.	
Improved resilience (clinical safety and service delivery/continuity) in the event of a change/disruption in the workforce (short or long term).	

What have patients and the public told us so far?

We gathered the previous patient feedback from a variety of sources into a Patient Feedback Paper in January 2022. This was to ensure that the patient perspective was considered at the solutions development stage by clinicians.

The paper is available on our website https://www.hwics.org.uk/get-involved/involvement-opportunities/stroke-services

What happens next?

We want to reflect on stroke services, and the journey so far, and ask patients and stakeholders for their views.

As part of this reflection, we will also be reviewing key project documents such as the transport modelling, population modelling, workforce planning and the Equality Impact Assessment.

We will then work with people, communities and stakeholders to reassess the options and this will include consideration of the location of services and the impact on other areas of the pathway including rehabilitation.

This work will be considered by the Stroke Programme Board before taking any potential solutions to the next stages of NHS governance and onwards through the service change process.

Have your say

We want to hear what you think about stroke services and the issues discussed in this paper. The engagement period will be open from 19 September 2022 to 11 November 2022.

After reading the information in this paper, we would like to know what you think about the following:

1. Do you think we have raised and explained all of the issues and challenges that may be associated with improving stroke services across Herefordshire and Worcestershire? If not, what do you think we have missed?
2. Have we considered all the potential solutions for improving stroke services? If not, what else should we consider?
3. When thinking about stroke services, is there anything we could be doing to support the prevention of stroke? If yes, please tell us what else we should consider.
4. Do you have any further feedback or comments?
5. Would you like to be involved in future stroke services engagement?

Please do tell us your views by using the survey link:
https://www.surveymonkey.co.uk/r/strokeservices2022

Or if you can email us on hw.engage@nhs.net or call 0330 053 4356 and ask for the engagement team.

This document is available in Welsh and Easy Read on our website or if you would like it in another language or format please contact hw.engage@nhs.net

More information is available on our webpage: https://www.hwics.org.uk/get-involved/involvement-opportunities/stroke-services

References and further information

Long Term Plan - https://www.longtermplan.nhs.uk/

National Guidance - SSNAP - Guideline Home (strokeaudit.org)

Stroke Incidence Briefing Document - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/678444/Stroke_incidence_briefing_document_2018.pdf

Herefordshire Council

Title of report: Progress Report

Meeting: **Health, Care and Wellbeing Scrutiny Committee**

Meeting date: **23rd September 2022**

Report by: **The Statutory Scrutiny Officer**

Classification
Open

Decision type
This is not an executive decision

Wards affected

(All Wards);

Purpose:

This report provides a brief summary update on issues previously considered by the Health, Care and Wellbeing Scrutiny Committee, including responses to information requests made by the committee, updates on resolutions made by the committee, including reports and recommendations to the executive and the executive response and executive decision made in respect of scrutiny reports and recommendations.

Recommendation(s)

That the progress report on scrutiny information requests, scrutiny reports and recommendations and other matters raised by the committee be noted.

Alternative options

1. The alternative is for the committee not to receive a Progress Report to update on matters since the last meeting, which would provide less clarity and transparency on the progress of issues since the last meeting.

Key considerations

2. Scrutiny committees have statutory powers to make recommendations to the Executive, as appropriate, and the Cabinet has a statutory duty to respond to scrutiny recommendations. They may also make reports and recommendations to external decision making bodies.

3. In tracking scrutiny recommendations, it is important that it is clear that the recommendations are addressed to the Cabinet, as the Executive decision making body of the council (or,

where appropriate, external agency), and to track the decision of the Cabinet and thereafter the implementation status of the Executive Response and Cabinet decisions.

4. Scrutiny committees also have the power to request information from council departments and certain other external organisations, from who they should expect a response. Scrutiny committees should be clear why they are requesting information and when they need the response by. Scrutiny committees may therefore wish to keep track of information requested at the previous meeting and for this to be received at the next ordinary meeting of the committee.

Scrutiny Committees at Herefordshire

5. The council has five scrutiny committees, established by full Council on 20 May 2022;
   i). Scrutiny Management Board
   ii). Environment & Sustainability Scrutiny Committee
   iii). Connected Communities Scrutiny Committee
   iv). Children & Young People Scrutiny Committee
   v). Health, Care & Wellbeing Scrutiny Committee.

6. The general role of the scrutiny committees is set out in Article 6 – Scrutiny of the Herefordshire Council Constitution, in accordance with the Local Government Act 2000. Part 3, Section 4 of the Constitution sets out the specific remits for each of the scrutiny committees. This includes a strategic management and coordination functions for the Scrutiny Management Board, as well as the thematic remits of the four other scrutiny committees. The Scrutiny Management Board is also responsible for the scrutiny of corporate cross cutting functions of the council.

7. Although scrutiny committees do not have any executive decision making powers, they do have statutory powers to make recommendations to Cabinet, as appropriate, and Cabinet has a statutory duty to respond to scrutiny recommendations. The scrutiny committees may also make reports and recommendations to external decision making bodies.

Progress from the Previous Meeting

<u>The Impact of the Intensive Poultry Industry on Human Health and Wellbeing</u>

8. At the last meeting on 22nd July 2022 the committee received a draft report from the Task and Finish Group on 'The Impact of the Intensive Poultry Industry on Human Health and Wellbeing'. The committee heard from Councillor Felicity Norman, Chairperson of the Task and Finish Group, and the Head of Public Protection and discussed the preliminary findings in the draft report

9. At the end of its consideration, the committee agreed that consideration of the final report should be considered at a future meeting and that members of the Task and Finish Group be invited to review the draft report and recommendations, taking into account the views and suggested revisions made by the committee.

<u>Health, Care and Wellbeing Scrutiny Committee Annual Work Plan 2022-2023</u>

10. At the last meeting, on 22nd July 2022 ,the committee agreed its work plan for the year. The committee's work plan was brought together with the work plans of the other scrutiny committees to make the Annual Scrutiny Work Programme 2022-2023, which was agreed by the Scrutiny Management Board on 5th September 2022.

Scrutiny Recommendations and Executive Response

11. In accordance with Part 4 Section 5 of the Herefordshire Council Constitution, the council's scrutiny committees may make recommendations to the full Council or the Cabinet with respect to any functions which are the responsibility of the executive or of any functions which are not the responsibility of the executive, or on matters which affect the borough or its inhabitants. The Health, Care and Wellbeing Scrutiny Committee may also make recommendations to the relevant NHS bodies or relevant health service providers or full Council.

12. Scrutiny committees may not make executive decisions and scrutiny recommendations therefore require consideration and decision by the appropriate decision maker; usually the Cabinet, but also full Council for policy and budgetary decisions and the NHS where it is the decision maker.

13. The Scrutiny Recommendation Tracker table will provide a summary of scrutiny recommendations made during the municipal year, so that the scrutiny committee can track the progress of the recommendations made.

14. The Scrutiny Recommendation Tracker table includes each scrutiny recommendation made and the date it was made, (which will be as is recorded in the committee minutes), identification of the decision maker (e.g. Cabinet), the Executive Response (the actual Cabinet decision), which may be different from the scrutiny recommendation and which will be minuted in the Cabinet minutes, the date the Executive Response/decision was made and an implementation review date.

15. The Scrutiny Recommendation Tracker enables the scrutiny committee to track whether their recommendations have been agreed, what actually was agreed (if different) and ask about any outcomes arising from the scrutiny recommendations, for example, service improvements, value for money savings and outcomes for residents.

16. If the relevant respective executive decisions and actions have been implemented, they will not be referred over to the scrutiny recommendation tracker report for the next municipal year, but that any that have not been implemented may be referred to the scrutiny recommendation tracker for the next committee cycle.

<u>Procedure for Recommendations from Scrutiny Committees</u>

17. Where scrutiny committees make reports or recommendations to the Cabinet, as soon as this has been confirmed, these will be referred to the Cabinet requesting an Executive Response and the issue will be published on the council's Forward Plan. This will instigate the preparation of a report to Cabinet and the necessary consideration of the response, the technical feasibility, financial implications, legal implications and equalities implications etc.

18. Where scrutiny committees make reports or recommendations to full Council (e.g. in the case of policy and budgetary decisions), the same process will be followed, with a report to Cabinet to agree its Executive Response, and thereafter, a report will be prepared for Council for consideration of the scrutiny report and recommendations along with the Cabinet's Response.

19. Where scrutiny committees have powers under their terms of reference to make reports or recommendations external decision makers (e.g. NHS bodies), where they do this, the

relevant external decision maker shall be notified in writing, providing them with a copy of the committee's report and recommendations, and requesting a response.

20. Once the Executive Response has been agreed, the scrutiny committee shall receive a report to receive the response and the committee may review implementation of the executive's decisions after such a period as these may reasonably be implemented (review date).

Community Impact

21. In accordance with the adopted code of corporate governance, the council is committed to promoting a positive working culture that accepts, and encourages constructive challenge, and recognises that a culture and structure for scrutiny are key elements for accountable decision making, policy development and review. Topics selected for scrutiny should have regard to what matters to residents.

Environmental Impact

22. Whilst this is an update on the work of the scrutiny committees and will in itself have minimal environmental impacts, consideration has been made in the consideration of Executive decisions and the Executive Responses provided by the Cabinet.

Equality Duty

23. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

24. A public authority must, in the exercise of its functions, have due regard to the need to –

    a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
    b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
    c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

25. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services. Whilst this is an update on the work of the scrutiny committees and will in itself have minimal equalities impacts, consideration has been made in the consideration of Executive decisions and the Executive Responses provided by the Cabinet.

Resource Implications

26. The costs of the work of the committee will have to be met from existing resources. It should be noted the costs of running scrutiny can be subject to an assessment to support appropriate processes.

27. The councillors' allowance scheme contains provision for co-opted and other non-elected members to claim travel, subsistence and dependant carer's allowances on the same basis as members of the council. If the committee agrees that co-optees should be included in an inquiry they will be entitled to claim allowances.

28. It is suggested that a scrutiny committee should only have one in-depth scrutiny task group inquiry running at a time.

29. Whilst this is an update on the work of the scrutiny committees and will in itself have minimal resource implications, consideration has been made in the consideration of Executive decisions and the Executive Responses provided by the Cabinet.

Legal Implications

30. The council is required to deliver a scrutiny function. The development of a work programme which is focused and reflects those priorities facing Herefordshire will assist the committee and the council to deliver a scrutiny function.

31. The Scrutiny Rules in Part 4 Section 5 of the council's Constitution provide for the setting of a work programme, the reporting of recommendations to Cabinet and the establishment of task and finish groups within the committee's agreed work programme.

32. There are no specific legal implications arising from this report which provides a progress update on recommendations made to Cabinet and subsequent Cabinet decision. Any legal implications arising from Cabinet Decisions will be detailed in the relevant Cabinet report.

Risk management

Risk / opportunity	Mitigation
There is a reputational risk to the council if the scrutiny function does not operate effectively.	The arrangements for the development of the work programme should help mitigate this risk.

Consultees

The Chair of the Health, Care and Wellbeing Scrutiny Committee.

Appendices

None.

Background papers

None identified**.**