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HEALTH AND WELLBEING BOARD AGENDA

Friday, 2 December 2016 at 10.00 am in the Whickham Room - Civic Centre

From the Acting Chief Executive, Mike Barker

Item	Business
1	**Apologies for Absence**
2	**Minutes** (Pages 3 - 10)
2a	**Action List (Pages 11 - 12)**
3	**Declarations of Interest**
	Members of the Board to declare an interest in any particular agenda item.
4	**Updates from Board Members**
	Items for Discussion
5	**Director of Public Health Annual Report**
	Presentation by Alice Wiseman
6	**Gateshead Council's Budget Proposals 2017/18**
	Presentation by Sheila Lock
7	**NHS Planning Update: Newcastle Gateshead CCG Operational & Commissioning Plan 2017-19** (Pages 13 - 18)
	Report presented by Joe Corrigan
8	**Gateshead Sexual Health Strategy** (Pages 19 - 40)
	Report presented by Gerald Tomkins
9	**NECA Commission Report 'Health and Wealth'** (Pages 41 - 50)
	Report presented by John Costello
	Items for Assurance
10	**Winter Preparedness**
	Presentation by Marc Hopkinson

Performance Management Items

11 **Better Care Fund Quarter 2 Return 2016/17** (Pages 51 - 66)

Report presented by John Costello

12 **Any Other Business** (Pages 67 - 68)

Time To Change Hub – Report Attached.

13 **Date and Time of Next Meeting**

Friday 20 January 2017 at 10am

Contact: Sonia Stewart; email; soniastewart@gateshead.gov.uk, Tel: 0191 433 3045,
Date: Thursday, 24 November 2016

GATESHEAD METROPOLITAN BOROUGH COUNCIL

HEALTH AND WELLBEING BOARD MEETING

Friday, 21 October 2016

PRESENT	Councillor Councillor Lynne Caffrey (Gateshead Council) (Chair)	
	Councillor Jill Green	Gateshead Council
	Councillor Ron Beadle	Gateshead Council
	Councillor Mary Foy	Gateshead Council
	Councillor Martin Gannon	Gateshead Council
	Councillor Malcolm Graham	Gateshead Council
	Councillor Michael McNestry	Gateshead Council
	Douglas Ball	Healthwatch Gateshead
	Dr Mark Dornan	Newcastle Gateshead CCG
	Dr Bill Westwood	Federation of GP Practices
	Sheila Lock	Gateshead Council
	Sally Young	Gateshead Voluntary Sector
IN ATTENDANCE:	Susan Watson	Gateshead NHS Foundation Trust
	Bob Brown	South Tyneside Foundation Trust
	Elizabeth Saunders	Gateshead Council
	Michael Laing	Gateshead NHS Foundation Trust
	John Pratt	Tyne and Wear Fire Service
	Iain Miller	Gateshead Council
	Gerald Tompkins	Gateshead Council
	John Costello	Gateshead Council
	Sonia Stewart	Gateshead Council

APOLOGIES:

Mark Adams, Emma Nunez, Helen Patterson, Ian Renwick, Alice Wiseman and Joe Corrigan

HW74 MINUTES

The Chair welcomed everyone to the meeting. She advised that John Pratt was in attendance from Tyne and Wear Fire and Rescue Service and set out the benefits of the Fire Service becoming a substantive member of the Board. She recommended that the Board accept this nomination and revised membership list. The Board endorsed this decision.

The minutes of the meeting held on 9 September were agreed as a correct record.

HW75 ACTION LIST

The Action List of the Meeting held on 9 September was noted.

It was also noted that a further update on the JSNA will be brought to the Board in September 2017. Also a further report to be brought back to the Board in the next six months on the National Joint review of Partnerships and Investment in the VCS in Health & Care Sector.

It was noted that there had been a suggestion regarding development work for the Board. It was noted that it would be good to talk about issues/challenges faced. It was suggested that the LGA could be asked to help up with this.

It is hoped that the new Chair of the LSCB will be able to attend the December meeting of the Board.

HW76 DECLARATIONS OF INTEREST

There were no declarations of interest declared.

HW77 UPDATES FROM BOARD MEMBERS

NECA Health and Social Care Commission

The commission set up by NECA has just reported with 10 recommendations. It is the intention to have a report on this and a discussion at the December meeting.

CCG

The CCG member practices voted to apply to NHS England for Level 3 Delegated Commissioning of primary care medical services. The application will be to commence delegated commissioning from April 2017.

A report out from the Connected People, Connected Communities event that took place in the summer has been provided to Board members with the agenda papers. Work is still ongoing through this project to tackle social isolation which is still a big killer.

The 'Great North Care Record' is a piece of work which looks to enable parts of the NHS and ultimately other care settings, to be able to see summaries of a patients primary care records if they, for example, attend the QE. The CCG is aware that there hasn't been the engagement with partners to-date that it would have liked; however, they have worked with GP practices and the region's Foundation Trusts. Flyers have gone to all practices and there is a website and phone number. Details of the initiative has been provided to Board members with the agenda papers and also shown on a presentation loop before this morning's meeting

Voluntary Sector

Newcastle CVS are holding a series of training events for voluntary and community organisations in Gateshead. It was reported that often organisations just need support in developing a suitable business plan to meet their needs.

CCG

The issue of communications was raised and how we can work better together, in particular in relation to information sharing about activities and events through our communications channels, with front line staff and others on key issues such as prevention and integration. In this connection, it was noted that there are discussions about having joint governance arrangements for the Gateshead footprint.I It was suggested that we probably need to have a more systematic approach. It was noted that as a Board we have a communications strategy and that perhaps there is some work we could do around that. It was suggested that we need to consider how best to take this forward and the value of having a forum where the comms teams get to together to discuss common issues (this may only need to be a one off discussion to put arrangements in place).

HW78 SUSTAINABILITY AND TRANSFORMATION PLAN SUBMISSION

The Board received a presentation from the CCG on their submission to NHS England for the Northumberland, Tyne and Wear and North Durham Sustainability and Transformation Plan.

The Board were advised that STP footprints are not new statutory organisations - they are about how the system will work together to improve health, care and finance for their local population.

This plan will act as an 'umbrella' plan holding underneath it a number of different specific plans to address certain challenges.

The submission is more of a current state in terms of Health and Wellbeing, Care and Quality and Funding and Finance. In our patch we have many Foundation Trusts rated by the CQC as 'outstanding' and 'good' and already have systems which are highly rated. This puts the local health and care economy in a good place to respond to the challenges and opportunities that lie ahead.

The Plan is divided into 3 main areas.

- Scaling up Prevention and Health and Wellbeing
- Reconfiguration of Hospitals – Out of Hospital Collaboration
- Optimal Use of Acute Sector

The presentation highlighted the specific actions identified for Newcastle and Gateshead, including how we make Mental Health part of all our discussions.

Next steps following from the submission today of the STP to NHS England will

include finalising a Comprehensive Engagement Plan, sharing the STP with organisational public boards and with patients, carers, health and care staff, the public and other stakeholders (from late October).

The Board was informed that there is no hidden plan within the STP. It was also noted that should any potential service changes emerge from the STP process, there will need to be full engagement and consultation with local people before any decision on the proposed change is made.

It was noted that the Board at this stage are not being asked to approve any plans. This presentation is purely to inform the Board what is to be submitted to NHS England. Engagement on the plan will commence following this submission.

The Board highlighted some key areas of concern.

The Board felt that the timescales given to the CCG from the centre have been too tight and not allowed the CCG to incorporate the period of full consultation on its submission that all would have wished. The Board felt that more time was required to consider the key issues so that there is clarity on the impact of the STP and that it can be assured that we are doing the right things for Gateshead. The engagement phase will enable this.

The Board also felt that the central drivers have been aboutfinances and the financial gap; however, other issues need to be given due consideration such as prevention and early intervention as local people continue to die earlier in Gateshead than in other parts of the country and their quality of live is poorer. We need to prevent people from becoming ill in the first place. People also need a good education and good quality jobs and local authorities have a key role to play here.

Given the significant financial and other challenges that lie ahead, difficult decisions will need to be taken further down the road. This will need to be done in a way that is open and transparent. It will be important that everyone is fully engaged in this process, has an opportunity to contribute to and shape the solutions that emerge. There needs to be joint ownership of the solutions across the local system as a whole. In particular, there needs to be a local ‘democratic’ component built into the STP process so that there is sufficient self-determination in taking this work forward.

A risk governance framework will also be required at local level, not just at regional level. The STP governance will include Local Authorities is leading the work. This will enable this to develop.

As well as addressing challenges, there are also opportunities to be explored to better meet the health and wellbeing needs of local people e.g. around prevention and early intervention. We will need to be mindful of these opportunities as we develop the detail of our plans locally.

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RESOLVED - (i) That the STP and information presented to the Board be noted. The Board has not been asked to sign off the STP submission to NHS England.

(ii) That it will be important that there is full engagement and consultation in developing the detail of the STP going forward. This will need to be done in a way that is open and transparent.

(iii) That there needs to be a particular focus on prevention and early help as key themes across the STP as a whole. Opportunities to better meet the health and wellbeing needs of local people need to be explored further and the prevention and early intervention agenda needs to be a key focus of our approach.

(iv) That the governance arrangements in taking this work forward needs to be right for us locally and incorporate a local democratic dimension to decision making.

HW79 COMMUNITY HEALTH SERVICES - MOBILISATION AND TRANSFORMATION

The Board received a presentation from Michael Laing, Associate Director, Community Services at the QEH regarding the mobilisation and transformation of community health services. Gateshead Care Partnership were recently awarded the contract to deliver community services within Gateshead. The Chair is Dr Bill Westwood and the Council has been fundamentally involved in the process.

Michael advised the Board that he felt this was the best opportunity since 1987 for patients to receive the best possible community care.

Some of the transferring services which will be delivered include, district nursing, community midwifery, and palliative care. The principles of the new service are to provide care closer to home, strong and effective partnership working, provide a multi-disciplinary team approach, have a strong local presence and profile, prevention at first primary point of contact and to be financially sustainable.

In the short term the aim of the service is for the safe transfer of customers and staff, this took place on 1 October. To develop the partnership and to communicate the change to partners. To create locally based integrated teams and adopt multi-disciplinary team working, also to improve the interface with secondary care and GPs. Phase 1 of the Intermediate care review will also commence.

In the medium term the aim of the service will be to ensure that short term changes are in place, to improve customer experience and performance and learn from them. To continue to develop the Gatesehad Care Partnership and look at reforming the approach to frailty and the aging population. Also in the medium term, there will be an aim to provide pharmacy services closer to home, to provide mental health services in the community and to carry out Phase 2 of the Intermediate Care Review.

In the long term, the aim is to ensure that medium term changes are in place, that technology is used more effectively, that there is improved prevention and self-care and that there are appropriate plans in place for the future.

The board were informed that when the partnership took over the service it was found to be in a very good placeand employees were experienced and committed. More work does needs to be done, however, in terms of progressing integration as per the direction of travel set out in the Transformation Plan agreed with the CCG.

The Board were informed that financial sustainability is critical to all partners and delivery will need to take place within the wider context of the local and national health and social care sector.

It was noted that there are opportunities around building multi-agency clusters within community settings across the borough, including community health services e.g. integrated teams around GP practices. This, in turn, could help to maintain the viability of key facilities such as the Blaydon primary care centre in the west of the borough.

It was also noted that schools have a role to play as part of local community clusters.

Developing the right skills and retaining a skilled workforce will be important. Opportunities to link with/work with local universities in this area will be key going forward.

RESOLVED That theinformation presented to the Board be noted.

HW80 GATESHEAD SEXUAL HEALTH STRATEGY

RESOLVED - That this report be deferred to a future meeting of the Board.

HW81 UPDATE ON SMOKING STILL KILLS - SMOKE FREE VISION 2025

RESOLVED - That this report be incorporated into the presentation at the December meeting by the Director of Public Health as part of her Annual Report.

HW82 CCG UPDATE ON ARRANGEMENTS FOR COMMISSIONING OF PRIMARY CARE MEDICAL SERVICES

The Board were provided with an update on the position under the 'Updates from Board members' section of the agenda.

HW83 CONNECTED PEOPLE, CONNECTED COMMUNITIES UPDATE

The Board were updated on this item, under the 'Update from Board members' section of the agenda.

HW84 GREAT NORTH CARE RECORD

The Board were provided with an update on this item under the 'Updates from Board

Members' section of the agenda.

HW85 LOCAL SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2015/16

The Local Adult Safeguarding Board Annual Report was provided to the Board for information.

HW86 ANY OTHER BUSINESS

HW87 DATE AND TIME OF NEXT MEETING

The next meeting of the Board is to take place on Friday 2 December 2016 (10.00 am).

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Item 2b

GATESHEAD HEALTH AND WELLBEING BOARD
ACTION LIST

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Matters Arising from 21st October 2016 meeting of the HWB			
Action List – HWB Development	It was suggested that the LGA could be asked to help with taking forward development work with the Board	Sheila Lock / John Costello	Ongoing.
Updates from Board Members	Circulate a copy of the slides for the Great Northern Care Record NECA Commission Report 'Health and Wealth' Look at ways we can work better together on communications	Sonia Stewart John Costello All	Completed On the agenda of the 2nd December meeting Ongoing
Gateshead Sexual Health Strategy	To defer consideration of this item until the next Board meeting.	Sonia Stewart	On the agenda of the 2nd December meeting
Update on Smoking Still Kills – Smoke Free Vision 2025	To incorporate this item as part of the DPH report to the HWB in December.	Alice Wiseman	The DPH report is on the agenda of the 2nd December meeting
Matters Arising from 9th September 2016 meeting of the HWB			
Gateshead JSNA 2016 Update	An update report to be brought to the Board in September 2017.	Alice Wiseman/Iain Miller	To feed into the Board's Forward Plan

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
HWB Forward Plan	Partners to contact John Costello with any additional items to be included within the Forward Plan	All	On-going
National Joint Review of Partnerships and Investment in VCS in Health & Care Sector	A further report to be brought back to the Board in three to six months time	Sally Young	To feed into the Board's Forward Plan
LSCB Annual Report 2015/16	The chair of the LSCB be invited to the HWB meeting that it is due to consider Commissioning Intentions for 2017/18.	Sonia Stewart	Complete
Matters Arising from 15th July 2016 meeting of the HWB			
Healthwatch Gateshead Annual Report 2015/16 and Priorities for 2016/17	That Healthwatch Gateshead bring back to the Board a more detailed forward/business plan for 2016/17.	Douglas Ball	Included within the Board's Forward Plan
Matters Arising from 10th June 2016 meeting of the HWB			
Smoking Still Kills	A 10 Year Tobacco Control Delivery Plan to be brought to the Board.	Iain Miller	Included within the Board's Forward Plan for January 2017
Drug Related Deaths in Gateshead	An update report to be brought to a future Board meeting.	Alice Wiseman	Included within the Board's Forward Plan

Item 7

HEALTH AND WELLBEING BOARD
2 December 2016

TITLE OF REPORT: NHS Planning Update – Northumberland, Tyne & Wear and North Durham Sustainability Transformation Plan and NHS Newcastle Gateshead CCG Operational and Commissioner Plan 2017 - 2019

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1. Purpose of the Report

1.1 This report provides an update on progress in developing the Sustainability and Transformation Plan (STP), and the development of the Operational and Commissioner Plan 2017 - 2019.

2. Introduction and Background

2.1 **Northumberland, Tyne & Wear and North Durham Sustainability Transformation Plan (NTWND STP)**

The intention of the STP was to drive genuine and sustainable transformation in health and care outcomes, and help to enable a shared understanding of where we are now, our ambition for 2021 and develop a plan as to how we get there, including our plans for closing three identified gaps:

- Health and wellbeing gap
- Care and quality gap
- Finance and efficiency gap

CCG Operational (Commissioner Plan) 2017 - 2019
In September 2016, NHS England released the planning guidance for 2017 - 2919. The document https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf explains how the NHS operational planning and contracting processes will change to support Sustainability and Transformation Plans (STPs) and the 'financial reset', setting out the financial and business rules for both 2017/18 and 2018/19. Plans will need to demonstrate:

- how they will be delivering the nine 'must-dos';
- how they **support delivery of the local STP**, including clear and credible milestones and deliverables;
- how they intend to reconcile finance with activity and workforce to deliver their agreed contribution to the relevant system control total;
- robust, stretching and deliverable activity plans **which are directly derived from their STP**, reflective of the impact that the STP's well-implemented transformation and efficiency schemes will have on trend growth rates, agreed by commissioners and providers and consistent

with achieving the relevant performance trajectories within available local budgets;

- how local independent sector capacity should be factored into demand and capacity planning from the outset, and local independent sector providers engaged throughout;
- the planned contribution to savings;
- how risks have been jointly identified and mitigated through an agreed contingency plan; and
- the impact of new care models, including where appropriate how contracts with secondary care providers will be adjusted to take account of the introduction of new commissioning arrangements for MCPs or PACS during 2017-19.

Each STP has become the route map for how the local NHS and its partners make a reality of the Five Year Forward View, within the Spending Review envelope. It provides the basis for operational planning and contracting across the STP footprint, with the 2017-19 operational planning and contracting round built out from STPs, as demonstrated in the requirements listed above.

In developing our operational plan for 2017 -2019 and agreeing contracts we are therefore working in partnership with our CCGs and partners across our STP to ensure alignment and reconciliation of each organisations operational plan in the STP footprint.

3. Progress to date

3.1 The STP was submitted to NHS England on 21st October 2016. The plan provides an understanding of the current position against the three gaps set out within the *NHS Five Year Forward View, and* has been developed through a process of robust analysis and modelling.

The plan sets out how we will achieve our vision for health and social care over the next five years, including key actions and activities for the STP developed through a clear understanding of the challenges we face in respect of Health and Wellbeing, Care and Quality and Finance and Efficiency.

The STP focuses on a number of key ***Transformational Areas*** that will:

- **Scale up Prevention, Health and Wellbeing** to improve the health and wellbeing of our public and patients utilising an industrialised approach designed by the Directors of Public Health from each of the local authorities.

- Improve the quality and experience of care through **Out of Hospital Collaboration** and **the Optimal Use of the Acute Sector**.

- Close the financial gap, which by 2021, if we did nothing to resolve the situation would be, £641million.

Our operational plan describes the CCGs approach to delivering the key transformational areas, and is reflected in the Plan on a Page at Appendix 1.

4. Next Steps

4.1 The work to date in developing the STP plan has been to create a case for change, which describes the gaps, challenges and on-going work, we now need to work together with partners to design the next steps. Joint workstreams have been established to take forward this transformation work, including mental health.

The draft STP was published earlier than previously reported on Wednesday 9th November on all CCG websites within the NTWND footprint, including engagement tools to help people feedback their views.

The formal engagement process will commence on 23rd November in order to inform the next version of the plan before consultation.

The first draft of the Operational Plan will be submitted to NHS England on 24th November, with final submission and all contracts signed on 23rd December 2016.

5. Recommendations

5.1 The Health and Wellbeing Board is asked to receive this report and note the progress made in the development of the NTW ND STP and the CCG Operational (Commissioner Plan) 2017 - 2019.

Contact: Hilary Bellwood, Head of Planning & Development NHS Newcastle Gateshead CCG Tel: 0191 217 2960 Email: hilarybellwood@nhs.net

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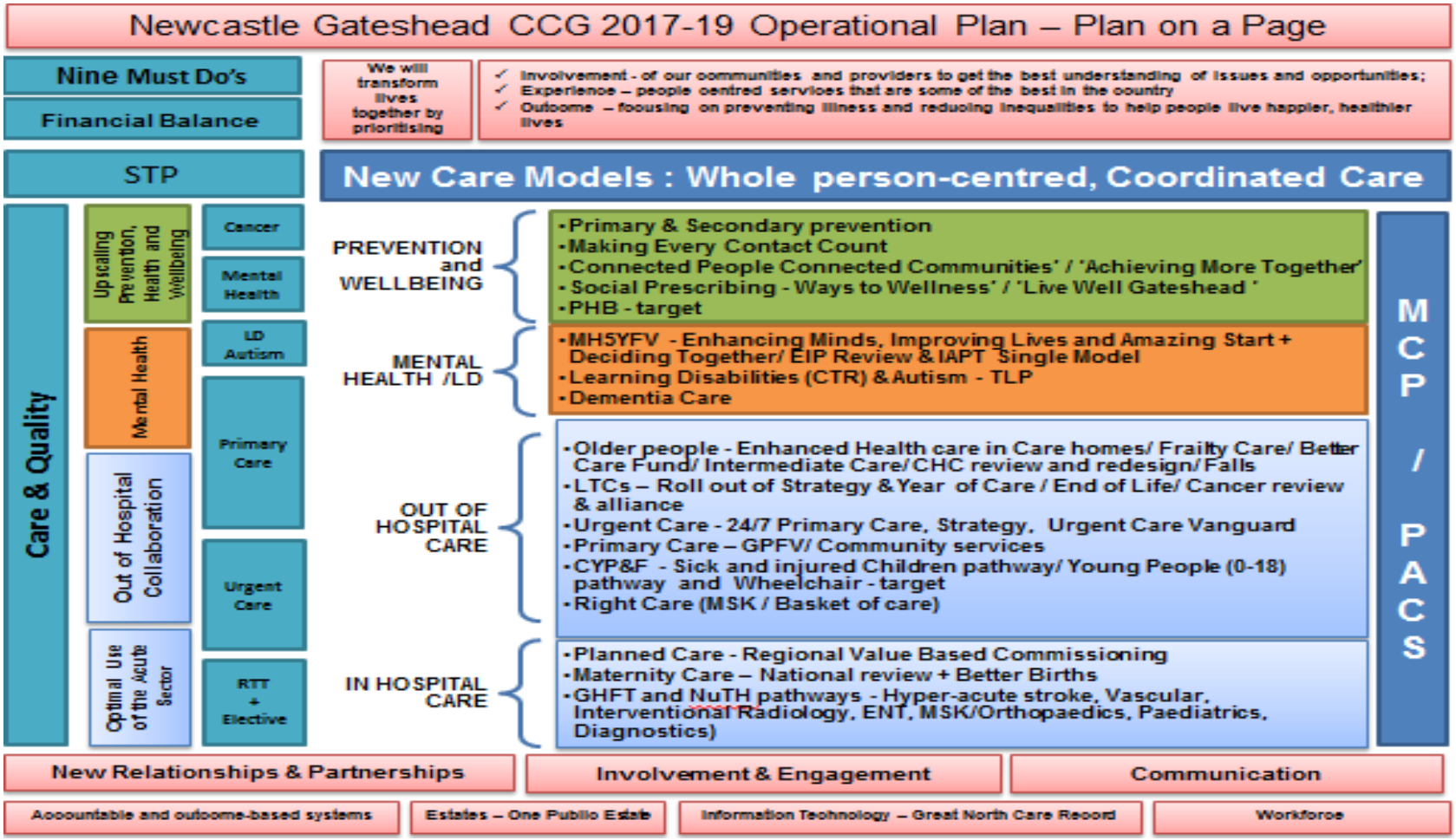
Newcastle Gateshead CCG Operational Plan 2017-19 – Plan on a Page



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Gateshead Council

HEALTH AND WELLBEING BOARD
2 December 2016

TITLE OF REPORT: Gateshead Sexual Health Strategy

Purpose of the Report

1 To seek the approval of the Health and Wellbeing Board (HWB) to the proposed Sexual Health Strategy for Gateshead.

Background

2 Sexual health is an important element of our overall health. It contributes to our quality of life, our self-esteem and our relationships, it has direct and indirect consequences for our physical and mental health, and it can impact on our life chances through our ability to pursue education and employment.

3 Sexual health services are one of the mandated public health services that Local Authorities commission, but certain services are commissioned by Clinical Commissioning Groups and NHS England. A clear set of priorities for sexual health will help us in determining how best to allocate resources to services across the partners and to focus and co-ordinate our efforts to improve sexual health in Gateshead.

4 Sexual health services encompass both sexual and reproductive health – i.e. the prevention and treatment of sexually transmitted infections, contraceptive services, and education and awareness with regard to both these broad areas.

5 The strategy has been developed through the Gateshead Sexual Health Partnership which brings together commissioners and providers of sexual health services in Gateshead.

Summary of Strategy

6 The strategy sets out our aims for sexual health, which are to:

a. Deliver a range of sexual health service provision, to achieve better health outcomes, and ensuring patient care is seamless by working across providers and commissioners;
b. Improve sexual health & wellbeing for Gateshead's residents across the life-course;

c. Continue to tackle stigma, discrimination and prejudice associated with sexual health matters;
d. Reduce inequalities and improve sexual health outcomes;
e. Build an honest and open culture where everyone is able to make informed and responsible choices about relationships and sex;
f. Recognise that sexual ill health can affect all parts of society; and
g. Reduce poor sexual health outcomes from infection and unwanted conceptions.

7 The strategy provides an overview of the commissioning and provision of sexual health services, the local need for services (covering both reproductive health and sexually transmitted infections), and the challenges we face.

8 The strategy will be underpinned by broad work on

- Better prevention;
- Better services;
- Better commissioning.

We will also focus on sexual health across the life-course approach, for:

- Children and young people;
- Adults up to age 50;
- Vulnerable/priority groups (men who have sex with men, people from black and minority ethnic communities, people living with HIV, the homeless, and people with learning disabilities); and
- Older adults.

9 The full strategy is attached at Appendix 1.

Next steps

10 Once agreed, the Sexual Health Partnership will develop an action plan and performance framework to support the strategy's implementation.

Recommendation

11 It is recommended that the HWB Board:

- Approves the proposed strategy
- Supports the development of the action plan and
- Receives an update report on progress in a year's time

Contact: Gerald Tompkins. Telephone (0191) 433 2914
geraldtompkins@gateshead.gov.uk

Gateshead Sexual Health Strategy

1. Introduction

Sexual health is an important element of our overall health. It contributes to our quality of life, our self-esteem and our relationships, it has direct and indirect consequences for our physical and mental health, and it can impact on our life chances through our ability to pursue education and employment.

Sexual Health Services are one of the mandated public health services that Local Authorities must commission. The Local Authority has a duty to ensure the provision of "open access sexual health services in its area … [including] advice on, and reasonable access to, a broad range of contraceptive substances and appliances … advice on preventing unintended pregnancy; … preventing the spread of sexually transmitted infections; … treating, testing and caring for people with such infections; and … notifying sexual contacts of people with such infections"[1]. Elements of sexual health services are also commissioned by CCGs and NHS England (see below).

In Gateshead, the Local Authority allocates approximately £2m from its Public Health Grant to sexual health services, but this Grant is being withdrawn by 2018, and Local Authority funding overall is being reduced, so the overall budget for sexual health services is very likely to fall. A clear set of priorities for sexual health will help us in determining how best to allocate those resources to services.

2. National drivers on sexual health

Sexual health is an important and wide-ranging area of public health. Having the correct sexual health interventions and services can have a positive effect on population health and wellbeing as well as individuals at risk.

The Government set out its ambitions for improving sexual health over an individual's life course in its publication - A Framework for Sexual Health Improvement in England (2013) ('the Framework'). The Framework identifies the differing needs of men and women and of different groups in society. It highlights that nationally there are many challenges still to be addressed:

- Up to 50% of pregnancies are unplanned
- Rates of infectious syphilis are at their highest since the 1950s
- Gonorrhoea is becoming more difficult to treat
- Almost half of adults newly diagnosed with HIV were diagnosed after the point at which they should have started treatment
- In 2010, England was in the bottom third of 43 countries in the World Health Organisation's European Region and North America for condom use among sexually active young people

The Public Health Outcomes Framework (2012) contains three specific indicators for sexual health:

[1] The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 – see paragraph 6

- Under 18 conceptions
- Chlamydia diagnoses in the 15-24 age group
- Late diagnosis of HIV

In December 2015 Public Health England (PHE) published a strategic action plan for health promotion for sexual and reproductive health and HIV. This plan identified the following as health promotion activities:

- Reduce onward HIV transmission, acquisition and avoidable deaths
- Reduce rates of sexually transmitted infections
- Reduce unplanned pregnancies
- Reduce rate of under 16 and under 18 conceptions

The priorities in the Framework for Sexual Health Improvement underpin PHE's strategic action plan for sexual and reproductive health and HIV.

3. Definition

The World Health Organisation (WHO) defines sexual health as "a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence."

This definition will be adopted in Gateshead.

4. Aim:

The Gateshead Sexual Health Strategy has been prepared to help the Gateshead Sexual Health Partnership articulate its aims for sexual health in Gateshead, and to set out how these aims can be achieved. Our ambition is to improve the sexual health and wellbeing of everyone in Gateshead.

We will aim to:

- Deliver a range of sexual health service provision, to achieve better health outcomes, and ensuring patient care is seamless by working across providers and commissioners;
- Improve sexual health & wellbeing for Gateshead's residents across the life-course;
- Continue to tackle stigma, discrimination and prejudice associated with sexual health matters;
- Reduce inequalities and improve sexual health outcomes;
- Build an honest and open culture where everyone is able to make informed and responsible choices about relationships and sex;
- Recognise that sexual ill health can affect all parts of society; and
- Reduce poor sexual health outcomes from infection and unwanted conceptions.

5. Current services and commissioning arrangements

Provision

- GPs provide contraception services (potentially including insertion and removal of long-acting and reversible contraception – LARCs), some treatment of STIs, testing/screening for infections and cervical cancer, referrals to secondary care, general advice.
- Pharmacies provide emergency hormonal contraception ('morning after' pill) and should offer access to free condoms (via C-card) and dual screening kits, co-ordinated by the Integrated Sexual Health Service (ISHS).
- Integrated Sexual Health Service: provided by South Tyneside NHS Foundation Trust (STFT), this delivers a one stop approach – addressing sexual and reproductive health needs, so includes both genito-urinary medicine (GUM) and contraceptive services. The staffing model is multi-disciplinary including a Consultant and an Associate Specialist, registered nurses/health advisors, healthcare assistants, outreach workers and administrative staff. The ISHS has a main base (its hub) at Trinity Health Centre in central Gateshead, providing levels 1,2 & 3 services (see Appendix A) plus "spoke" services (providing level 1 & 2 services) at clinics in Blaydon, Dunston, Wrekenton and Low Fell. Dedicated services for young people are available at some sites. The service also provides outreach services to priority groups who may be vulnerable and reluctant to visit clinics. The contract runs to the end of March 18, with the option to extend for a further year.

Figure 1: Integrated Sexual Health Model

- Additionally, residents may choose to access services outside of the area. Local authorities are mandated to ensure comprehensive, open access, confidential sexual health services are available to all people who are present regardless of area of residence. The greatest flow of

Gateshead residents out of area is to the New Croft Centre in Newcastle. There are also specialist services in Newcastle for people with HIV (NHS England does not commission HIV specialist services within Gateshead).

Commissioning responsibilities

- Gateshead Council commissions the ISHS, as well as contraceptive and sexual health services from GPs and emergency hormonal contraception from pharmacies.
- Newcastle Gateshead CCG commissions terminations of pregnancy and contraception for gynaecological reasons (Mirena Coil for Menorrhagia).
- NHS England commissions routine primary care services that may include the testing and treatment of STIs, and referral to relevant specialist services, as well as specialist services including HIV treatment.

(See Appendix B for further detail)

6. Sexual Health Needs in Gateshead

Overview

Sexual health needs vary according to factors such as age, gender, sexuality and ethnicity, and some groups are particularly at risk of poor sexual health. It is crucial that individuals are able to live their lives free from prejudice and discrimination. However, while individuals' needs may vary, there are certain core needs that are common to everyone. There is ample evidence that sexual health outcomes can be improved by:

- accurate, high-quality and timely information that helps people to make informed decisions about relationships, sex and sexual health;
- preventative interventions that build personal resilience and self-esteem, and promote healthy choices;
- rapid access to confidential, open-access, integrated sexual health services in a range of settings, accessible at convenient times;
- early, accurate and effective diagnosis and treatment of sexually transmitted infection (STIs), including HIV, combined with the notification of contacts who may be at risk; and
- joined-up provision that enables seamless patient journeys across a range of sexual health and other services – this will include community gynaecology, antenatal and HIV treatment and care services in primary, secondary and community settings;
- providing services to vulnerable groups who are particularly at risk of poor sexual health including children in care and Care Leavers.

Reducing the burden of HIV and STIs requires a sustained public health response based around early detection, successful treatment and partner notification, alongside promotion of safer sexual and health-care seeking behaviour.

Every effort should be made to eliminate local barriers to pregnancy diagnosis and where requested abortion referral, STI testing and contraception provision (which should be made available free and confidentially at easily accessible services). Alongside the effective clinical

response, promoting safer sexual behaviour among individuals – including use of the most effective contraceptives, condom use and regular testing – remains crucial.

Sexually transmitted infections in Gateshead

In 2014 (the most recent year for which full data is available) 1534 new STIs were diagnosed in residents of Gateshead, a rate of 767.0 per 100,000 residents (compared to 797.2 per 100,000 in England). More than half (56%) of these new STIs were in young people aged 15-24 years (compared to 46% in England).

The following data relate to 2015 and to Gateshead unless otherwise stated.

The most commonly diagnosed STI is chlamydia, with 227 cases per 100,000 people. Chlamydia is most prevalent amongst young people, with two thirds of cases across the north east occurring amongst those aged 16-24. Although there has been a fall in the number of cases in the most recent figures, the rate of diagnosis had previously changed little since 2007. There is broadly an even gender balance in chlamydia cases, but men who have sex with men (MSM) account for almost 10% of the male cases. The diagnosis rate amongst 16-24 year olds in Gateshead is 1761 per 100,000, compared to a national target rate of 2,300 (a key Public Health Outcomes Framework – PHOF – indicator), and a national rate of 1861 (both per 100,000). This rate is a measure of control activity rather than the level of the disease in the community.

The diagnosis rate of gonorrhoea is worse than the regional but better than the England average, with 69.7 diagnoses per 100,000, compared to 57.8 across the North East and 72.5 nationally. Almost two thirds of gonorrhoea cases were amongst men, although the proportion of cases amongst women has risen, indicating a rise in heterosexual transmission. Infections with gonorrhoea are more likely than chlamydia to result in symptoms and it is used as a marker for rates of unsafe sexual activity: the number of cases may be a measure of access to STI treatment, and has increased significantly – by more than 125% – since 2010 in Gateshead.

There were 10.5 cases of syphilis per 100,000 people in Gateshead, most of which are amongst men. This compares with a North East rate of 5.9 and a national rate of 9.5 per 100,000. The local rate has not changed significantly since 2010.

The diagnosis rate of genital warts in Gateshead is also worse than the North East average, with 137 first cases per 100,000, but the rate has not changed significantly since 2012. Genital warts are the second most commonly diagnosed STI in the UK and are caused by infection with specific subtypes of human papillomavirus (HPV); recurrent infections are common, with patients returning for treatment. Between 2014 and 2015 across the North East there was a drop in infection rates amongst women aged under 20, which is likely to be linked to the introduction of the HPV immunisation programme in 2008. Note that the HPV vaccination uptake coverage in Gateshead is 93.5%, compared to the England average of 86.7% and regional average of 91.3%.

There were 65 cases of herpes per 100,000 people in Gateshead. This has risen since 2012, but not significantly. More than 50% of cases recur, and the herpes simplex virus cannot be cured: treatment can however reduce the frequency and severity of symptoms.

There were fewer than 10 new HIV diagnoses in Gateshead in 2015, and each year across the North East there are approximately 5 new cases per 100,000 people (this is approximately half the national rate). In Gateshead it is estimated there are approximately 190 people living with HIV. Diagnosis late in the course of disease has a substantial impact on long-term outcomes, and in Gateshead between 2012 and 2014, an estimated 27% of HIV diagnoses were made at a late stage, compared to 42% in England. The demographics of people newly diagnosed with HIV have changed considerably in the North East in recent years: the proportion of cases diagnosed in MSM has increased, following a long period where heterosexual transmission was more common; in addition, an increasing proportion – now over 50% – of patients newly diagnosed with HIV identify as 'white British'.

Overall, in 2014 a lower percentage of all tests carried out (excluding chlamydia in under 25yr olds) were actually diagnosed as positive: this is a lower positivity rate than the England average.

In 2014, 7% of North East residents diagnosed with a new STI in a GUM clinic were MSM, but they accounted for 67% of syphilis infections, and 23% of gonorrhoea. For Gateshead men, where sexual orientation was known 19.4% of new STIs (GUM clinics only) were among MSM. In Gateshead in 2015, 91% of male syphilis cases and 49% of male cases of gonorrhea were MSM.

Across the north east, black ethnic groups are disproportionately affected by STIs: in 2014, those who identified as 'black Caribbean' have an incidence of STIs that is 230% higher than those who identify as 'white'.

In the five year period from 2010 to 2014, an estimated 8.7% of women and 8.3% of men presenting with a new STI at a Gateshead GUM clinic were re-infected with a new STI within twelve months.

Where data are available (for chlamydia, gonorrhoea and syphilis), they show that across the North East as a whole STI incidence rates are highest in the most deprived areas.

Reproductive health in Gateshead

In 2014 there were 2753 conceptions to women in Gateshead, a rate of 72.0 per 1,000 women aged 15-44. This is higher than the North East rate (70.5) but lower than the England rate (78.0).

Amongst under-18's, the conception rate was 34.7 per 1,000 women aged 15-17, compared to 30.2 per 1,000 across the North East and 22.8 per 1,000 in England as a whole. Approximately 41.2% of all teenage conceptions led to abortion, compared to 40.1% across the North East and more than half (51.1%) in England overall. The local under-18 birth rate was 11.4 per 1,000, compared to 10.4 per 1,000 across the North East and 6.7 in England. Teenage pregnancy is associated with poorer outcomes for both young parents and their children. Teenage mothers

are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems.

In 2015, the total abortion rate in Gateshead was 15.1 per 1,000 women aged 15-44, which is higher than the regional rate of 14.1 but lower than the national rate of 16.7. Amongst women aged under 25, the abortion rate is lower, at 12.4 per 1,000, but 24.3% of women in this age group having an abortion have had one before – this is similar to the proportion across the North East as a whole (24.0%) but lower than England overall (26.5%). High levels of previous abortions are an indicator of lack of access to good quality contraception services and advice as well as problems with individual use of contraceptive method.

In 2014 the total rate of long acting reversible contraception (LARC) prescribed, excluding injections, per 1,000 women aged 15-44 was 51.5 for Gateshead, 49.1 for North East and 50.2 in England. In primary care the rate was 27.4 for Gateshead, 26.7 for North East and 32.3 in England. The rate of LARCs prescribed in sexual and reproductive health (SRH) services per 1,000 women years was 24.1 for Gateshead, 22.4 for North East and 17.8 for England. Amongst women using the specialist sexual health services, 59.2% chose user-dependent methods, such as condoms or the pill, that rely on daily compliance. LARC methods, such as contraceptive injections, implants, the intra-uterine system (IUS) or the intrauterine device (IUD), are highly effective as they do not rely on daily compliance and are more cost effective than condoms and the pill. However, it should be noted that although injections are easily given and do not require the resources and training that other LARC methods require, they have a higher failure rate than the other LARC methods.

7. Challenges

Based on the needs, activity, and feedback from stakeholders the main challenges we need to address are:

- *Low awareness of sexual health matters:*
  There is a perception amongst professionals working in the field that service users have a low level of awareness of sexual health matters, although we have limited local data on this[2]. This includes understanding what and how sexual health issues affect individuals; how to maintain good sexual health; what services are available and, importantly, when and how to access them. There is no population-based activity to promote and educate on sexual wellbeing. PHSE is no longer a part of the schools' curriculum, although some work is being done across the NE region to review provision of sex and relationships education.

[2] In the Gateshead Health Related Behaviour Survey (2012), 43% of Yr 12-15 pupils said they either had 'never heard of' chlamydia or 'knew nothing about it' and 17% of pupils said that they knew that there was a special contraception and advice centre available locally for young people.

- *Poor sexual health and risk-taking*
  "Poor sexual health is not evenly distributed across society. It is linked closely to deprivation and is associated with particular disadvantaged groups within the population"[3]. A national survey has found that people tend to have more sexual partners than 25 years ago, and that pregnancy is a conscious choice in only approximately 55% of pregnancies[4]. Unplanned pregnancy is associated with poorer outcomes for both mother and child. Although the needs section above shows on many measures Gateshead is performing close to the national or regional averages, there are nevertheless high rates of U18 conceptions, approximately 1 in 5 conceptions ends in abortion and STIs are common (particularly amongst young people aged under 25, MSM and in more deprived areas).

- *Lack of early identification and intervention in STIs, and high rates of transmission*
  Locally around 8.5% of people diagnosed with a new STI at a GUM clinic during the five year period from 2010 to 2014 were re-infected with a further new STI within twelve months. In Gateshead, between 2012 and 2014, 26.7% (95% CI 12.3-45.9) of HIV diagnoses were made at a late stage of infection.

- *Limited collaboration between commissioners and amongst providers*
  The multiplicity of commissioners and providers of sexual health services make collaboration more complex, but essential – for example to ensure seamlessness between services. There are however legal frameworks governing interactions, for example to protect patient confidentiality.

- *Need to develop workforce*
  There is a need to ensure all staff have an appropriate level of knowledge and skill in respect of sexual health for their role. This applies to clinical and non-clinical staff working in general practices and pharmacies, the integrated sexual health service and in other services where staff may touch on sexual health matters (for example in A&E, midwifery and local authority children's and adults social care teams) – every contact counts. Training needs to be tailored for different roles.

- *Access to services*
  This includes issues of location, appointments systems, choice, the website and travel into neighbouring areas. Some concerns have been expressed about access and waiting times, given the balance between appointments and drop-in sessions, timing of some sessions, etc. The website provides a good base to promote access.

8. Objectives

- To develop individuals' awareness, across the life course, of what sexual and reproductive health issues affect them and of how to maintain good sexual health;
- To ensure Gateshead has a full range of sexual and reproductive health services, accessible to all, in line with national policy and guidance that meets the need of the local population;

[3] Lancet Editorial: Sex, health, and society: ensuring an integrated response. Lancet 2013; 382: 1787
[4] Wellings K et al. The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). Lancet 2013; 382: 1807–16

- To reduce levels of unplanned conceptions and ensure services support and facilitate women's reproductive choices;
- To ensure that people with sexually transmitted infections are identified early and receive appropriate treatment and support, leading to reduced transmission, and reduced risk to individuals and communities;
- To develop a skilled workforce across primary care and specialist services; and
- To ensure there is a joined-up approach to commissioning and provision of sexual health services for the residents of Gateshead.

7. The Strategy

Our strategy will be underpinned by broad work on
- Better prevention
- Better services
- Better commissioning.

We will also focus on sexual health across the life-course approach, for
- Children and young people
- Adults up to age 50
- Vulnerable/priority groups (MSM, BME, HIV, homeless, people with learning disabilities) and
- Older adults.

A. Better prevention

Why is this important?

- People of all ages need to be able to make informed decisions about their sexual relationships, understand the sexual health risks they face and know how to protect themselves from unwanted conceptions and STIs, including awareness of how to access services;
- The level of conceptions, abortions, previous abortions and incidence of STIs has been outlined above;
- Early identification and treatment of STIs is likely to reduce the risk of onward transmission, leading to reduced incidence.

What are we already doing?

- The ISHS has lead responsibility locally for communications and campaigns;
- Working with other organisations regionally to maximise local impact of national campaigns;
- A regional group co-ordinates local campaigns and communication activities;
- The ISHS maintains a website that provides information on services and wider sexual health matters;
- Dual-screening young people (aged 15-24) for chlamydia and gonorrhoea, both in clinics and via self-testing kits;
- Providing free condoms via the C-card scheme. A regional group helps co-ordinate schemes across the North East;

- Uptake of HPV immunisation locally is high.

Areas for action

- Increase proportion of women using LARC rather than user-dependent methods of contraception, particularly via GP practices;
- Raise uptake of dual-screening tests for young people;
- Review C-card programme to increase availability and uptake, including considering use of further outlets;
- Develop programme of campaigns and increase on-line and social media presence to raise awareness of sexual health, including risks and the signs and symptoms of infection, in the local population;
- Raise awareness of sexual health, including risks and the signs and symptoms of infection, amongst staff across agencies to promote early intervention for treatment.

B. Better Services

Why is this important?

- A comprehensive sexual health service is essential to meet the needs of the local population. This should include "Level 1" services such as risk assessment, contraceptive information, pregnancy testing, screening and immunisation; "Level 2" services including testing for and treating sexually transmitted infections and provision of LARC; and "Level 3" services including outreach and specialised treatment. Not all services can be provided locally within Gateshead;
- A comprehensive service has to be accessible: this includes location and timing of services, publicity and how people are treated when they attend;
- For many women the GP is their first port of call for sexual health matters, and 80% of school age children have visited their GP in the previous 12 months. Provision of sexual health services enables GPs to retain useful skills, eg in counselling;
- Services can only do so much. If we want people to maintain their own good sexual health then we need to provide them with the tools to achieve this.

What are we already doing?

- The ISHS in Gateshead (see above) provides GUM and reproductive services on an open access basis, through the hub and spoke model;
- The ISHS's website http://www.gatesheadsexualhealth.co.uk/ includes information on all services available, including C-card, dual screening, clinic times, etc;
- There is expertise in the ISHS which can support service delivery and training of others;
- Working with colleagues in the region to establish a regional framework for LARC training;
- GPs provide contraceptive advice and other services as part of their routine primary care, and a number of them are additionally commissioned to provide LARC;
- A number of pharmacies provide emergency hormonal contraception;
- The ISHS delivers training open to all staff with an interest in sexual health, including GPs and practice nurses, youth workers, and safeguarding teams;

- A regional research group shares good practice and innovation in sexual health services.

Areas to consider for action

- The configuration of local services needs to be kept under constant review to reflect identified need, patterns of access, levels of use, emerging challenges, the resources available, etc. This includes the geographic delivery through the hub and spoke model, clinic availability and appointments systems. This will require collating and monitoring service data and improving the quality of data;
- Development of the relationship between the ISHS, GP practices and pharmacies as a network of services supported by the ISHS;
- Establish contraceptive pathways with abortion providers to ensure timely access to contraception pre- or post-abortion;
- The ISHS website needs to be reviewed and developed further – for example to allow on-line booking of appointments and on-line services etc.;
- Need to develop a formal training programme on an on-going basis, to ensure staff within the ISHS, others directly delivering sexual health services such as GPs, practice nurses and Pharmacists, as well as others with a key role in improving sexual health, including youth workers, teachers, social care staff, midwives and health visitors, have access to relevant training;
- Using innovative practice and outreach to engage with vulnerable and hard to reach groups.

C. Better commissioning

Why is this important?

- The Local Authority has a duty to "*provide, or … secure the provision of, open access sexual health services in its area*". This should be based on an understanding of the sexual health needs of the local population;
- This means that everyone in a local authority area must be able to access services, irrespective of age, gender or sexual orientation, and without referral through a professional such as a GP;
- There are multiple providers and multiple commissioners of sexual health services, so we need to ensure there are no gaps between providers, and to minimise any duplication whilst preserving choice;
- Patients move between different providers at different times for different interventions, or along a single pathway.

What are we already doing?

- A sexual health needs assessment was carried out in 2014 and is summarised and updated above;
- Gateshead Council commissions the ISHS (see section 3) as well as commissioning some sexual health services via GPs and Pharmacies (see above);
- Gateshead has initiated commissioning of HIV home sampling service as part of a national campaign to improve access and increase testing;

- Gateshead residents can also access services in other areas, for example where they work. There is a high level of use of services in Newcastle;
- The performance of the local service is monitored to help us to judge whether we are achieving our goals, target activity on emerging problems, etc.;
- Gateshead Council is reviewing how we pay for the integrated service: at present the contraceptive service is under a block contract, whilst the GUM elements are paid via a tariff;
- There is a regional project underway to explore the potential for greater collaboration between commissioners across the North East;
- Gateshead Council convenes a sexual health partnership which aims to promote good sexual health and wellbeing.

Areas for action

- The Council will change the way it procures services from GPs and Pharmacies to make this less bureaucratic and increase coverage;
- The Council will work with STFT to ensure the service provided represents the best value for money, taking account of the outcome from the development work on the integrated tariff and the resources available to the Council;
- The Council will ensure the KPI's used in the contract with the provider reflect the most important issues for sexual health services and the delivery of this strategy;
- The Council will consider whether to extend the contract with STFT into the 4th year. It will review current provision and explore future commissioning options and delivery models; and
- Review remit and membership of SHP.

D. Young people

Why is this important

- It is at this stage in life that most people start to form relationships and become sexually active, yet many young people do not receive sex and relationships education until after they or some of their peers have begun sexual activity;
- Young people remain one of the populations most at risk of poor sexual health. Young people therefore need to understand how and where to access services, and what services can do;
- Young people aged under 25 experience the highest STI rates, including chlamydia and gonorrhoea;
- Although the rate of teenage conceptions in Gateshead has fallen by almost 40% since 1998, it is the 11th highest in England, at 34.7 per 1,000. This is a key PHOF indicator: teenage pregnancy is associated with poorer outcomes for both young parents and their children;
- Young people, including children in need, can be at risk of exploitation;
- It is important to support young people who are looked after as part of the Council's Corporate Parenting responsibilities.

What are we already doing?

- SRE provision is a statutory requirement for pupils in secondary education in maintained schools, but not for independent schools, free schools or academies. However, content, status and quality of SRE is only subject to policy guidance. In Gateshead there are ten high schools (including Emmanuel College) but only two are maintained;
- A regional review of SRE is underway, led by Public Health England;
- The ISHS provides 3 sessions exclusively for young people, on Tuesday at Dunston, Thursday at Wrekenton, and Friday at Low Fell, although young people can also access any of the general clinic sessions;
- The ISHS is the responsible lead for the C card scheme that enable young people to obtain free condoms via a number of outlets across Gateshead;
- Supporting the development of the regional C Card App to increase awareness of C Card outlets;
- Dual screening young people for Chlamydia and Gonorrhoea is available via any of the ISHS clinics;
- The ISHS website has a specific section for young people;
- The Council now has responsibility for the commissioning the healthy child programme for children and young people aged 0-19.

Areas to consider for action

- Increase knowledge and awareness among all groups in the local population of sexual health and local sexual health services including:
  - all methods of contraception and where to access them;
  - the different STIs, associated potential consequences and what to do if you have symptoms;
  - how to reduce the risk of transmission;
  - building emotional resilience to increase the ability to make informed decisions about sexual relationships.

  Develop programme of campaigns targeted at young people, increase on-line and social media presence to raise awareness of sexual health;
- Establish links with schools and colleges as a means to increase knowledge and awareness amongst young people, as well as exploring potential for on-site delivery;
- Establish links with services supporting children in need to ensure sexual health services are accessible to them;
- Increase uptake of LARC through awareness campaigns and specialist training programmes;
- SHP to consider recommendations from regional SRE work, with Children's Services and local schools;
- Need to consider how to ensure the best fit between the healthy child programme and the ISHS, including early intervention and prevention through the 0-19 pathway;
- Consider how can we support parents to help them access information and guidance on how to talk to their children about relationships and sex;
- The ISHS is the responsible lead for the C card scheme that should enable young people to obtain condoms via a number of outlets across Gateshead;
- Raise uptake of dual-screening tests for Chlamydia and Gonorrhoea for young people, by increasing outlets and availability, including provision of home sampling kits;

- Consider use of “You’re welcome” branding.

E. Adults up to age 50

Why is this important

- Sexual activity is an important part of intimate relationships for most people;
- People need access to a choice of contraceptive methods to help them manage their fertility, and support and advice to help them in making those choices;
- A substantial proportion of STIs occur amongst this age group.

What are we already doing?

- The ISHS provides ready access to advice, contraception and testing and treatment for STIs;
- Many people in this age group use their GPs for access to contraception.

Areas to consider for action

- Increase knowledge and awareness among all groups in the local population of sexual health and local sexual health services including:
  - all methods of contraception and where to access them
  - the different STIs, associated potential consequences and what to do if you have symptoms
  - how to reduce the risk of transmission
  - building emotional resilience to increase the ability to make informed decisions about sexual relationships
- Increase uptake of LARC through awareness campaigns and specialist training programmes.

F. Priority and vulnerable groups

Why is this important

- There are groups within the population who are known to be at risk of exclusion from routine sexual health services. These include teenagers, Looked After Young People and Care Leavers, young people on the edge of care, the homeless and rootless, asylum seekers and refugees, those with mental health problems, women involved in the criminal justice system and victims of sexual violence, and those suffering from domestic abuse or from alcohol and drug problems;
- Universal approaches to sexual health improvement may not be relevant to these groups and others who are at high risk of STIs, for example MSM and those from black African and Caribbean backgrounds);
- Services have a statutory duty to make reasonable adjustments to accommodate the needs of groups with protected characteristics, such as people with learning disabilities;

- Local evidence[5] suggests most sex workers engage in so called 'survival' sex work; they present with multiple, complex problems including addiction, homelessness, mental ill health and offending. They are generally known to a wide range of services, though 'bounce around' statutory provision without engaging, representing a high cost with limited positive outcomes.

What are we already doing?

- The ISHS provides ready access to advice, contraception and testing and treatment for STIs, and seeks to target MSM through its website, etc;
- The ISHS is expected to prepare an annual equality impact assessment of its provision;
- All ISHS and practice staff are trained in and should work in accordance with safeguarding processes;
- Providing HIV home sampling tests (remotely requested via web) which are intended for vulnerable / high risk groups e.g MSM and those of African origins;
- STFT is undertaking an Equality Impact Assessment of the integrated service.

Areas to consider for action

- Increase knowledge and awareness among all groups in the local population of
  - all methods of contraception and where to access them
  - the different STIs and associated potential consequences
  - how to reduce the risk of transmission
  - building emotional resilience to increase the ability to make informed decisions about sexual relationships;
- There is a lack of information on the health needs of these groups and a lack of tailored sexual health promotion programmes or outreach services to engage with them. Measures could include developing links with other statutory services, such as Looked After Services, community and voluntary organisations (such as Evolve), and working with these to identify opportunities for outreach delivery or providing domiciliary appointments for certain groups;
- To consider and respond to the findings from the equality impact assessment of the service;
- Increase uptake of LARC for those at risk of exclusion, through awareness campaigns and specialist training programmes;
- To develop an understanding of the specific needs and barriers to service engagement for individuals vulnerable to sexual exploitation, with particular focus on those moving through the 'age of transition' and are most at risk of disengaging from services;
- To develop a plan to identify and support individuals with additional needs and high risk taking behaviour:
  - this should be informed by an equality impact assessment carried out by the ISHS
  - to understand the risks of STIs and how to protect themselves
  - to understand how alcohol and drug use impacts on decisions about sex, including negotiating safer sex

[5] PEER: Exploring the lives of sex workers in Tyne and Wear http://www.nr-foundation.org.uk/downloads/PEER_finalreport_full_v1_2.pdf

    - to make "reasonable adjustments" in order to meet the individual needs of people with protected characteristics, e.g. those with learning disabilities;
- To ensure sexual health services are knowledgeable and appropriately trained in child sexual exploitation, trafficked and modern slavery of young people and young adults in the community;
- We will need to consider the local implications of any national decision on funding for HIV pre-exposure prophylaxis.

G. Older adults

Why is this important

- Although the need for sexual health services may reduce as people get older, their needs should not be overlooked;
- Older adults may be newly single following bereavement or relationship break-up, the need for sexual health services may be new to them, and they may have lower levels of awareness of those services and of risks;
- National data shows an increase in STI's amongst the over 50's population, although in the North East the absolute numbers of older people who receive diagnoses of STIs are small.

What are we already doing?

- The ISHS provides ready access to advice, contraception and testing and treatment for STIs;
- Many people in this age group use their GPs for access to contraception.

Areas to consider for action

- Increase knowledge and awareness among all groups in the local population of
    - all methods of contraception and where to access them;
    - the different STIs and associated potential consequences;
    - how to reduce the risk of transmission;
    - where to get access to prompt, confidential STI testing, treatment, information and support;
- Potential delivery of HIV treatment and care co-commissioned with NHSE.

8. Next Steps

Once this strategy is agreed, an action plan will be developed, setting out key milestones and lead responsibilities. The implementation will be monitored by the Sexual Health Partnership, supported by a revised performance framework focussed on the key public health outcomes, which will be part of the Council's overall performance reporting.

August 2016

Resources

- Better prevention, better services, better commissioning: the national strategy for sexual health and HIV. (Department of Health, July 2001)
- A Framework for Sexual Health Improvement in England (Department of Health, 15 March 2013)
- Commissioning Sexual Health Services and Interventions: Best Practice For Local Authorities (Department of Health, 21 March 2013)
- Making it work: A guide to whole system commissioning for sexual health, reproductive health and HIV (Public Health England, revised March 2015) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf
- NICE guideline PH3: Sexually transmitted infections and under-18 conceptions: prevention (National Institute for Clinical Excellence, February 2007)
- NICE guideline CG30: Long-acting reversible contraception (National Institute for Health and Care Excellence, October 2005 updated September 2014)
- NICE guideline PH51: Contraceptive services for under 25s (National Institute for Health and Care Excellence, March 2014)
- NICE Local Government Briefing LGB17: Contraceptive services (National Institute for Health and Care Excellence, March 2014)
- Improving outcomes and supporting transparency. Part 1A: A public health outcomes framework for England, 2013-2016 (Public Health England, November 2013)
- Gateshead Local Authority HIV, sexual and reproductive health epidemiology report (LASER): 2014 (Public Health England)
- Public Health England Fingertips Profile http://fingertips.phe.org.uk/profile/sexualhealth/data#page/1/gid/8000058/pat/6/par/E12000001/ati/101/are/E08000037
- North East Annual Sexually Transmitted Infections Report. Surveillance report. Data for 2015 (Public Health England Centre North East, Field Epidemiology Services. August 2016)
- The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 . (HM Government. Queen's Printer of Acts of Parliament, 2013).
- Standards for the management of sexually transmitted infections (STIs). (British Association for Sexual Health and HIV, 2010) http://www.bashh.org/documents/2513.pdf .
- An overview of Local Authority commissioned services for the prevention of sexually transmitted infection in the North East (draft report) (Simon Howard, Public Health England, 2016)
- Local sexual health strategies from: University Hospitals Birmingham (Umbrella), Hertfordshire County Council, London Borough of Ealing, London Borough of Wandsworth, Leicestershire County Council, Knowsley Council, St Helens Council, Durham County Council
- The Sex Education Forum: http://www.sexeducationforum.org.uk/home.aspx
- PEER: Exploring the lives of sex workers in Tyne and Wear http://www.nr-foundation.org.uk/downloads/PEER_finalreport_full_v1_2.pdf

Appendix A

Levels of sexual health services

Level 1:

- Sexual history and risk assessment
- STI testing for women
- HIV testing and counselling
- Pregnancy testing and referral
- Contraceptive information and advice
- Assessment and referral of men with STI symptoms
- Cervical cytology screening and referral
- Hepatitis B immunisation

Level 2:

- Intrauterine device insertion (IUD)
- Testing and treating sexually transmitted infections
- vasectomy
- Contraceptive implant insertion
- Partner notification
- invasive sexually transmitted infection testing for men

Level 3:

Level 3 clinical teams will take responsibility for sexual health services needs assessment, for supporting provider quality, for clinical governance requirements at all levels, and for providing specialist services which could include:

- outreach for sexually transmitted infection prevention
- outreach contraception services
- specialised infections management, including co-ordination of partner notification
- highly specialised contraception
- specialised HIV treatment and care

Source: Better prevention, better services, better commissioning: the national strategy for sexual health and HIV. (Department of Health, July 2001)

Appendix B

Commissioning responsibilities

Sexual Health Commissioning Responsibilities from April 2013

Local Authorities will	Clinical Commissioning	NHS Commissioning
comprehensive sexual health services, including: • Contraception,including LESs (implants) and NESs (intrauterine contraception) including all prescribing costs – but excluding contraception provided as an additional service under the GP contract • STI testing and treatment, chlamydia testing as part of the National Chlamydia Screening Programme and HIV testing • sexual health aspects of psychosexual counselling • Any sexual health specialist services, including young people's sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion work, services in schools, colleges and pharmacies	most abortion services (but there will be a further consultation about the best commissioning arrangements in the longer term) sterilisation vasectomy non-sexual health elements of psychosexual health services gynaecology, including any use of contraception for non-contraceptive purposes.	contraception provided as an additional service under the GP contract HIV treatment and care, including post-exposure prophylaxis after sexual exposure promotion of opportunistic testing and treatment for STIs, and patient requested testing by GPs sexual health elements of prison health services Sexual Assault Referral Centres cervical screening specialist fetal medicine

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Gateshead Council

HEALTH AND WELLBEING BOARD
2 December 2016

TITLE OF REPORT: NECA Commission Report 'Health and Wealth: closing the gap in the North East'

Purpose of the Report

1. To seek the views of the Health and Wellbeing Board on the NECA Commission Report 'Health and Wealth: closing the gap in the North East', which was presented to the NECA Leadership Board on 11th October.

Background

2. The joint NECA/NHS Commission for Health and Social Care Integration was established as an independent commission earlier this year, chaired by Duncan Selbie, Chief Executive of Public Health England.

3. The Commission has been looking into how the NHS, councils and other public, private and VCS sector bodies can take a place based approach to further develop the work they do together to improve health and wellbeing and reduce health inequalities across the North East against a backdrop of significant financial pressures across the system.

4. The Commission's report is a 'call to action' for leaders across the health and care system in the NECA area to transform the health and wellbeing of North East residents and, in so doing, help to improve the performance of its economy and the prosperity of its people.

5. It was agreed by the NECA Leadership Board that each local authority and NHS organisation within the NECA area be invited to consider the contents of the report over a period of 6 weeks or so. The Commission is seeking an endorsement of its recommendations and a commitment to participate in their implementation.

Starting Point & Key Assumptions

6. The report recognises the remarkable progress made in many aspects of health and care despite the challenges of widespread deprivation and a 'post-industrial' economy. It notes, in particular, the significant progress in tackling the burden of cardiovascular disease and reducing the prevalence of smoking.

7. It acknowledges, however, that although the NE has had the fastest increase in life expectancy of any region of the UK, the health and wellbeing gap with the rest of the UK and health inequalities within the region itself remain high. It states that closing this gap with the nation as a whole over the next decade

would lead to 400,000 additional years of healthy life for people within the NECA area.

8. This translates to continuing, significant pressures on our health and care system - pressures that will increase further in the future due to such factors as a growing elderly population (many with multiple and complex long term needs).

9. Side by side with a health and care system that is not sustainable if 'business as usual' continues, the Commission rightly refers to a system over-focussed on the treatment of ill health at the expense of preventing it. The report states that 60% of expenditure on health and care is spent on tackling the consequences of ill health (hospital care, specialist care), compared to only the 3% devoted to public health and 17% to adult social care.

10. Over and above the implications this has for the health and wellbeing of local people (in particular, quality of life, healthy life expectancy, working days lost compared to the rest of the country), there are also knock-on implications for the north east's ability to increase economic growth, attract investors, increase productivity etc.

11. This leads to a 'vicious', self-perpetuating cycle where health inequality impacts upon peoples opportunities to secure 'good' quality work that can drive economic growth (and secure further 'good' employment for the region). This, in turn, impacts upon the opportunities available for future generations, not least our children who need the best start in life as advocated by the Marmot Review.

12. Going forward, the Commission is asking leaders across the health and care system to cut through this vicious cycle and puts forward a number of recommendations which it states can be implemented through existing structures.

How the Commission's Recommendations have been Shaped

13. The recommendations developed by the Commission have been shaped by:

    - The need for a substantial shift in resource investment towards prevention. Some of this investment in prevention has the potential to yield benefits and release resources for further investment in prevention in the short to medium term (e.g. interventions to reduce the risk of mortality in people with established diseases such as heart disease, cancer, diabetes; lifestyle interventions around smoking, alcohol related harm etc.), whilst the benefits of other forms of investment may take longer to realise (e.g. to address worklessness, poverty, poor housing educational attainment etc.).

    - The fact that that social care plays a critical preventative function within the wider health and social care system, maintaining people's ability to live independently and ensuring that deterioration in people's health is picked up early.

- The need to value the 'assets' within communities and to increase peoples' control over their own health.
- The importance of economic growth and employment in improving the health and wellbeing of local people. Currently, this is hampered by the burden of ill-health which impacts upon productivity and constrains the ability of the economy to grow – in 2011/12, 1.6m working days were reportedly lost due to workplace injury and ill-health.

- The need to enable the VCS to fully realise its potential in helping to address the challenges we face.

- The Commission's remit to consider drivers of health and wellbeing beyond the health and care sector.

Core Themes

14. Three core themes have been identified:

    - The need to shift resources towards **prevention**,
    - How investment in prevention links with greater **productivity**, and
    - The importance of **system leadership/governance** arrangements to make this happen across a NE footprint.

Action Required at Different Spatial Levels

15. The Commission concludes that concerted action is required at different spatial levels, that 'no one size fits all', including action:

    - by individual local authorities and/or CCGs;
    - at a local health economy level
    - at NECA level or beyond

Ten Recommendations

16. Ten recommendations have been put forward by the Commission (see appendix) and can broadly be grouped together as follows:

    Prevention – a radical shift in investment towards prevention across the health and care system (around £160m a year by 2020/21). This would see increased preventive spend assigned to a dedicated preventive investment fund managed on a cross-system basis. It would bring together contributions from all partners who stand to benefit from the expected savings, including central government.

    Towards this end, the region should work with CIPFA to establish a baseline of current preventive spend and a means of tracking increases in spending over time. It is also recommended that the region should act as a pilot area to trial work being carried out by Public Health England and CIPFA to develop tools to assess the effectiveness of public health investment.

Whilst the Commission acknowledges that it will be for NECA partners to determine the exact allocation of increased preventive resources to meet the needs of the region, it states that the particular challenges faced by the NECA area suggest that increased resources could be divided roughly equally between early years support, the wider determinants of health, lifestyle-based secondary prevention and sustaining social care while improving integration with health services.

Among the forms of integration cited by the Commission that are likely to be most effective are:

- Arrangements in which a single lead professional has an oversight of all health and social care support provided to an individual, both in the community and, if possible, in hospital;
- Joint mechanisms across health and social care for giving people control over personal budgets/personal health budgets for their care and support;
- Shared system-wide approaches to working with carers as partners;
- Integrated approaches to rehabilitation and reablement;
- Working arrangements which ensure that staff at all levels in different services that support the same group of people are in frequent formal and informal contact – e.g. through joint appointments, co-location etc.

The Commission also recommends that public sector partners across the NECA area integrate preventive action and action to tackle inequalities in all decisions to ensure that health and wellbeing impacts are fully factored in e.g. decisions on public transport, leisure facilities, housing, planning and skills.

Workforce, Employers & Employment – a programme of primary care training to help people get the best support to enable them to get back to work as quickly as possible; creating a supportive environment that enables employees to be proactive in protecting their own mental health and wellbeing; promoting employer participation in the Better Health at Work Award; and addressing the importance of job quality and in-work progression.

Cultural Change – across organisations within the health and care system so that each £ is used most effectively to support the health and wellbeing of local people, irrespective of the source of the funding.

Governance Arrangements – at NECA level to drive forward the recommendations, through shared accountability and a focus on delivery.

System Incentives – the realignment of system incentives and payment systems to drive forward recommendations to break the existing vicious cycle and measurably improve the health and wellbeing of all local people and reduce health inequalities.

Some Issues for Consideration

Shift Towards Prevention/Freeing up Resources

17. The Commission's acknowledgment of the need for a substantial shift in investment towards prevention is to be welcomed and, specifically, the

important role played by public health and social care as part of a whole system approach.

18. Getting the right balance of different forms of preventative investment will be crucial if further resources are to be released upstream towards longer term preventative work. This challenge is all the greater at a time of significant financial constraint as there is no 'new money' within the system to pump prime initiatives and/or meet double running costs.

19. Investment in new approaches will need to be funded from within the local system in a way that is sustainable. For instance, secondary prevention measures to address ill-health in its earliest stages can reduce the need for costly acute care within months and years (e.g. falls, CVD rehabilitation, depression, COPD) enabling savings to be reinvested in greater prevention but only if undertaken as part of a whole system approach and with whole system buy-in.

20. If more resources can be released in this way, there should be greater capacity to invest in primary prevention to prevent ill-health in the first place, including investment directed at the wider determinants of health – best start in life, a job, a home etc.

21. Whilst key themes running through the Commission's recommendations will no doubt be supported across the NECA patch, progress in taking forward the key transformation areas of the Northumberland, Tyne & Wear and North Durham Sustainability and Transformation Plan (STP) will determine in no small part system success in securing the shift towards prevention that has been advocated by the Commission. The two are necessarily interlinked.

22. The NECA Commission sees STPs as offering an opportunity, through acute care collaboration/rationalisation, to free up resources to allow preventative investment to yield fruit, to improve and support community based care and social care. As much work remains to be done to map out how this can be achieved in practice, it is too early to judge how this will pan out locally, the potential for resource release to the system as a whole and the timescales associated with this. An initial Out of Hospital Care framework has been developed through the STP process to support this work.

Making Every Contact Count

23. As well as the Commission's recommended shift in investment towards prevention, there is the need for a culture shift in professional practice in health and social care so that greater emphasis is placed upon 'making every contact count' i.e. by encouraging changes in behaviour that have a positive effect on the health and wellbeing of individuals and communities.

24. To do this, organisations need to build a culture that supports continuous health improvement through the contacts it has with individuals. Doing this can help to improve health and wellbeing amongst service users, staff and the general public and reduce health inequalities.

Health, Wellbeing and Productivity

25. In acknowledging the strong links between health, wellbeing and productivity, the Commission identified the need to focus on the benefits of healthy workplaces and being sufficiently healthy for work. It also highlights the need to provide opportunities for those furthest away from the labour market, including the long term unemployed, people with disabilities and mental ill-health, and young people with low skills and lack of work experience.

26. More broadly, there is a need to ensure that reducing economic and health inequalities are integral to local economic development strategies and their delivery.

Governance

27. Further clarification is needed on how the governance arrangements at a NECA level would interface with those for STPs in practice. National NHS guidance published in September confirmed that STPs will be there for the long haul so this is an important consideration.

28. NHS Planning guidance is also encouraging CCGs to work across larger footprints – further consideration needs to be given to what this could mean across a NE footprint, a local health economy footprint, and local authorities and partner organisations within that footprint.

29. There is a need to ensure that oversight and decision making relating to our health and care system, as well as workstreams established to take forward key transformation areas incorporate a local 'democratic dimension' that local authorities can provide both individually and collectively.

System Leadership

30. System leadership will be key to taking forward both the recommendations from the NECA Commission and the direction of travel set out in the STP. Linking to the point under the Governance section above regarding the need for a democratic mandate to facilitate service transformation, local authorities have a key role to play here.

31. The Commission could arguably have said more about the system leadership role and place shaping role of local authorities in addressing the wider determinants of health and driving economic growth within our region.

Proposal

32. It is proposed that the Board endorse the NECA Commission's recommendations in principle and consider the issues that have been raised within this report.

Recommendations

33. The Health and Wellbeing Board is asked to:

    (i) endorse the recommendations of the NECA Commission in principle;

(ii) comment upon the issues set out in this report.

Contact: John Costello (0191) 4332065

Appendix

NECA//Commission's Report

Health and Wealth: closing the gap in the North East

The Commission's 10 Recommendations

Recommendation 1: NECA partners should set themselves an ambition to radically increase preventive spending across the health and care system and wider determinants of health and wellbeing.

Recommendation 2: Public sector partners across the NECA area should integrate preventive action and action to tackle inequalities in all decisions.

Recommendation 3: Increased preventive spend should be assigned to a dedicated preventive investment fund managed on a cross-system basis and bringing together contributions from all partners who stand to benefit from the expected savings, including central government.

Recommendation 4: NECA partners should develop a programme of primary care training to support primary care staff in helping people access the best support to enable them to get back to work as quickly as possible.

Recommendation 5: The Commission recommends addressing mental health at three levels:

i. Improve the leadership and skills of managers at all levels within NHS and local authority organisations to create a supportive environment that enables employees to be proactive in protecting their own wellbeing.

ii. Commissioners of IAPT services should work with their service providers to ensure employment support is included as part of the IAPT offer on a sustainable basis to support those individuals who require this service to avoid sickness absence or to return to work as quickly as possible.

iii. NHS Commissioners and Providers should work with the NECA Employment, Skills and Inclusion workstreams to develop an integrated employment and health service.

Recommendation 6: The Better Health at Work Award (BHAWA) scheme should be the preferred approach for employers to adopt to improve workplace wellbeing. NECA partners should set a target for the proportion of the workforce working for employers involved in the award scheme, and monitor progress towards this target.

Recommendation 7: The refreshed Strategic Economic Plan and NECA's employment and skills programme should continue to address the importance of in-work progression and job quality.

Recommendation 8: Leaders within organisations will need to look beyond the interests of their own organisations to drive improvement in wellbeing outcomes across NECA, leading a cultural change to a care and health system in which each health and care £ is used most effectively to support wellbeing, independent of the source of the funding.

Recommendation 9: Governance should be established at NECA level to drive forward implementation of these recommendations, bringing together local authorities, CCGs, NHS FTs and the voluntary sector to progress the health and wellbeing agenda through shared accountability and focused on implementation and delivery.

Recommendation 10: The NECA area should align financial payment systems and incentives with the overall objectives of the health and care system to improve health and wellbeing and reduce health inequalities.

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Gateshead Council

HEALTH AND WELLBEING BOARD
2 December 2016

TITLE OF REPORT: Better Care Fund: 2nd Quarterly Return (2016/17) to NHS England

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Purpose of the Report

1. To seek the endorsement of the Health & Wellbeing Board to the Better Care Fund return to NHS England for the 2nd Quarter of 2016/17.

Background

2. The HWB approved the Gateshead Better Care Fund (BCF) submission for Gateshead at its meeting on 22 April 2016, which in turn was approved by NHS England in July 2016.

3. NHS England is continuing its quarterly monitoring arrangements for the BCF which requires a template return to be submitted in respect of our BCF Plan for each quarter of 2016/17. The Board endorsed the Quarter 1 return for 2016/17 at its meeting on 9th September 2016.

Quarter 2 Template Return for 2016/17

4. In line with the timetable set by NHS England a return for the 2nd quarter of 2016/17 has been submitted on the 25th November. The return sets out progress in relation to budget arrangements, meeting national conditions, and performance against BCF metrics. It also includes a narrative progress update section.

Future BCF Returns for 2016/17

5. The deadline set by NHS England for the completion of future quarterly returns for 2016/17 are as follows:

   Q3 2016/17: 24th February 2017

   Q4 2016/17: 24th May 2017

6. These will continue to be brought to the Board for endorsement as required.

Proposal

7. It is proposed that the Board endorse the 2nd Quarter BCF return for 2016/17 which has been submitted to NHS England (attached as an excel document).

Recommendations

8. The Health and Wellbeing Board is asked to endorse the Better Care Fund 2nd Quarter return for 2016/17.

Contact: John Costello (0191) 4332065

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 25th November 2016

The BCF Q1 Data Collection

This Excel data collection template for Q2 2016-17 focuses on budget arrangements, the national conditions, income and expenditure to and from the fund, and performance on BCF metrics.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an overview of progress with your BCF plan, the wider integration of health and social care services, and a consideration of any variances against planned performance trajectories or milestones.

Cell Colour Key

Data needs inputting in the cell
Pre-populated cells
Question not relevant to you

Throughout this template cells requiring a numerical input are restricted to values between 0 and 100,000,000.

Content

The data collection template consists of 8 sheets:

Checklist - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements - this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the BCF Policy Framework 16-17 and BCF planning guidance.
4) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
5) Supporting Metrics - this tracks performance against the two national metrics, a DTOC metric, a Non-Elective Admissions metric, locally set metric and locally defined patient experience metric in BCF plans.

6) Additional Measures - additional questions on new metrics that are being developed to measure progress in developing integrated, cooridnated, and person centred care.
7) Narrative - this allows space for the description of overall progress on BCF plan delivery and performance against key indicators.

Checklist

This sheet contains all the validations for each question in the relevant sections.

All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:

The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 7 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This section requires the Health & Wellbeing Board to confirm if funds have been pooled via a Section 75 agreement. Please answer as at the time of completion.

If it had not been previously stated that the funds had been pooled can you now confirm that they have now?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Policy Framework 16/17 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf) and Better Care Fund Planning Guidance 16/17 (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/) have been met through the delivery of your plan. Please answer as at the time of completion.

It sets out the eight conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' or 'No - In Progress' that these have been met. Should 'No' or 'No - In Progress' be selected, please provide an estimated date when condition will be met, an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed.

Full details of the conditions are detailed at the bottom of the page.

4) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the following information:

Forecasted income into the pooled fund for each quarter of the 2016-17 financial year
Actual income into the pooled fund in Q1 & Q2 2016-17
Forecasted expenditure from the pooled fund for each quarter of the 2016-17 financial year
Actual expenditure from the pooled fund in Q1 & Q2 2016-17

Figures should reflect the position by the end of each quarter. It is expected that the total planned income and planned expenditure figures for 2016-17 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan or amendments to forecasts made since the previous quarter.

5) Supporting Metrics

This tab tracks performance against the two national supporting metrics, a Delayed Transfers of Care metric, a Non-Elective Admissions metric, the locally set metric, and the locally defined patient experience metric submitted in approved BCF plans. In all cases the metrics are set out as defined in the approved plan for the HWB and the following information is required for each metric:

An update on indicative progress against the six metrics for Q2 2016-17
Commentary on progress against each metric

If the information is not available to provide an indication of performance on a measure at this point in time then there is a drop-down option to indicate this. Should a patient experience metric not have been provided in the original BCF plan or previous data returns there is an opportunity to state the metric that you are now using.

Guidance on accessing CCG based NEA numerator data from SUS via the 'Activity and Planning Report' has been circulated in tandem with this report in order to enable areas to perform their own in year monitoring of NEA data. This guidance document can also be accessed via the embeded object below.

Guide to accessing CCG based NEA data from SUS via

NEA denominator population (All ages) projections are based on Subnational Population Projections, Interim 2014-based (published May 2016) found here:
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Please note that the Non-Elective Admissions per 100,000 population (All ages) population projections are based on a calendar year.

Delayed Transfers Of Care numerator data for actual performance has been sourced from the monthly DTOC return found here:
http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

DTOC denominator population (18+) projections are based on Subnational Population Projections, Interim 2014-based (published May 2016) found here:
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1

Please note that the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+) population projections are based on a calendar year.

Actual and baseline data on Re-ablement and Residential Admissions can be sourced from the annual ASCOF return found here:
http://content.digital.nhs.uk/searchcatalogue?productid=22085&q=ascof
Please note these are annual measures and the latest data for 2015/16 data was published 05/10/2016. Plan data for these metrics in 2016/17 were submitted by HWBs within Submission 4 planning returns and final figures are displayed within the 'Remaining Metrics Enquiry' tab of the Submission 4 report.

6) Additional Measures

This tab includes a handful of new metrics designed with the intention of gathering some detailed intelligence on local progress against some key elements of person-centred, co-ordinated care. Following feedback from colleagues across the system these questions have been modified from those that appeared in last years BCF Quarterly Data Collection Template (Q2/Q3/Q4 2015-16). Nonetheless, they are still in draft form, and the Department of Health are keen to receive feedback on how they could be improved / any complications caused by the way that they have been posed.

For the question on progress towards instillation of Open APIs, if an Open API is installed and live in a given setting, please state 'Live' in the 'Projected 'go-live' date field.
For the question on use and prevalence of Multi-Disciplinary/Integrated Care Teams please choose your answers based on the proportion of your localities within which Multi-Disciplinary/Integrated Care Teams are in use.

For the PHB metric, areas should include all age groups, as well as those PHBs that form part of a jointly-funded package of care which may be administered by the NHS or by a partner organisation on behalf of the NHS (e.g. local authority). Any jointly funded personal budgets that include NHS funding are automatically counted as a personal health budget. We have expanded this definition following feedback received during the Q3 reporting process, and to align with other existing PHB data collections.

7) Narrative

In this tab HWBs are asked to provide a brief narrative on overall progress, reflecting on performance in Q2 16/17.
A recommendation would be to offer a narrative around the stocktake themes as below:
Highlights and successes
What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?
Challenges and concerns
Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?
Potential actions and support
What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

Better Care Fund Template Q2 2016/17

Data Collection Question Completion Checklist

1. Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

2. Budget Arrangements

Funds pooled via a S 75 pooled budget? If not previously stated that the funds had been pooled can you confirm that they have now? If no, data provided?
Yes

3. National Conditions

			7 day services		Data sharing							
	1) Are the plans still jointly agreed?	2) Maintain provision of social care services	3i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	3ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken #Standard 8?	4i) Is the NHS Number being used as the consistent identifier for health and social care services?	4ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	4iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	4iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	5) Is there a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	6) Is there agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	7) Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care	8) Agreement on local action plan to reduce delayed transfers of care (DTOC), including a locally agreed target
Please Select Yes, No or N/a - In Progress)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "N o - In Progress" please enter estimated date when condition will be met if not already in place DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "N o - In Progress" please provide an explanation as to why the condition was not met within the quarter (in line with signed off plan) and how this is being addressed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

4. I&E (2 parts)

			Q1 '16/17	Q2 '16/17	Q3 '16/17	Q4 '16/17
Income to		Forecast	Yes	Yes	Yes	Yes
		Actual	Yes	Yes		
		Please comment if there is a difference between the annual totals and the pooled fund	Yes			
Expenditure From		Forecast	Yes	Yes	Yes	Yes
		Actual	Yes	Yes		
		Please comment if there is a difference between the annual totals and the pooled fund	Yes			
Commentary on progress against financial plan:			Yes			

5. Supporting Metrics

		Please provide an update on indicative progress against the metric?	Commentary on progress
NEA	Yes	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
DTOC	Yes	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
Local performance metric	Yes	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
If no metric - please specify	Yes	Yes	Yes
Patient experience metric	Yes	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
Admissions to residential care	Yes	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
Reablement	Yes	Yes	Yes

6. Additional Measures

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service-user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Yes	Yes	Yes	Yes	Yes	Yes
From Hospital	Yes	Yes	Yes	Yes	Yes	Yes
From Social Care	Yes	Yes	Yes	Yes	Yes	Yes
From Community	Yes	Yes	Yes	Yes	Yes	Yes
From Mental Health	Yes	Yes	Yes	Yes	Yes	Yes
From Specialised Palliative	Yes	Yes	Yes	Yes	Yes	Yes

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Yes	Yes	Yes	Yes	Yes	Yes
Projected 'go-live' date item/s/vt	Yes	Yes	Yes	Yes	Yes	Yes

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Yes
Total number of PHBs in place at the end of the quarter	Yes
Number of new PHBs put in place during the quarter	Yes
Number of existing PHBs stopped during the quarter	Yes
Of all residents using PHBs at the end of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	Yes
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes

7. Narrative

Brief Narrative	Yes

Cover

Q2 2016/17

Health and Well Being Board	**Gateshead**
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Who has signed off the report on behalf of the Health and Well Being Board:	Councillor Lynne Caffrey

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
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Budget Arrangements

Selected Health and Well Being Board:	Gateshead

Have the funds been pooled via a s.75 pooled budget?	Yes
If it had not been previously stated that the funds had been pooled can you confirm that they have now?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question, which is pre-populated, the data is from a previous quarterly collection returned by the HWB.

National Conditions

Selected Health and Well Being Board: Gateshead

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within this quarter (in-line with signed off plan) and how this is being addressed?

Condition (please refer to the detailed definition below)	Q1 Submission Response	Please Select ('Yes', 'No' or 'No - In Progress')	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:
1) Plans to be jointly agreed	Yes	Yes		
2) Maintain provision of social care services	Yes	Yes		
3) In respect of 7 Day Services - please confirm:				
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes	Yes		
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (standard 9)?	No - In Progress	No - In Progress	31/03/20	New contract awarded for Community services whch will see a transformation programme over 5-7 years. Learning emerging from Primary Care Access Progr
4) In respect of Data Sharing - please confirm:				
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes	Yes		
ii) Are you pursuing Open APIs (ie system that speak to each other)?	No - In Progress	No - In Progress	30/09/18	Following initial stakeholder events held in 2015, significant progress has been made to develop more robust plans for delivering information sharing between stakeholders, including across health and social care. The CCG has co-ordinated the development of the Newcastle Gateshead Local Digital Roadmap, which outlines the ambition across Newcastle Gateshead to deliver a paper free care system by 2021. Stakeholder organisations were involved in
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes	Yes		
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	No - In Progress	No - In Progress	30/06/17	The local information networks are working with other CCGs and providers at a regional level to develop patient communications at a regional level, with posters, leaflets and a patient helpline for queries around information sharing going live in September 2016. Further work is scheduled to underake patient engagement and local communications to support implementation of the information sharing agenda.
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	Yes		
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	No - In Progress	No - In Progress	31/03/20	Newcastle Gateshead has well established governance arrangements supporting 'Better Care'. There is joint ownership across both Health and LA commissioners and providers to lead on the development and implementation of the plans.
7) Agreement to invest in NHS commissioned out-of-hospital services	No - In Progress	No - In Progress	31/03/20	Through the STP process there is a recognition that investment in Out of Hospital services is fundamental to sustainability of the whole system, therefore moc
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	Yes		

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services
Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.
Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

• To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
• To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2017 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number
The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:
• confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
• ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.

This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

8) Agreement on local action plan to reduce delayed transfers of care (DTOC)
Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

• Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
• Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
• Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
• Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
• Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
• Demonstrate engagement with the independent and voluntary sector providers.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Gateshead

Income

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£4,121,962	£4,121,962	£4,121,962	£4,121,962	£16,487,846	£16,487,846
	Forecast	£4,121,962	£4,121,962	£4,121,962	£4,121,962	£16,487,846	
	Actual*	£4,121,962					

Q2 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£4,121,962	£4,121,962	£4,121,962	£4,121,962	£16,487,846	£16,487,846
	Forecast	£4,121,962	£4,121,962	£4,121,962	£4,121,962	£16,487,846	
	Actual*	£4,121,962	£4,121,962				

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q2 actual differs from the Q2 plan and / or Q2 forecast	N/A

Expenditure

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,771,462	£3,982,462	£4,552,462	£4,181,462	£16,487,846	£16,487,846
	Forecast	£3,771,462	£3,982,462	£4,552,462	£4,181,462	£16,487,846	
	Actual*	£3,771,462					

Q2 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,771,462	£3,982,462	£4,552,462	£4,181,462	£16,487,846	£16,487,846
	Forecast	£3,771,462	£3,586,540	£4,754,540	£4,375,305	£16,487,846	
	Actual*	£3,771,462	£3,586,540				

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q2 actual differs from the Q2 plan and / or Q2 forecast	There has been some slippage in the implementation of the enhanced enablement service, however forecast spend is still anticpated to be in line with plan by the end of the year

Commentary on progress against financial plan:	Actual expenditure figures show full expenditure against schemes within the BCF pool.

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB. Pre-populated Plan, Forecast and Q1 Actual figures are sourced from the Q1 16/17 return previously submitted by the HWB.

National and locally defined metrics

Selected Health and Well Being Board: Gateshead

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Year to date performance in Non Elective activity is currently above planned levels by circa 841 admisisons or 7%, however CCG QIPP schemes and the Care Homes Vanguard are expected to bring activity within planned levels by the year end.

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Q2 to date performance is 25.5% above trajecotry, 1883 delayed days compared to 1500 per 100,000 population. However we are undertaking an in depth analysis with providers to understand the reason for the unexpected increase and to vaildate data that has been collected to date.

Local performance metric as described in your approved BCF plan	Estimated diagnosis rate for people with dementia
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	71.3% estimated dementia diagnosis rate compared to 70% target.

Local defined patient experience metric as described in your approved BCF plan	Patient/Service User Experience metric Improve the percentage of patients who responded " Yes Definitely" to the following question from the GP patient survey: "For respondents with a long-standing health condition: In the last 6 months, have you had enough support from
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	Mid year 44% compared to 48% end of year 16/17 target. This is an improvement on the 15/16 level of 43%.

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	For April to September 2016, there were 161 permanent admissions into residential or nursing care. This represents 417.1 admissions per 100,000 population (based on 2014 population projections) showing an improvement in performance compared to the same point last year of 167 permanent admissions (441.2 per 100,000 population).

Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	The indicator value stands at 79.2% (347 out of 438) for all of those aged 65 and over that were discharged from hospital into reablement and still at home 91 days later. The value is lower than the same period last year, which was 83.6% (404 out of 483) and is also below the challenging target of 87.5%.

Footnotes:

For the local performance metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB.
For the local defined patient experience metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB, except in cases where HWBs provided a definition of the metric for the first time within the Q1 16-17 template.

Additional Measures

Selected Health and Well Being Board: Gateshead

Improving Data Sharing: (Measures 1-3)

1. Proposed Measure: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Measure: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Shared via interim solution
From Hospital	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Shared via interim solution
From Social Care	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Shared via interim solution
From Mental Health	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Not currently shared digitally
From Specialised Palliative	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Shared via interim solution

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	In development	In development	In development	In development	In development	In development
Projected 'go-live' date (dd/mm/yy)	N/A	N/A	N/A	N/A	N/A	N/A

3. Proposed Measure: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot commissioned and planning in progress

Other Measures: Measures (4-5)

4. Proposed Measure: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	54
Rate per 100,000 population	26.8

Number of new PHBs put in place during the quarter	53
Number of existing PHBs stopped during the quarter	0
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	97%

Population (Mid 2016)	201,221

5. Proposed Measure: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	Yes - in some parts of Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	Yes - throughout the Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures were updated to the mid-year 2016 estimates as we moved into the new calendar year.

Narrative

Selected Health and Well Being Board: Gateshead

Remaining Characters	30,589

Please provide a brief narrative on overall progress, reflecting on performance in Q2 16/17. A recommendation would be to offer a narrative around the stocktake themes as below:

Highlights and successes

What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?

Challenges and concerns

Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?

Potential actions and support

What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

Successes - For April to September 2016, there were 161 permanent admissions into residential or nursing care. This represents 417.1 admissions per 100,000 population (based on 2014 population projections) showing an improvement in performance compared to the same point last year of 167 permanent admissions (441.2 per 100,000 population). At this stage, performance is on track to achieve the year-end target of 388 admissions (1,005.1 per 100,000 population). The improvement in performance can be attributed to the introduction of a panel process in April where service managers have closer scrutiny and control over new admissions.

Achievements - The Care Home Project is already delivering improvements in outcomes for the Care Homes residents:

- The number of non elective admissions for Care Homes residents with a UTI is the lowest since 2014
- Comparing months 1-5 in 15/16 against 16/17, non elective admissions in the care home residents population has reduced by 4.1%
- There has been a levelling out of A&E attendances for care home residents

Dementia diagnosis continues to improve.

Challenges - Reablement - The indicator value stands at 79.2% (347 out of 438) for all of those aged 65 and over that were discharged from hospital into reablement and still at home 91 days later. The value is lower than the same period last year, which was 83.6% (404 out of 483) and is also below the challenging target of 87.5%. (see explanation and actions being taken to address this issue under the Supporting Metrics Tab).

Potential actions and support

In terms of DTOC figures, we will be undertaking an in depth analysis with providers to understand the reason for the unexpected increase and to vaildate data that has been collected to date. We will be undertaking further development of the community bed model as part of this work.

The local hospital is joining the acute frailty network to support their development of an interface model of older peoples care and learning is expected to positively influence the out of hospital metrics.

We will look at the support offered from local CNE/BCF teams in order to understand how this can help with improvements.

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Item …….

HEALTH AND WELLBEING BOARD
December 2016

TITLE OF REPORT/BRIEFING: Time to Change Hub

Purpose of the Report

1. To seek the support of the Health & Wellbeing Board to proceed with a joint bid with Newcastle Health and Wellbeing Board and Newcastle Gateshead CCG to deliver a local Time to Change hub *www.**time-to-change**.org.uk/get-involved/**hubs***

Background

2. Too many people with mental health problems are made to feel isolated, ashamed and worthless. But with the right support from those around them, people can recover and have equal opportunities in all areas of life. Time to Change has been set up to support communities, schools and workplaces to open up to mental health; to talk and to listen. Their strategy is about targeting people through three interrelated activities; social leadership, social marketing, and social contact.

3. Time to Change is a national mental health anti-stigma campaign and social movement funded by the Department of Health, Comic Relief and the Big Lottery Fund. It is run by Mind and Rethink Mental Illness.

4. Time to Change intervention aims are to empower communities to lead and embed local change together, through setting up a number of 'Time to Change Hubs across the country. Health and Wellbeing Boards and Local Authorities are being encouraged to come together with local partners and make their local community a Time to Change Hub.

5. A Time to Change Hub is a partnership of local organisations, and people, who are committed to ending mental health stigma and discrimination. Collectively and independently, they initiate and run regular local activities to challenge mental health prejudice, coming together to align and maximise the impact of their combined activity. They provide encouragement, support and tools to those that are already campaigning locally and to those that aspire to join the campaign, as well as seeking to encourage anti-stigma and discrimination policies and best practice within both their own organisations and relevant local strategies.

6. A Hub is organised and sustained by local organisations and individuals, supported by Time to Change. Hub areas are geographically defined by agreed postcode areas (e.g. aligned to a Local Authorities jurisdiction or similar), set to ensure optimum focus and impact for the campaign locally. Time to Change Hubs are not organisations in their own right or part of a franchised network.

7. Mental health organisations across Gateshead and Newcastle, from NHS trusts to the smaller VCS organisations are well connected and practiced in open, collective work and campaigning, while we are also fortunate in having some of

the longest-lasting and most respected mental health service user and carer groups in the country, who are visibly active, have a wide and diverse reach and are well networked, locally, regionally and nationally.

8. Newcastle and Gateshead are especially well-placed to host the regional hub, since members of the Newcastle/Gateshead Mental Health Programme Board have a well-established pattern of connected, joint working, have assisted with the creation of the Newcastle/Gateshead mental health collaborative, ReCoCo (www.recoverycoco.com) and the partner agencies, who importantly include those with direct lived experience, already fulfil many of the functions of a time to Change hub.

9. Each Hub will receive 18 months direct support from Time to Change from the date of their appointment. After this period Time to Change would expect Hubs to commit to continuing to work around mental-health anti-stigma and discrimination independently for a reasonable period to ensure local changes in attitude and behaviour are sustained.

10. The sums available are a £10,000 'Champions Fund' to dispense awards ranging between £100 and £500 for a variety of creative activities to encourage people to talk about mental health in different and unusual settings, and a £15,000 contribution towards staff time / costs incurred in administering the Champions Fund and Hub partnership.

Proposal

11. The proposed Time to Change Hub bid will be a partnership between Newcastle and Gateshead, supported through Newcastle Gateshead CCG and the Mental Health Programme Board (MHPB).

12. The proposed 'hub host' will be the Newcastle Gateshead Mental Health Programme Board, led by Newcastle Gateshead CCG, which already leads on a number of strategies for mental health improvement on behalf of the two statutory boards.

13. The Hub host will coordinate; the writing of the proposal, the recruitment of organisational support to oversee the programme, the administration of the Champions Fund and Hub partnership and the collation of an evaluation of the programmes.

Recommendations

14. The Health and Wellbeing Board is asked to endorse the proposed partnership with Newcastle and Newcastle Gateshead Mental Health Programme Board to oversee the development and delivery of the 'Hub' programme.

Contact:
Alice Wiseman, Director of Public Health
Telephone: (0191) 433 2777