Hampshire Health and Wellbeing Board Meeting

9 December 2021

NHS
Hampshire, Southampton and Isle of Wight
Clinical Commissioning Group

STARTING WELL:
Children and Young People' Mental Health Local Transformation Plan

NHS Hampshire, Southampton and Isle of Wight CCG

Hampshire Health and Wellbeing Board
09 December 2021

Ciara Rogers, Deputy Director Mental Health Transformation and Delivery

Current Picture - The impact of Covid-19 on mental health & emotional wellbeing of 0-25s

Whilst it is still too soon to know the full and lasting impact of the Covid-19 Pandemic upon children and young people and families' mental health, it is already clear that it has affected some groups more than others. There is evidence that coronavirus (COVID-19) and related interventions, such as social distancing and stay at home guidance including school and early years setting closures, have likely had a negative effect on some children and young people's mental health and wellbeing, it is unknown how long any impacts might last.

New and/or increased anticipated needs as a result of Covid-19 due to loss of connectedness at school and in society, family functioning impacting on risk and protective factors, increased trauma are likely to include the following:

Increase in crisis presentations including self-harm
Increase in complexity of cases presenting to CAMHS including those with social care needs
Higher volume of mental health difficulties including depression, behavioural difficulties and family relationship challenges
Increased anxiety e.g. due to lockdown/virus fears, transition back to school, separation anxiety
Worries about exam cancellation and moving into next phase of education
Increased incidents of domestic violence, and child abuse due to family/parental stress due to work/financial impact
Increased number and severity of eating disorders
Bereavement and Loss
Increase in violent crime – impact on mental health and aspirations

The known longer term impact on children and young peoples health outcomes will continue to be evidenced. We do know that Nationally, compared to their peers, young people under CAMHS services on average:

Leave school educationally 18 months behind their peers
Are 20 x less likely to enter higher education & employment
Are 20 x more likely to enter the judicial system in adulthood
75% will become adults under CMHT care

Working with system partners, we are committed to taking action now, as well as developing long term plans for 21—22 and beyond which align with the clinical need, National NHS priorities, and link with partners to build on the need, develop prevention based approaches and focus on mental wellbeing rather than illness.

Hampshire Children and Young People's Mental Health Local Transformation Plan (LTP) 2021/22 Overview

NHS England have required CCGs to publish a LTP each year since 2015. This is usually in March, this year it's September due to COVID.

LTPs do not cover Primary Care or Specialised Inpatient Services

Since 2015, NHS England have increasingly specified nationally the areas for local investment, the amount of investment and the key performance indicators

The CCG significantly exceeded the NHS England investment requirements in 2021/2

Key successes so far in 2021/22 include:

- Launch of new digital counselling service: Kooth.com
- Expanded Community Counselling services
- Further expansion of community crisis support
- Supporting Hampshire CAMHS with significant new investment
- Developing and rolling out Psychiatric liaison services
- Rolling out Mental Health Support Teams (MHSTs) in schools & 'Link Programme'
- Supporting Tier 4 Provider Collaborative led "Closer to Home" programme
- Learning Disability & Autism Early Adopter – Key Worker programme
- New Autism assessment service launched in October 2021
- Working jointly with system partners to support developments in HCC led services
- Public Health Led All Age Needs assessment
- The Mental Health People Plan

Hampshire CAMHS Clinical Model

Sussex Partnership NHS Foundation Trust

Adapted from THRIVE elaborated framework (Wolpert, M., Harris, R., Hodges, S., Fuggle, P., James, R., Wiener, A., McKenna, C., Law, D., York, A., Jones, M. and Fonagy, P. (2015) THRIVE elaborated) & Charlie Waller Memorial Trust (www.cwmt.org.uk)

The main principles of the clinical model:

1. The overarching model is based upon the THRIVE conceptual framework.
2. The interventions we offer will be evidence based and NICE compliant.
3. Offering low, medium and high intensity interventions, routinely starting with the least intrusive.
4. Effective targeting of resources using a stepped care evidence based approach
5. Treatment approaches are based on formulation and individualised where indicated.

Hampshire CAMHS Recruitment (as at August 2021)

These new models will take time to develop and embed. We are anticipating 18 to 24 months. We are at the beginning of this work.

WTE total additional posts	WTE offered	WTE started
103	78	40

correct as at 31 August 2021

Our main focus until recently has been recruitment. However, in recent weeks we have started to work through the detail of revising clinical care pathways, systems and processes to support the development of the new services.

We are anticipating that some services will start to become operational and deliver clinical activity by mid-September onwards. The clinical activity will increase over time although significant impacts will not be seen for a number of months. Fully recruited, we anticipate being able to deliver an additional 27,000 clinical contacts per annum across all Service areas.

NHS
Sussex Partnership
NHS Foundation Trust

Our Key Risks, Issues and Next steps

RISKS

Finances - We are aware that there is a need to continue to develop our investments to fully meet the needs of young people, however the national funding we can expect for next year and beyond is unlikely to fully meet the demand across our wide range of priorities for prevention, early intervention and treatment requirements. There is a risk we will not be able to deliver all of the priorities at this stage, however we continue to work closely with partners to outline the needs and focus on key priority areas.

Delivery - Hampshire does not have unusually high levels of need compared to other parts of England but does have poorer access and long waits for access to services at present. Self harm is a key issue for our services.

ISSUES

Inequalities - we need to do more to focus on addressing inequalities within Hampshire and will be utilising the outputs from our All age needs assessment to support this work moving forward.

Workforce – despite our high levels of investment we do not have sufficient workforce in post at present to met demand, and continue to work on our recruitment and retention strategies within the people plan.

Prevention - we need more focus on prevention and early help, in partnership with HCC to really develop our offer of support and are committed to supporting our partners in every way we can.

NEXT STEPS

2022/23 Hampshire Local Transformation Plan (LTP) and beyond to 2023/24 and 2024/25

ICS Development – we will ensure Hampshire has a strong focus as a ‘place’ within the ICS developments for our NHS reform, allowing us to work locally and jointly with our Hampshire partners.

Programme Team established to take forward the prevention and early intervention work, working in partnership across Children’s Social Care, Public Health and the NHS

Hampshire County Council

Joint Strategic Needs Assessment workshop summary

Hampshire Health and Wellbeing Board

Joint Strategic Needs Assessment - Context

Duties and powers under the 2007 Act (as amended by the Act)

Joint Strategic Needs Assessment identifies 'the big picture', in terms of the health and wellbeing needs and inequalities of a local population". Producing a JSNA is a mandatory requirement designed to help organisations with service planning and the commissioning process.

This is a fundamental necessity of the Health & Social Care Act 2012 Local partnerships, but principally the local Health & Wellbeing Board and partners, are expected to prioritise based on the information and evidence in their local JSNA and other sources, as it highlights where there are gaps in knowledge or services and so helps inform effective decision making

Who is responsible for JSNAs?
Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare JSNAs and JHWSs, through the health and wellbeing board.

The responsibility falls on the health and wellbeing board as a whole and so success will depend upon all members working together throughout the process.

JSNA Work Programme Update

Hampshire and Isle of Wight COVID-19 Health Impact Assessment: completed to be published December 2021

On the 11th March 2021 the World Health Organisation declared COVID-19 a pandemic, 15 months on this report aims to look at the impact COVID-19 has had on the residents of Hampshire & IOW.

COVID-19 has exposed, exacerbated, and created new inequalities. People across the UK, and indeed the world, have been harmed by the virus in very different ways. What has COVID-19 meant for our local population groups and their future population health and social care needs.

JSNA Core Documents: Late winter 2021/22

- Demographics including protective characteristics, deprivation and life expectancy - to be published January 2022
- Inclusion health groups – homelessness, drug and alcohol dependence, travellers, sex workers, vulnerable migrants, victims of modern slavery, people in contact with CJS - will be published January 2022
- Vital Statistics – mortality and birth data - to be published January 2022

JSNA Main Chapters: 2021/2022 linked to the social determinants of health model

Healthy People To be published April 2022	Healthy Living To be published April 2022	Healthy Places To be published January 2022
This chapter focuses on the age structure of our population and future projections and the socio demographic characteristics of our population.	This chapter focuses on risk factors including behavioural risk factors and the wider determinants of health.	This chapter focuses on place, the area assets and the social and commercial drivers for health

Inequalities: age, ethnicity, religion, learning or physical disability, sex, sexual orientation,

Demography & Vital Statistics JSNA Chapter

This chapter focuses on the age structure of our population and future projections and the socio demographic characteristics of our population.

To include

- Current population – resident and registered
- Challenges of an ageing population
- Protective characteristics
  - Age
  - Disability
  - Gender reassignment
  - Marriage and civil partnerships
  - Pregnancy and maternity
  - Race
  - Religion or belief
  - Sex
- Population density
- Urban Rural communities
- Population forecasts including Old Age Dependency Ratio projections
- Vital statistics
  - Births – general fertility rate
  - Deaths inc. excess deaths
  - Migration
- Socio economic factors – some paused for Census 2021 results
  - Employment / Unemployment
  - Housing
  - Lone parents
  - Lone 65+ households
- Deprivation
- Housing developments

Paused for Census 2021 data

Healthy People

This chapter focuses on the health outcomes of our population and the health inequalities which are evident and also links closely with the Inclusion Health Groups chapter

To include;

- Mortality/avoidable deaths
- Physical Health conditions
  - Long Term Conditions/multimorbidity
- Mental wellbeing
- Population groups
  - Older people – falls ,frailty, sensory impairment
  - Carers
  - Ethnic minority groups
  - Learning Disabilities
  - Homeless
  - Veterans
  - Alcohol and drug dependence
  - Travellers

Healthy Lives

This chapter focuses on risk factors including behavioural risk factors and the wider determinants of health.

To include

- GBD 2019 findings- burden of ill health
- Physiological risk factors – diabetes, excess weight, hypertension, high blood sugars
- Behavioural risk factors – alcohol misuse, drug misuse, smoking, physical activity, healthy diet, sexual health
- CYP – education, training employment
- Employment/economy
- Protective measures, cancer screening, sexual health, vaccination coverage
- Maternity
  - Smoking and alcohol in pregnancy
  - Teenage pregnancy
  - Low birth weight
  - Breastfeeding
- Risk factors for children
- Domestic violence

Possible further sections

  - child poverty
  - Looked after children
  - Social educational needs
  - Autism
  - overweight and obesity in children

Healthy places

This chapter focuses on the social and commercial drivers for health

- Access to green space
- Influencing planning
  - Including green space planning
  - Alcohol licensing
- Air pollution
- Road safety
- Food insecurity and food deserts
- Access to housing
  - Healthy homes inc. fuel poverty
  - Affordability
  - Access to accommodation
  - Overcrowding
  - Homelessness/temp accommodation
- Access to services
  - Distance to GP
  - Distance to Pharmacy
  - Distance to community facilities – sports/leisure
- Mental wellbeing vulnerabilities and strengths
- Social connectiveness/isolation
- Digital
  - Access to broadband – mosaic data
- Crime
- Climate change including active travel, recycling and green energy sources.

Inclusion Health Groups

People who are socially excluded, typically experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), experience stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases). These experiences frequently lead to barriers in access to healthcare and extremely poor health outcomes. People belonging to inclusion health groups have extremely poor health outcomes, often much worse than the general population, lower average age of death, and it contributes considerably to increasing health inequalities. Includes homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery

Joint Strategic Needs Assessment Workshop

COVID-19 Health Impact Assessment

General feeling that the key areas of focus and impacts presented were a representative reflection for all partners in the workshop.

What have been the main impacts on your population/area?

- Mental health concerns – including 'low level' mental ill health concerns, carers, work force
- Housing - policy impacts on homelessness – districts have seen increased numbers of transient families and sofa surfers requiring housing support and are in addition to those who are street homeless. This will require years of work and resources. Housing debt increases also driving housing problems
- Trauma - Long term service user outcomes – quality of life – mental and physical health and safety. Also need to think about suicide prevention (suicide rate quadrupled amongst people exposed to domestic abuse nationally) in workplace policies and mental health services for prison health
- Inactive lifestyles have grown– links to physical and mental health. Increases in obesity
- Empowerment of people to measure and report long term condition reviews e.g., oximetry@home and BP@home however a huge upturn in anxiousness with inability to make decisions about simple illness - imbalance of public expectation of need versus clinicians' advice
- Fire and Rescue: Staff absence and providing staff resource to the pandemic response such as vaccination centers, driving ambulances, working in ICU wards which had had an adverse impact on their primary employment
- The long-term fatigue around the changing profile of the virus on the work and home environment and how this impacts on mental health of colleagues.
- Impact of Long COVID in staff is a concern for all workforces

Which key areas of focus are most important to you and what role can you play to support these?

- Increasing inequalities in a range of health outcomes previously not known.
- Social isolation – including children and young people, role of digital exclusion and this potentially exacerbating social isolation due to online nature of services, reliance on phones to contact services excluding those on expensive 'pay as you go' contracts.
- Deconditioning in elderly with increase diagnosis of dementia or memory loss. Mobility problems exacerbated by deconditioning still waiting for review due to backlog of elective care
- Economic impact specifically on young people and pensioners

Joint Strategic Needs Assessment Workshop

Health Index and Global Burden of Disease presentation and JSNA chapters scope

What are the local priorities for population health? Which should be included in the Healthy People and Healthy Lives chapters?

- Life course approach: reports need to include data for children and young people as well as adult populations
- Capitalise on the increased community resilience – asset mapping to identify community groups and volunteers conducted by district colleagues– although recognition this has declined more recently
- The stratification of risk which factors the three elements of people, lives and places is similar to the Person-Centered Approach the National Fire Chief's Council have adopted with eight areas of vulnerability which consider the three areas of person, home and behaviours.
- Modifiable behaviours data, smoking particularly smoking in pregnancy, physical activity, healthy weight
- Risk factor data – high blood pressure, high cholesterol

Are there areas which require more detailed reports to be undertaken

- More detailed data on ethnic minority groups
- Insight into what local communities feel is important - examples from local people/ neighbourhoods on what it looks and feels like living in these places
- Healthcare access for people who are not registered with a GP and those digitally and financially excluded from online and telephone services
- Data on quality of housing as well as on demographics of those more likely to experience homelessness / unstable housing.

Joint Strategic Needs Assessment Workshop

Next steps

- JSNA will be a data resource for partners to use to inform their planning and priorities.
- Public Health suggest that a second JSNA workshop in the new year is held. This will be a practical workshop to introduce and explain the new data resources that have been developed.
- An ask to the members of the board to identify key people, strategic and analysts, in their organisation's to engage with the JSNA data workshops
- What is the national picture/evidence ? Do we understand this locally?
- What detailed reports should be prioritized to help understand local population health better?

Hampshire Integration and Better Care Fund Refresh

2021-22

Policy Requirements

- Delayed and subsequently published 30 September 2021
- Required a narrative plan and planning template
- Plan based on the Health and Wellbeing Board footprint – although NE Hampshire included Frimley system
- Revised metrics
- Required submission 16 November 2021 for national assurance process.

Our Challenges - recap

- Ageing population with Long Term Conditions
- Reducing inequalities
- Whole system complexity
- Difficult financial situation
- Urgent Care System pressures
- Workforce overall in local labour market
- Changing cultures

What did the BCF programme aim to do ?

- The policy was announced by the Government in June 2013 intended as a “catalyst” for change.
- Provides a single pooled budget to support health and social care services to work more closely together in local areas.
- Underpin joint plans developed and agreed by the Health and Wellbeing Board and approved by the Clinical Commissioning Groups and Hampshire County Council.
- Satisfy national conditions and performance measures.

Our Hampshire Plan

Originally aimed to:

- support acceleration of local integration of health & care services through joint commissioning & partnership working.
- help address demographic pressures in adult social care
- facilitate the provision of more joined up care in the community by changing the way health and social care work together to improve outcomes for people, reducing duplication.

Components to our plan

Formulated in key phases:

Phase 1

- 2014 - 2016
- Integrating delivery of services for older people including dementia and carers
- Establish a joint integration team sponsored by HCC and all CCGs to implement the programme

Phase 2

- 2016 - 2018
- People with learning disabilities and mental health needs, adults with long term conditions and people who may need NHS Continuing Healthcare

Phase 3

- 2018 - 2019
- Young people in transition including those who require complex rehabilitation and access to NHS Continuing health care

Protecting Social Care Services

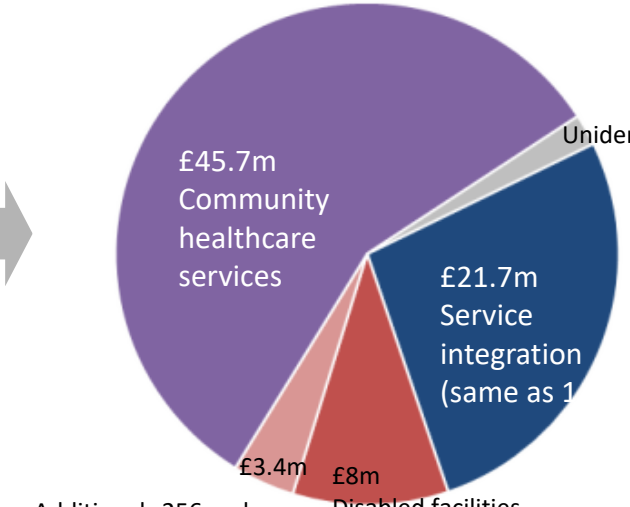
Source of funds

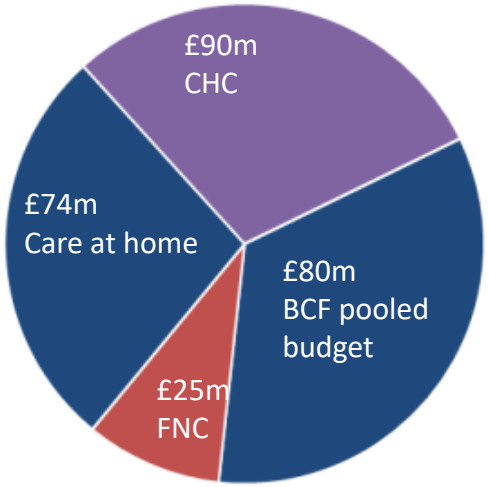
14/15 **BCF statutory** transfer of existing s256 -service integration from health to social care for the benefit of health

15/16 **BCF statutory requirement** of pooled budgets totaling £80m to be spent on delivering integrated care to realise efficiency savings

BCF 'Plus'15/16 total funding of c.£280m from ASC and CCGs on activities where health and care interface directly

£21.7m 14/15 transfer of £21.7m for service integration





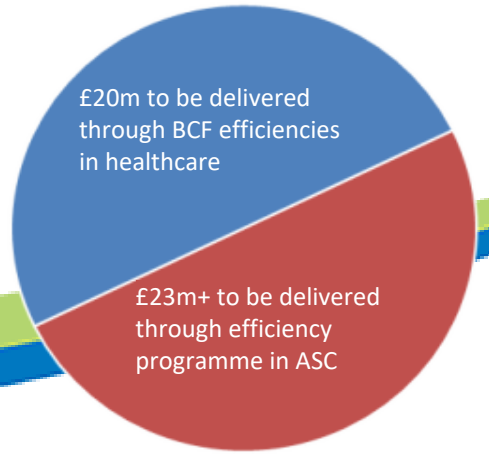
HCC ASC efficiency saving target for 15/16 is £43m plus demography and complexity pressures of c£10m on gross budget of £427m

System wide budgetary pressures & efficiency plans

Additional challenges to be mindful of -CCG QIPP efficiency plans and provider CIP plans total budget £1.4bn

Acute providers and community providers also have CIP efficiency programmes to deliver

£50m Collective CCG efficiency savings target for 2015/16



Phase 1 Out of hospital care model to deliver real changes:

Cost effective planned pathways
Improved GP access to specialist advice
Transfer activity from high cost hospital based services to the community
Systematic redesign creating greater standardisation

Advice and information through wider Community, village Agents, Carer Support Day opportunities
Falls prevention, telehealth, telecare meals on wheels
Housing and extra care
Winter warmth
Crime and disorder
Employment
Gardening schemes etc

People spend appropriate time in hospital
Rapid access to high quality Hospital care when needed
Decisions in line with agreed care plan
Discharge planning starts at admission involving the ICT
Early supported discharge to minimise length of stay
Option to step-down to community

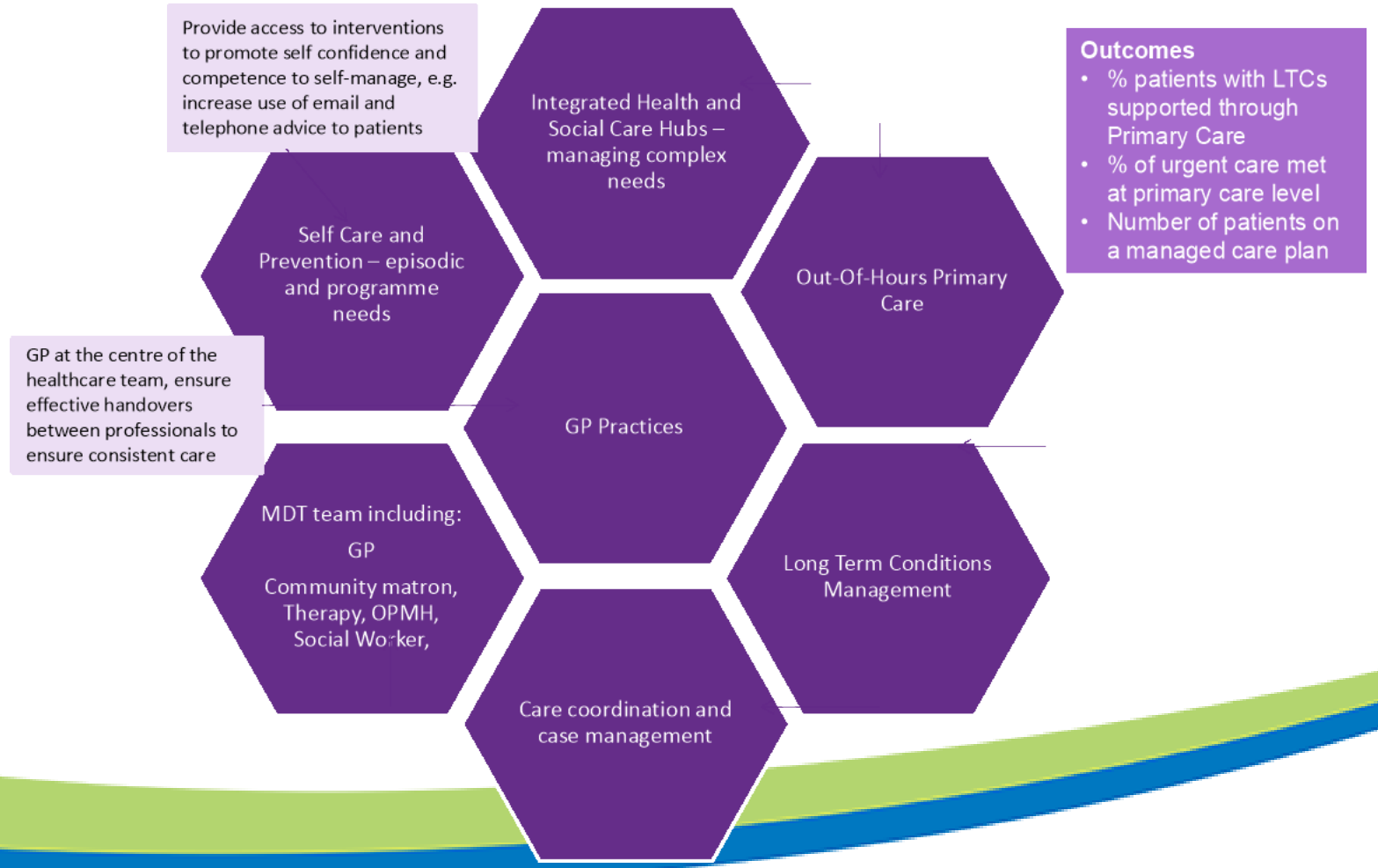
Access to responsive primary care services
Improving how we organise and deliver primary care
GPs at the centre of an expanded team
Shifting from reactive to more proactive care

Rapid response in a crisis
24/7 rapid triage <1 hour when urgent
Assessment through ambulatory care whenever possible
Short term stabilisation then retune to community
Community bed alternatives
Patient management aligns with ACP; 111 able to access this

Proactive Integrated Care Team
Integrated Care Teams serving practices clusters / 50,000 population
Risk stratification of cluster population with proactive multidisciplinary care planning & case management
All patients with LTCs have a personal health plan emphasising self care
Single point of contact via central administrative hub
Single, integrated clinical record

Focuses on the out of hospital care model

Integrated Care Teams – with primary at the centre



What has happened?

- Changes in policy – Vanguard, NMOC etc
- Multiple organisational changes and changes to structures and governance
- Some progress on “Out of Hospital care”
- More challenging financial circumstances
- 2018 Newton / CQC – “we could do better”
- NHS Long Term Plan priorities
  - Greater focus on population with supported self management / strengths based
  - Boost to out of hospital including prevention
  - Boost to primary care profile
  - Redesigning emergency care
  - Digital enabling goes large!

Current issues

Competing factors: e.g.

- Alignment in recovery from COVID-9 / Hospital Discharge and Home First programme
- Co-commissioning (NHSE / CCGs)
- Coterminocity

IBCF Programme:

- Was never “new” funding although initially included financial risk share agreement
- Has become an enabler to other work streams
- Monitoring & evaluation framework set nationally
- Future arrangements 2022 and beyond

Investment 2021/22 - £137,344,836

NB: IBCF was never "new" money so any change to the allocation of funds will require a substitution from elsewhere

Social Care	Hampshire, Southampton & IOW CCG	Frimley CCG	CCG Total	HCC	Total
Revised Split (removing additional spend)					
S256's					
Section 3 - Service Integration	£18,895,466	£2,724,063	£21,619,529		£21,619,529
Section 3 - 14/15 Increase through AT	£4,598,878	£630,096	£5,228,974		£5,228,974
Section 4 - Adult Services	£1,012,112	£50,752	£1,062,864		£1,062,864
Section 6 - Community Enablement	£132,345	£0	£132,345		£132,345
Section 8 - Sitting Service/Day Care	£33,866	£0	£33,866		£33,866
Section 10 - Welcome Home Support	£55,847	£0	£55,847		£55,847
Section 15 - Palliative Care	£216,463	£0	£216,463		£216,463
Section 19 - OPMH Dementia Advisors	£142,045	£17,571	£159,615		£159,615
15/16 Agreement - OPMH Dementia Advisors	£193,003	£33,086	£226,089		£226,089
Section 26 - Frogmore Dementia Days	£0	£33,019	£33,019		£33,019
ICES	£2,606,810	£357,766	£2,964,577		£2,964,577
Agreed to Transfer	**£27,886,836**	**£3,846,352**	**£31,733,189**	**£0**	**£31,733,189**

Investment 2021/22

Out of Hospital Care

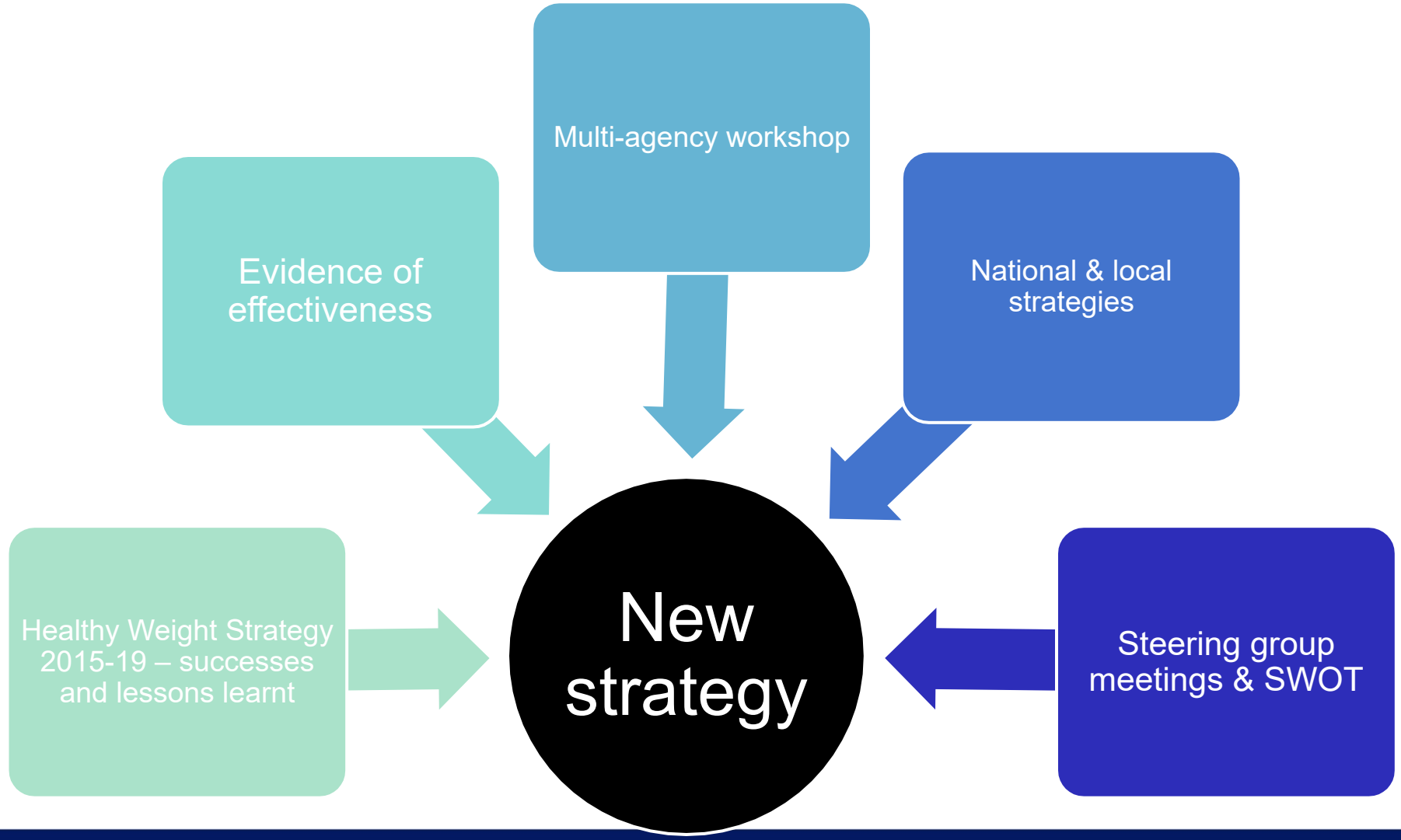
Community Services					
SOUTHERN HEALTH: Community Care Teams					
OT's	£2,162,641	£361,336	£2,523,977		£2,523,977
Physios	£2,897,720	£435,430	£3,333,150		£3,333,150
Nursing	£28,673,188	£3,850,357	£32,523,545		£32,523,545
Fleet Hospital Community Beds	£0	£1,860,736	£1,860,736		£1,860,736
LD Community	£3,050,616	£0	£3,050,616		£3,050,616
OPMH Community Teams	£14,394,151	£0	£14,394,151		£14,394,151
Wheelchair services	£750,343	£0	£750,343		£750,343
Solent NHS Trust	£0	£0	£0		£0
Podiatry	£1,247,995	£0	£1,247,995		£1,247,995
Frimley Health NHS Foundation Trust: Community Care Teams	£0	£0	£0		£0
Rehab	£0	£1,263,720	£1,263,720		£1,263,720
Physios	£0	£51,156	£51,156		£51,156
Agreed Transfer	**£53,176,654**	**£7,822,734**	**£60,999,388**	**£0**	**£60,999,388**
Other Services					
Disability Grant			£0	£14,252,433	£14,252,433
Winter Pressures Grant			£0	£4,754,497	£4,754,497
Meeting Adult Social Care Needs				£25,605,329	£25,605,329
Further Service to be Identified			£0	£0	£0
Agreed Transfer	**£0**	**£0**	**£0**	**£44,612,259**	**£44,612,259**
TOTAL TRANSFER VALUE AGREED	**£81,063,491**	**£11,669,086**	**£92,732,577**	**£44,612,259**	**£137,344,836**

Next Steps?

- Awaiting guidance for 2022 and beyond and possible longer time horizon
- Maturity of revised national conditions and data being used to measure performance
- Hampshire population resides in two NHS systems ? how this should be addressed
- What would it take for the Hampshire system to be more bold about extending integration further with new NHS structures and governance

Healthy Weight Strategy 2022 - 2026

Mohammed Jawad (Speciality Registrar)
Sian Davies (Consultant in Public Health)
Darren Carmichael (Public Health Principal)


Multi-agency workshop
Evidence of effectiveness
National & local strategies
Healthy Weight Strategy 2015-19 – successes and lessons learnt
New strategy
Steering group meetings & SWOT

Where are we now?

Hampshire facts at a glance:	
• 62% of adults • 31% of Year 6 • 22% of Year R …are overweight or obese.	• 58% meet the recommended '5-a-day' on a usual day • 32% of children are physically inactive • 23.5% of adults are physically inactive

Populations most at risk

- Geographical areas of deprivation
- Ethnic minority populations at greater risk of overweight and obesity
- Those who live with long term conditions such as cardiovascular disease and diabetes
- Those with learning or physical disabilities
- Those who live with mental health conditions
- Older adults (45-74 years).

Evidence – effective interventions

- Multi-agency, joined up interventions which target the root causes of ill health
- Educational setting-based interventions including healthy school environments
- Creating more physical activity–supportive built environments
- Tier 2 Weight Management services.

Strategic Objective - 1

1. We will support places and communities to enable residents to achieve a healthier weight.

New developments	Regeneration	Transport
Spatial planning	Whole systems approach pilots	Link with climate change actions
Food insecurity	Retail	Communication & Marketing

Strategic Objective - 2

2. We will work with health, care, education and community settings and systems to promote healthier weight across the life course.

- Pregnancy and new parents
- Early years/schools
- Workplaces
- Physical activity for key population groups

Strategic Objective 3

3. We will reduce inequalities in health by focusing on people and populations most at risk.

- Ethnic minorities
- Men
- People with learning disabilities
- People with mental health conditions
- Older adults (45-74 years)
- People living in areas of deprivation

Next steps

- August 2021: First Draft prepared
- September 2021: Workshops with partners
- October 2021: Finalise First Draft
- December 2021: Presentation at Health and Wellbeing Board

- January 2022: Action Planning workshop with partners
- February 2022: Finalise strategy with action plan, community engagement plan and weight stigma position Statement
- March 2022: Implementation

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