Gateshead Council

Public Document Pack

HEALTH AND WELLBEING BOARD AGENDA

Friday, 3 March 2017 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) The minutesof the meeting held on 20 January 2017 are attached for approval.
2a	**Action List - 20 January 2017 (Pages 11 - 14)** The Action List from the Board Meeting on 20 January 2017 is attached to note.
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	**10 Year Tobacco Control Action Plan** (Pages 15 - 52) Report attached to be presented by Alice Wiseman and Iain Miller
6	**STP Update** (Pages 53 - 56) Report attached to be presented by Joe Corrigan
7	**Development of OSC Work Programmes for 2017/18: Emerging Themes** (Pages 57 - 74) Report attached to be presented by John Costello
	Performance Management Items
8	**Better Care Fund Quarter 3 Return 2016/17** (Pages 75 - 94) Report attached to be presented by John Costello
	Items for Assurance
9	**Primary Care (Medical Services) Governance Arrangements** (Pages 95 - 102) Report to follow

10 **Health Protection Assurance Report** (Pages 103 - 134)

Report attached to be presented by Alice Wiseman

Items for Information

11 **Long Term Conditions Strategy** (Pages 135 - 188)

Report attached to be presented by Samantha Hood

12 **Health and Social Care Statement of Intent** (Pages 189 - 196)

Report attached to be presented by John Costello

13 **Any Other Business**

14 **Date and Time of Next Meeting**

Friday 28 April 2017 at 10am

Contact: Sonia Stewart; email; soniastewart@gateshead.gov.uk, Tel: 0191 433 3045
Date: Thursday, 23 February 2017

GATESHEAD METROPOLITAN BOROUGH COUNCIL

HEALTH AND WELLBEING BOARD MEETING

Friday, 20 January 2017

PRESENT	Councillor Councillor Lynne Caffrey (Gateshead Council) (Chair)	
	Councillor Ron Beadle	Gateshead Council
	Councillor Mary Foy	Gateshead Council
	Councillor Martin Gannon	Gateshead Council
	Councillor Michael McNestry	Gateshead Council
	Dr Mark Dornan	Newcastle Gateshead CCG
	Ian Renwick	Gateshead Health NHS Foundation Trust
	Dr Bill Westwood	Federation of GP Practices
	Sheila Lock	Gateshead Council
	Sally Young	Gateshead Voluntary Sector
IN ATTENDANCE:	John Costello	Gateshead Council
	Elizabeth Saunders	Gateshead Council
	Sonia Stewart	Democratic Services
	Steph Downey	Gateshead Council
	Gerald Tompkins	Gateshead Council
APOLOGIES:	Councillor Jill Green and Councillor Malcolm Graham Mark Adams, Douglas Ball, Alice Wiseman and Joe Corrigan	

HW101 MINUTES

RESOLVED - That the minutes of the meeting held on 2 December 2016 be agreed as a correct record.

HW102 ACTION LIST

RESOLVED - that additions and work in progress as listed on the action list be noted.

HW103 DECLARATIONS OF INTEREST

There were no declarations of interest.

HW104 UPDATES FROM BOARD MEMBERS

Gateshead CBC

The Board were advised that Gateshead CBC has been renamed as CBC Health but will remain Gateshead based and focussed.

Newcastle/Gateshead CCG

The Board were advised that the CCG are providing management support to North Tyneside CCG It is hoped that this will provide opportunities for joint working.

Gateshead Council

The Council's budget consultation process is drawing to a close, a report will go to Cabinet and Council towards the end of February which will incorporate the feedback received.

TWFRS

Currently the fire service are undertaking a couple of pilots, one is as co-responders with the Ambulance Service and this has been evaluated, the outcome of which will be shared when available. The second is a Safe & Well visit signposting people to services if required.

Gateshead NHS Foundation Trust

The Board were advised that it has been one of the worst winters, with many patients having respiratory ailments.
The QE have won a National Award from RICS (Royal Institute of Chartered Surveyors).
The Chief Executive advised that the QE are fortunate to have over 3,000 skilled and committed staff. There is evidence of good take up of flu jabs amongst staff. It was noted that the current cohort of trainee doctors are not favouring General Practice as a career path.There are significant workforce challenges in the north east which are multi-faceted.. It was also noted that half of the current GP workforce locally are approaching retirement.

It was noted that there is an item on workforce in the Board's forward plan. It was agreed that a group of people get together to plan a presentation to a future meeting of the Board on local workforce challenges and opportunities whilst also highlighting some of the good work that is taking place across local organisations.

Newcastle City Council

Newcastle are to launch their new Obesity Strategy, an aim of which is for the City's population to lose 100,000 llbs in weight. Hugh Fearnley-Whittinstall is to launch the strategy

HW105 BME NEEDS ASSESSMENT

The Board received a presentation on the work to produce a BME Needs Assessment, this work was requested in September 2016 and the report provided to the Board is an interim report to provide an update. A working group was established, however, capacity has been an issue. Whilst some local authority level data is available, the group have been reliant on national data. The group was in contact with the Diversity Forum and set up some focus groups to gather views.

There is a statutory duty in relation to the BME community to have their needs included in the Joint Strategic Needs Assessment. Data has shown that BME communities have been growing over the past 20 years. Data also shows that BME communities are living in the most deprived areas of the Borough.

Some of the key findings of the assessment have shown the following:

- The prevalence of long term conditions such as type 2 diabetes, coronary heart disease and stroke is up to 6 times higher (and they occur from a younger age) in the BME population.
- In addition, these groups progress from being at-risk to being diagnosed with these conditions at twice the rate of the white population.
- Tackling the issues will help tackle health inequalities, and satisfy public sector obligations under the Equality Act 2010.

Public Health Issues or Determinants of Ill health

- The evidence confirms that Asian, black African and African-Caribbean and other minority ethnic groups are at an equivalent risk of diabetes, other health conditions or mortality at a lower BMI measurement than the White European population.
- Focus group participants had mixed knowledge of diabetes and health checks. Some knew about diabetesas it was common in their country of origin, others did not understand the condition.
- Cancer is emerging as an important issue for South Asians, it is important that they have access to information about cancer, including methods of prevention through lifestyle, diet and how to spot symptoms early.
- Data could be gathered from local cancer registers, hospital Episode statistics, public health observatories and local cancer networks
- Further work is required to meet the screening needs of this population e.g. collect and analyse data on the rate of oropharyngeal cancers, note of any demographic patterns
- Further work with local South Asian communities to understand how to make services more accessible e.g. if smokeless tobacco cessation services are provided within existing mainstream tobacco cessation services

Key recommendations of the assessment are as follows:

- NICE and other sources highlight the need to raise awareness for BMI measurement and thresholds that can be used for recognising risk as a

trigger for intervention

- Extend the use of lower BMI thresholds to trigger action to prevent type 2 diabetes among black African and African-Caribbean and Asian populations
- Ensure practitioners are aware that members of black, Asian and other minority ethnic groups are at an increased risk of chronic health conditions at a lower BMI
- Ensure member of black, Asian and other minority ethnic groups are aware that they face an increased risk of chronic health conditions at a lower BMI than the white population (below BMI 25kg/m2)
- Use existing local black and other minority ethnic information networks to disseminate information on the increased risks these groups face at a lower BMI
- Use family based educational intervention as a means of building on existing beliefs, attitude and behaviours, with a community based word of mouth approach.
- Local Authorities and their partner organisations ensure that services that they commission or provide include a focus on people from minority ethnicities and particularly within the 25-39 age groups.
- Outreach services are important to encourage engagement with local services and provide information
- Plan, design and coordinate activities to promote the uptake of HIV testing among local black African communities in line with NICE guidance on community engagement
- Seek to develop trust and relationships between organisations, communities and people
- Communities should be involved in all aspects of the plan which should take account of existing and past activities to address HIV and general sexual health issues among these communities
- Promote accessible services to teach English as a second language
- Consult families from BME communities about information in appropriate languages and ways of promoting to BME communities
- Provide advocacy, translation and interpretation services for families from BME communities who require support during and health and social care pathways
- Ensure service providers' information on services is readily available in appropriate languages and is promoted to BME communities
- Commission peer support forums for parents and carers from local BME communities and, where appropriate, tailored support services
- Commission services that are accessible for local BME communities e.g. in appropriate locations and at appropriate times, e.g. promote stop smoking services to communities prior to Ramadan
- Ensure that the BME communities chapter of the Health and Wellbeing Board's Joint Strategic Needs Assessment is updated to reflect the HNA and linked to all other chapters
- It is recommended that the Health and Wellbeing Board members ensure that their respective organisations and organisations who they commission with are actively aware of their requirement to collect and analyse data across workforce and delivery areas in their performance measurements and monitoring

RESOLVED - (i) That the information contained in the report be noted.
(ii) that an analysis of primary care data is undertaken to investigate important risk profiles for this population
(iii) that an action plan be developed to propose solutions to ensure BME communities receive important messages regarding access to appropriate services
(iv) that the action plan be implemented in appropriate ways to ensure solutions to the issues and recommendations as set out in the Health Needs Assessment

HW106 SPECIAL EDUCATIONAL NEEDS AND DISABILITIES (SEND) JOINT COMMISSIONING ARRANGEMENTS

The Board received a presentation on both the expected inspection by OFSTED of the Special Educational Needs Service and Joint Commissioning Arrangements in place.

It was noted that the opportunity has also been taken to look at workstreams and joint working.

The focus of the inspection will be:

- How effective the local area works together to identify children and young people with SEND.
- How effective local areas are at assessment and meeting need
- How effective the local area is at improving outcomes.

In preparing for the inspection,a nominated officer has been identified and a Self Evaluation has been completed - this is in draft for consultation. We are also developing joint commissioning arrangements and have submitted key strategy and policy documents to Cabinet which have been approved. Preparation is ongoing to brief staff and partners who may need to attend focus groups as part of the inspection.

As part of the preparation for the inspection, Joint Commissioning Intentions have been developed in partnership with Newcastle-Gateshead CCG. These intentions have been informed by 'good practice' examples from across the country. The commissioning intentions identify what services are currently in place for children and young people with SEND and what is working and what is not working with the current arrangements.

The joint arrangements clearly outline commissioning objectives and intentions, governance and reporting mechanisms.

The Board were informed that this has been a real opportunity to look at pathways and commissioning arrangements and that this has been done in co-production with young people and their families. Once the inspection has been undertaken there will be a report back to the Board with the details of the outcomes.

RESOLVED - (i) That the information in the presentation be noted
(ii) That a further report be presented to the Board following the outcome of the inspection

HW107 GATESHEAD CANCER LOCALITY WORK GROUP

The Board received a report on the development of a work programme by the Gateshead Cancer Locality Working Group.

The group is a multi-agency approach to improving cancer outcomes in Gateshead. The group has successfully evaluated its first work plan from 2015/16 and during this time the World Class Outcomes for Caner document was produced and adopted as the National Cancer Strategy.

The Strategy contains 93 actions in six priority areas to be delivered at a local, regional and National level. These actions have been considered in the North East Cancer Network (soon to become the Northern Cancer Alliance) as well as all the cancer locality groups.

The Six Strategic Priorities are:

- Spearhead a radical upgrade in prevention and public health
- Establish patient experience on par with clinical effectiveness and safety
- Make the necessary investments required to deliver a modern high quality service
- Drive a national ambition to achieve earlier diagnosis
- Transform our approach to support people living with and beyond cancer
- Ensure commissioning, provision and accountability processes are fit-for-purpose

Two areas have been identified by the Gateshead Cancer Locality Work Group which would benefit from a mutli-agency approach.

Smoking – reducing the prevalence of smoking must be one of our priorities if we are to reduce the incidence of cancer.

1-year survivorship. There is a complex interaction between early detection, where the disease has less chance to develop; through high quality treatment and support with individual patient responsibility post-treatment; and support with individual patient responsibility. A person shares a number interactions with many agencies represented in the GCLG and a number of key projects need to be aligned to deliver the maximum impact.

RESOLVED - That the board endorse the information contained within the report and the work of the Gateshead Cancer Locality Group.

HW108 STRATEGIC REVIEW OF CARERS SERVICES

The Board received a report on the current position with regards to the Strategic Review of Carers Services.

In response to the implementation of the Care Act 2014 Gateshead Integrated Commissioning Group agreed for Gateshead Council to take the lead on the review of Carers Services in Gateshead.

This has been seen as an exciting opportunity for both Gateshead Council and Newcastle Gateshead Clinical Commissioning Group in taking an innovative approach to the integrated commissioning of carers services across Gateshead.

Engagement has taken place with commissioned providers to understand the current offer for carers. Further engagement work is planned, including with the Newcastle Gateshead CCG Local Engagement Board, an on-line Carers Survey, and engagement with carers, commissioned providers, care management teams and stakeholders.

The proposed next steps include evaluating our findings from engagement activity and the Health Needs Assessment for Carers to assist us to:

- Determine outcomes which will deliver a better offer for Carers
- Design models of future care and support services
- Consult on suggested models of future care and support services
- Utilise this work as an exemplar to integrate health and social care services in line with our strategic direction

RESOLVED - That the current position be noted and a further report be brought to the Board on completion of the review.

HW109 PERFORMANCE REPORT FOR THE HEALTH AND CARE SYSTEM

A report was presented to the Board to provide an update on the performance within the Health and Social Care system to enable the Health and Wellbeing Board to gain an overview of the current system and to provide appropriate scrutiny.

A suite of indicators was proposed to the Board in July 2015 and agreed as the basis for a performance management framework which would be brought to the Health and Wellbeing Board on a regular basis.

Because of the diverse range of indicators included in the Framework, the frequency with which metrics are updated varies. The latest available data for each indicator in reported.

Agency performance leads have highlighted metrics that are worthy of particular consideration by the Board. This could be because they represent a cross cutting issue or have been identified as an area of significant improvement or key risk.

RESOLVED - That the information be noted by the Board.

HW110 DATE AND TIME OF NEXT MEETING

Joint Health & Wellbeing Board and Community Safety Board - Friday, 17 February 2017 at 10am.

Health & Wellbeing Board - Friday 3 March 2017 at 10am.

Item 2a

GATESHEAD HEALTH AND WELLBEING BOARD
ACTION LIST

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Matters Arising from Joint HWB/CSB Meeting on 17th February 2017			
Impact of Alcohol	To bring an updated Substance Misuse Strategy and Action Plan to the Board.	Joy Evans/Alice Wiseman	To feed into the Board's Forward Plan
Matters Arising from 20th January 2017 meeting of the HWB			
Updates from Board Members	A discussion to take place on workforce issues and their implications for Gateshead at a future Board meeting.	All	To feed into the Board's Forward Plan
BME Needs Assessment	An analysis of primary care data to be undertaken to investigate important risk profiles for this population. An action plan to be developed to propose solutions to ensure BME communities receive important messages regarding access to appropriate services. The action plan to be implemented in appropriate ways to ensure solutions to the issues and recommendations as set out in the Health Needs Assessment.	All	Ongoing

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Special Educational Needs and Disabilities (SEND) Joint Commissioning Arrangements	A further report to be presented to the Board following the outcome of the inspection.	Elizabeth Saunders	To feed into the Board's Forward Plan
Strategic Review of Carers Services	A further report to be brought to the Board on completion of the review.	Elizabeth Saunders	To feed into the Board's Forward Plan
Matters Arising from 2nd December 2016 meeting of the HWB			
Gateshead Sexual Health Strategy	An update on progress to be brought to the Board in a year's time.	Alice Wiseman/ Gerald Tompkins	To feed into the Board's Forward Plan
NECA Commission Report Health & Wealth	Individual organisations to also submit comments on the report to NECA as appropriate.	All	Ongoing
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.
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
HWB Forward Plan	Partners to contact John Costello with any additional items to be included within the Forward Plan.	All	On-going

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
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
Matters Arising from 15th July 2016 meeting of the HWB			
Healthwatch Gateshead Annual Report and Priorities	That Healthwatch Gateshead bring back to the Board a more detailed forward/business plan.	Douglas Ball	To feed into 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 on the Board's Agenda for March 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

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Gateshead Council

HEALTH AND WELLBEING BOARD
3 March 2017

TITLE OF REPORT: Gateshead 10 Year Tobacco Control Action Plan

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Purpose of the Report

1. To seek the endorsement of the Health & Wellbeing Board for the Gateshead 10 year Tobacco Control delivery plan.

Background

2. The Gateshead Director of Public Health Annual Report 2015/16, "Tobacco: a smoking gun", made the case for tackling tobacco and the introduction ended with the DPH's commitment that "We will do whatever it takes to end the harm that is caused to our families and communities by tobacco".

3. Smoking remains the biggest killer in Gateshead and is the single most preventable cause of premature death. More people die from smoking related illness than all other causes each year. More than half of smokers will die early from a smoking related illness. A large number of smokers will also be living the last years of their life incapacitated by smoking related conditions such as respiratory disease, circulatory problems and cancers.

4. Smoking costs Gateshead's economy around £30m each year with each smoker who smokes on average 20 a day spending around £2,190 - £3,000+ on smoking each year, that's between £10,950 and £15,000 after five years.

5. Smoking exacerbates inequalities. Smoking accounts for over half of the difference in risk of premature death between social classes.

6. 23,712 Gateshead households have at least 1 smoker, 34% of which fall below the poverty line. If smokers stopped and the money was recirculated back into the household budget, it would lift around 2,655 Gateshead homes, 4,434 Gateshead people, out of poverty (ASH Ready Reckoner, 2015).

7. Our ambition is for a smoke free Gateshead, a place where our communities are not affected by the harm caused by tobacco.

8. The previous delivery plan ran to 31 March 2015, in line with the national tobacco control strategy, and this action plan outlines the way forward to 2025. We are still awaiting a national strategy but feel that we need to set out how we will reach 5% prevalence by 2025 and can't let inertia take hold.

9. Our ambitious target for this 10 year plan is 5% smoking prevalence in all adults by 2025 and this Action Plan identifies work in eight areas and actions that partners can implement which will help us achieve that target.

Work to date

10. Delivered a paper to Gateshead Health and Wellbeing Board (HWB) in June 2016 making the case for action on tobacco control. This included recommendations to:
    - Ensure a greater focus on tobacco control activity by all partners on Health and Wellbeing Board for Gateshead.
    - Undertake a CLeaR review of the Gateshead Smokefree Tobacco Alliance in July 2016 in partnership with HWB members.
    - Develop a local 10 year delivery plan based on both the output of the CLeaR assessment and national, regional and local intelligence.

11. We reviewed the work of Gateshead SmokeFree Tobacco Alliance using a national standard, CLeaR, identifying strengths and areas for improvement.

12. Linked with Fresh, Smoke Free North East Office of Tobacco Control, to learn from best practice and for expert critique on the development of the Action Plan.

13. The Director of Public Health's Annual Report 2015/16 "Tobacco: A smoking gun" laid the challenge to partners to act so that we can truly say we are a smoke-free community, where no one, irrespective of their personal circumstances or where they live, is adversely affected by tobacco.

14. We have made good progress over the last 10 years, reducing prevalence from 33% in 2006 (2006 Health Profile) to 18.3% in the general population and 25.6% in Routine and Manual groups in 2016 (PHE Fingertips). However we still have a long way to go to reach our target of 5% by 2025. Delivering evidence based tobacco control requires long term strategic commitment in eight key areas, six as identified by the World Bank www.worldbank.org/ and two others as proposed by Fresh www.freshne.com/ , the North East England Regional tobacco control office. This Gateshead 10 Year tobacco control plan gives the framework for our next steps.

Recommendations

15. The HWB is asked to endorse the Gateshead Smoke Free Tobacco Alliance Tobacco Control Action Plan 2016 – 2025.

16. Partners of the HWB are asked to commit to delivering the Action Plan between now and 2015.

Contact: Alice Wiseman, Director of Public Health, Telephone (0191) 4332777
alicewiseman@gateshead.gov.uk

Making Smoking History in Gateshead

Gateshead Smoke Free Tobacco Alliance
Tobacco Control Action Plan

The Vision

Smoking Prevalence of 5% or below in Gateshead by 2025

A 10 Year plan for Tobacco Control 2016 - 2025
Making Smoking History in Gateshead - Executive summary

Introduction: Smoking is the biggest cause of death and disease in Gateshead and there is a clear need to continue the work on reducing smoking prevalence in all age groups with targeted work with those who are most disadvantaged. Our Vision is to reach a Smoking Prevalence of 5% or below in Gateshead by 2025. We have made good progress over the last 10 years, reducing prevalence from 33% in 2006 (2006 Health Profile) to 18.3% in the general population and 25.6% in Routine and Manual groups (2016 PHE Fingertips). However we still have a long way to go to reach our target of 5% by 2025. Delivering evidence based tobacco control requires long term strategic commitment in eight key areas, six as identified by the World Bank www.worldbank.org/ and two others as proposed by Fresh www.freshne.com/ , the North East England Regional tobacco control office. These eight areas ensure the mechanisms are in place to drive the agenda forward. This 10 year plan outlines how partners working together can help Gateshead achieve this vision. A snapshot of actions under each area is shown below.

1. **Developing infrastructure, skills and capacity at local level and influencing national action.**

lliance overseeing 10 year tobacco plan

Support of Fresh, Regional tobacco control office

2. **Reducing exposure to second hand smoke.**

Maintain compliance with current smokefree legislation and Increase public support for Smoke Free areas and Homes e.g. Smoke Free Homes focus and Increase in smoke free outdoor zones in public areas across Gateshead.

3. **Supporting smokers to stop.**

Encourage an environment where more and more smokers decide to quit, regardless of how. Target support to Stop Smoking for disadvantaged groups/communities. Also look to reduce harm through support for evidence based harm reduction.

Stop smoking support to become a key offer across the NHS in Gateshead.

4. **Media communications and social marketing.**

Support year round media and public relations on tobacco issues and increase stakeholder communications on tobacco issues.

5. **Reducing the availability of tobacco products and reducing supply of tobacco.**

Deliver an intelligence led and targeted enforcement programme to reduce availability and supply of tobacco products to children.

Support advocacy efforts for licensing for whole tobacco retail and supply chain.

6. **Reducing the promotion of tobacco.**

Ensure compliance with legislation to reduce tobacco promotion (e.g. Plain packaging) and advocate for further restrictions.

7. **Tobacco Regulation.**

Ensure partner involvement in lobbying activity when required in response to tobacco and nicotine regulation issues.

8. **Research, Monitoring and evaluation**

Research into equity of delivery and uptake of Stop Smoking Services

A vision to reduce smoking prevalence in Gateshead to 5% by 2025

Tobacco Control - The Challenge

Smoking is the biggest preventable cause of death globally, killing half of all smokers prematurely. In the 20th century, the tobacco epidemic killed 100 million people worldwide. During the 21st century, it could kill one billion. http://www.fctc.org/fca-news/general-news/795-what-is-the-death-clock Smoking causes 50 different conditions and costs the NHS £2.7 billion to treat every year. Tobacco is a leading cause of health inequalities and is responsible for half the difference in life expectancy between rich and poor.

Tobacco is unique. It is the only product that kills when it is used entirely as intended. Tobacco is not abused. It is marketed by the tobacco industry to be smoked and inhaled. In doing this, it kills half of its consumers.
(Tobacco Control Advocacy toolkit – A guide to Planning Advocacy activity to tackle tobacco 2010)

In 2011 the government published the White paper 'Healthy Lives, healthy People: A Tobacco Control Plan for England" https://www.gov.uk/government/publications/the-tobacco-control-plan-for-england. A five year plan which under the leadership of local authorities, the government wanted to encourage the development of partnerships in tobacco control where anyone who can make a contribution is encouraged to get involved. In implementing comprehensive tobacco control in their communities, they encourage local authorities to maximise local involvement by building tobacco control alliances that include civil society. The Government are in the process of writing a new Tobacco Control Plan and this is due to be published in the New Year 2017. Initial indications are there will be a big focus on tackling health inequalities.

While the Public Health Outcomes Framework http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042 will provide the key source of information about progress on reducing tobacco use, the government set three national ambitions to focus tobacco control work across the whole system:

- *Reduce smoking prevalence among adults in England: To reduce (aged 18 or over) smoking prevalence in England to 18.5 % or less by the end of 2015, meaning around 210,000 fewer smokers a year*
- *Reduce smoking prevalence among young people in England: To reduce rates of regular smoking among 15 year olds in England to 12% or less by end of 2015*
- *Reduce smoking during pregnancy in England: To reduce rates of smoking throughout pregnancy to 11% or less by the end of 2015*

(HM Government 2011 Healthy Lives, Healthy People: A Tobacco control Plan for England)

All three of these targets shown below have been met, building on the progress that has been made in the past 10 years where we have seen smoking prevalence in Gateshead fall from 33% in 2006 to the current 18.3% in 2016. This has been achieved by adopting an

evidence based, comprehensive approach to tobacco control and has been well received by the public. Recent You Gov surveys show there is great support to do more and go further, with policies that protect children and young people particularly popular. There is also strong agreement for banning smoking in hospital grounds.

Smoking and young people

Smoking among young people is associated with a range of factors, operating at individual, social, community and societal levels, which increase children's and young people's risk of becoming smokers. In particular, smoking uptake is linked to disadvantaged social, educational and economic trajectories. Young people are most at risk of becoming smokers if they grow up in families and communities where smoking is the norm and where they have access to cigarettes. Children whose parents and/or siblings smoke are more likely to become smokers.

The most effective way to reduce youth smoking rates is to change the adult world. Smokfree legislation of 2007 has seen a reduction in Adult smoking prevalence and therefore less role models for young people in our communities. Level of smoking amongst young people is at an all-time low with targets to reduce rates of regular smoking among 15 year olds in England to 12% or less by end of 2015 met and surpassed. Our biggest priority over the next 10 years, and most effective way to reduce smoking in young people, is to support more adults to stop smoking.

Exposure to Secondhand smoke

Disadvantaged children, young people and adults are also likely to be exposed to higher levels of second-hand smoke (SHS) than those from more privileged backgrounds. This is due to lower levels of smoking restrictions in the home. More action is needed to protect these vulnerable groups from SHS exposure where they live, in cars and in Public Places. Action is needed to prevent smoking uptake in children, to help vulnerable adults to quit and to protect children and adults from SHS.

Smoking Prevalence in Gateshead

Smoking prevalence in Gateshead in adults aged 18+ years is 18.3% (Tobacco Control Profile http://www.tobaccoprofiles.info/tobacco-control). Amongst Routine and Manual Groups this rises to 25.6%. Smoking is far more common among unskilled and low income workers than among professional high earners. The more disadvantaged someone is, the more likely they are to smoke and to suffer from smoking-related disease and premature death. Smoking affects health inequalities across many other axes. The poorer health of people in the north of England compared to the south is in part due to higher rates of smoking in the north. Smoking rates are also higher among people with a mental health condition, prisoners, looked-after children, and LGBT people (ASH, 2016).

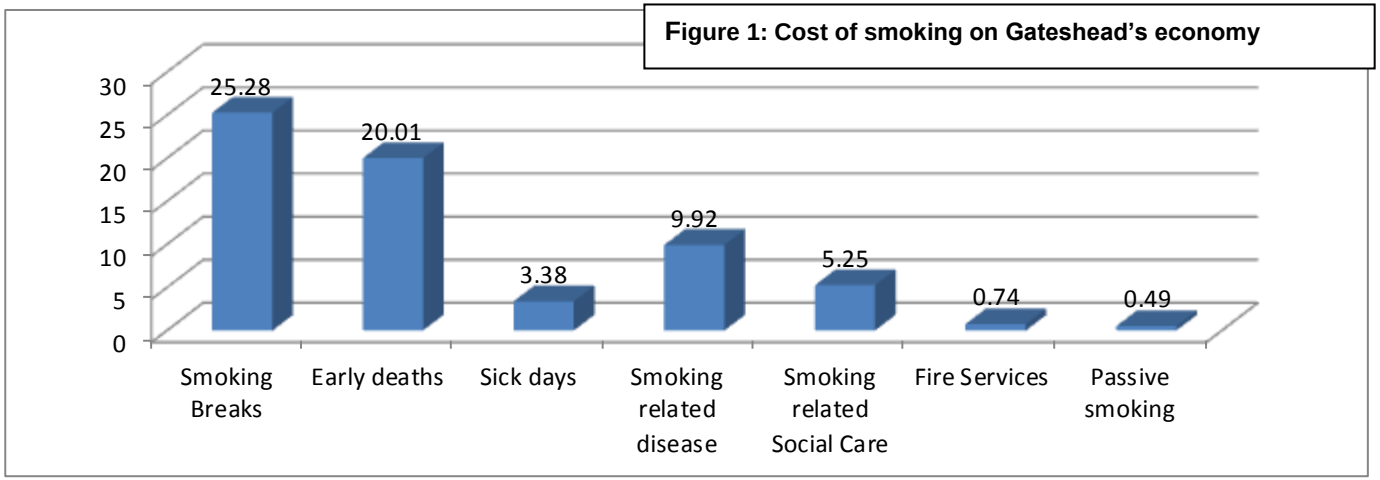
Health inequalities will be reduced though measures that have a greater effect on smokers in higher prevalence groups. In practice, this means both prioritising population level interventions which disadvantaged smokers are more sensitive to and targeting interventions on these smokers.

Smoking and impact on Gateshead residents

How much is smoking costing Gateshead

The total annual cost of smoking in Gateshead is £65.1m, that's £1,936 per smoker / year. This is broken down as shown in the graph below. This cost is in comparison to a total contribution in tobacco duty of £34.79m, leaving a shortfall and cost to society of just over £30m every year.

Figure 1: Cost of smoking on Gateshead's economy



Early deaths due to smoking result in 1,117 years of lost productivity and a cost of £20m in Gateshead. There are also 37,876 days of productivity lost because of smoking related sick days, at a cost of £3m. (ASH: 2015).

23,712 Gateshead households have at least one smoker, 34% of which fall below the poverty line. If smokers stopped and the money was recirculated back into the household budget, it would lift around 2,655 Gateshead homes, 4,434 Gateshead people, out of poverty (ASH Ready Reckoner, 2015).

Illicit tobacco sales account for approximately 5% of sales. This is money going into the hands of criminal gangs, avoiding duty and tax. There is strong Public support to curb the sale of Illicit tobacco.

A person who smokes on average 20 cigarettes a day spends between £2,190 and £3,000 on smoking each year, that's between £10,950 and £15,000 after five years.

The Local Tobacco Control Profiles for England, Public Health England (2016), is a tool that provides a snapshot of the extent of tobacco use, tobacco related harm, and measures being taken to reduce this harm at a local level. These profiles have been designed to help local government and health services to assess the effect of tobacco use on their local populations. They will inform commissioning and planning decisions to tackle tobacco use and improve the health of local communities.

The tool allows local authorities to benchmark against other local authorities in the region and the England average. The table below compares Gateshead with the England average. The red rectangles show where Gateshead is worse than the England average, with Smoking attributable mortality, smoking attributable hospital admissions and smoking at delivery worse than the national averages. However smoking at time of delivery is equal lowest in the Region at 13.2%.

Compared with benchmark Better | Similar | Worse | Not compared

Table1. Tobacco Control Profiles for England - Gateshead results

Indicator	Period	England	North East region	County Durham	Darlington	Gateshead	Hartlepool	Middlesbrough	Newcastle upon Tyne	North Tyneside	Northumberland	Redcar and Cleveland	South Tyneside	Stockton-on-Tees	Sunderland
Smoking Prevalence in adults - current smokers (APS)	2015	16.9	18.7	19.0	17.9	18.3	22.8	20.8	18.6	18.0	16.6	17.2	17.4	18.4	21.5
Smoking Prevalence in adults in routine and manual occupations - current smokers (APS)	2015	26.5	26.5	24.5	24.5	25.6	28.1	31.1	25.1	26.5	26.7	25.5	24.0	29.3	29.4
Successful quitters at 4 weeks	2015/16	2598	2972	3545	2286	3328	3252	2147	1728	2184	2322	2478	4555	3282	3824
Smoking status at time of delivery	2015/16	10.6*	16.7*	18.1	14.8	13.2*	18.1	19.8	13.2*	13.2	15.0	19.8	21.8	18.1	18.0
Smoking attributable mortality	2012 - 14	274.8	359.1	367.8	311.4	398.2	390.2	410.8	361.8	345.7	300.3	351.7	391.3	319.8	401.7
Smoking attributable hospital admissions	2014/15	1671	2446	2236	1770	2710	2643	2508	2663	2727	2119	2280	2751	2401	2829
Supporting information - Deprivation score (IMD 2015)	2015	21.8	-	25.7	23.6	25.9	33.2	40.2	28.3	21.3	20.5	28.6	30.6	24.6	29.7

Reducing smoking prevalence in Gateshead

The aim of tobacco control is to make smoking less **desirable, accessible** and **affordable**. In Gateshead the aim is to improve health and reduce health inequalities by reducing the number of smokers. This will be achieved by preventing the uptake of smoking and assisting those who want to stop.

Delivering evidence based tobacco control requires long term strategic commitment to ensure the mechanisms are in place to drive the agenda forward. The vehicle to deliver this then relies on the commitment of a range of partners understanding and supporting the evidence and coming together in the form of a local tobacco control alliance.

Reducing smoking prevalence and reducing the use of tobacco will help Gateshead to:

- Cut costs to local public services
- Protect children from harm
- Boost the disposable income of the poorest people
- Reduce health inequalities
- Drive real improvement across key measures of population health

As identified by Public Health England (2016) the examples of indicators which would be positively affected include:

- Sickness absence
- The number of children in poverty
- Numbers of low birth-weight babies
- Pregnant women smoking at time of delivery
- Smoking prevalence rates in adults and children
- Infant mortality and all cause preventable mortality
- Mortality from cardiovascular disease
- Mortality from cancer
- Mortality from respiratory disease
- Preventable sight loss

We are already seeing the benefits to the health of Gateshead's population through the reduction in smoking prevalence and the reduction in exposure to secondhand smoke over the past years, especially since smoke free legislation was put in place in 2007.

To continue to reduce smoking prevalence further, there needs to be a long term commitment to achieve a vision of *Making Smoking History*. Making Smoking History in Gateshead means a commitment to improve health, reduce health inequalities by reducing the death, disability and disease caused by smoking.
Smokers that manage to quit reduce their lifetime cost to the NHS and social care providers by 48%. The biggest short-term savings opportunity lies in helping smokers who are in contact with the NHS; the greatest long-term savings would come from preventing people from ever smoking altogether (PHE 2016).

Our Vision is for Smoking Prevalence of 5% or below in Gateshead by 2025

This tobacco action plan therefore supports this vision over a ten year period, 2016 – 2025, and aspires to reducing smoking prevalence to 5% in adults, pregnant women and children and young people by 2025.

According to ASH (2012) effective tobacco control requires three domains; **C**hallenge tobacco control services; Local **lea**dership and **R**esults demonstrated by outcomes.

Taken from ASH (2012) **CLeaR** Thinking Excellence in local tobacco control

A CLeaR review was initiated in July 2016 with Alliance members working in partnership with H&WB Board members. The CLeaR Self-assessment looked at 11 key areas which are identified to contributing to a successful tobacco alliance and a diagram identifying its strengths and weaknesses is shown in **Appendix 1.** The findings and recommendations of this review were shared in a paper to the H&WB

Board in October 2016 to enable partners to comment on the strengths and areas for improvement for the alliance. The key recommendations identified in the paper were:

1 Continue the excellent work being delivered around Compliance, including initiatives to tackle illegal tobacco, enforcement and compliance with existing legislation such as Plain Packaging and support work at National and Regional level around Licensing of Retailers.

2 Review the impact on Stop Smoking Services with the move from support from external providers via a Hub to support from Council teams. There is a need to identify positive aspects but also be vigilant for any unexpected downturn in trajectories for access and outcomes.

3 Prevalence is at an all-time low but we have still got to achieve a further 13% reduction to hit the Vision and target of 5% smoking prevalence by 2025. This will require targeted work with specific groups with high smoking prevalence rates such as pregnant women, Mental Health issues and low income groups/communities. Support of FRESH at Regional level is an important contribution to achieving this target.

4 Support at Leadership level needs to be enhanced across all partner organisations and there are opportunities to enhance the Gateshead Health and Wellbeing strategy which is currently being refreshed for 2016 – 2019. There is also the potential for getting the issue onto the Health Overview Scrutiny Committee (OSC) forward plan to enable them to scrutinise progress towards the 2025 target.

5 Leadership could also be taken by ensuring that partner organisations work towards the 5% target using their existing commissioning arrangements but also looking at potential innovation. Two examples might be:

5.1 The CCG including implementation of NICE guidelines on Tobacco into all provider contracts e.g. Continuation of Baby Clear model for Midwifery Departments.

5.2 Commissioning secondary care based Stop Smoking Service. This could include the implementation of a “Stop before the Op” intervention.
Case study: a briefing on the short-term benefits of preoperative smoking cessation in London modelled up to 5,300 fewer post op complications, resulting in up to 4,000 bed days saved, £1.1m savings to commissioners and up to £2.8m savings to hospital trusts.

Implementing NICE guidance PH45 within treatment / care pathways is recommended. This supports a programme of harm reduction enabling temporary abstinence or smoking reduction, such as a ‘stop before the op’ initiative. This improves medical outcomes and reduces complications.

The Gateshead Smokefree Tobacco Control Alliance brings together partners from across the Borough to work together to implement action locally. If we are serious about achieving 5% smoking prevalence by 2025 all partners will need to work together to achieve the end target. The benefits for the health of the Gateshead population are great and will help to improve outcomes in relation to all the indicators identified on page 6 of the report above.

The 10 Year action plan is developed around the World Health Organisations (WHO) key targets from their Framework Convention on Tobacco Control (FCTC) and the seven articles identified below:

- Article 20 – Research, surveillance and exchange of information (Monitoring)
- Article 8 – Protection from exposure to tobacco smoke (Smoke-free environments)
- Article 14 – Demand reduction measures concerning tobacco dependence and cessation (Cessation programmes)
- Article 11 – Packaging and labelling of tobacco products (Warning labels)
- Article 12 – Education, communication, training and public awareness (Mass media)
- Article 13 – Tobacco advertising, promotion and sponsorship (Advertising bans)
- Article 6 – Price and tax measures to reduce the demand for tobacco (Taxation)

The additional strand of developing local infrastructure is added to oversee and drive the agenda at local level and to establish the effectiveness of the work. Action needs to happen in each of these eight strands to give Gateshead every chance of achieving their aim.

The Eight key areas of the 10 year plan are therefore:

1. Developing infrastructure, skills and capacity at local level and influencing national action.
2. Reducing exposure to second hand smoke.
3. Supporting smokers to stop.
4. Media communications and social marketing.
5. Reducing the availability of tobacco products and reducing supply of tobacco.
6. Reducing the promotion of tobacco.
7. Tobacco and Nicotine Regulation.
8. Research, Monitoring and evaluation

Next Steps – Progress to 2025

Although the plan is a 10 year action plan with key activity to get us to 5% prevalence by 2025, it will have an annual refresh in April because as policy changes the plan will have to change with new directions at local, Regional and National level.

The plan will be overseen by the Gateshead Smokefree Tobacco Alliance and will report up to the Gateshead Health and Wellbeing Board on an annual basis and as requested by the Board.

Gateshead 10 Year Tobacco Control Plan

2016 -2025

Area 1: Developing Infrastructure, skills and capacity at local level and influencing national action.					
Objective	**Milestone End of Quarter**	**Performance measure**	**Lead officer / Delivery partner**	**Performance RAG**	**Update Reports Quarter One**
Develop a sustainable 10 year Tobacco Control Action plan for Gateshead with engagement and representation from key partners. DPH Annual Report 2015/16 Recommendation 2 **Note:** The plan will support the Government's 2017 updated Tobacco Control plan DPH Annual Report 2015/16 Recommendation 1	December 2016 - December 2025	Action Plan developed and signed off by H&WB Board By January 2017	Gateshead Smoke Free Tobacco Control Alliance partners		
Conduct Annual refresh of the plan and report progress up to the Health and Wellbeing Board.	Annual Review in April each year	Plan review conducted and amendments made where identified.	Public Health lead		
The objectives of the plan, by 31 March 2025, are to:					
Reduce smoking prevalence	18.3% in 2016	5% prevalence by 2025	Public Health		

among adults 18 year + by 1.5% per year to 5% by 2025.	13.8% in 2019 9.3% in 2022 5% in 2025		lead		
Reduce smoking prevalence in routine and manual groups by 2.3% per year to 5% by 2025 DPH Annual Report 2015/16 Recommendation 3	25.6% in 2016 18.7% in 2019 11.8% in 2022 5% in 2025	5% prevalence by 2025	Public Health lead		
Reduce smoking prevalence among young people (15 year olds) by 0.8% per year to 5% by 2025	12.4% in 2016 10% in 2019 7.6% in 2022 5% in 2025	5% prevalence by 2025	Public Health lead		
Reduce smoking during pregnancy by 0.9% per year to 5% by 2025 DPH Annual Report 2015/16 Recommendation 5	13.2% in 2016 10.5% in 2019 7.8% in 2022 5% in 2025	5% prevalence by 2025	Gateshead Health NHS Foundation Trust Public Health		

Show progress in tackling local inequalities in smoking rates on a year by year basis. DPH Annual Report 2015/16 Recommendation 3	Faster decline in smoking rates in Routine and manual groups than the general smoking population (as above)	National data e.g. Annual Population survey (APS) Health Equity Audit	lead Public Health lead and Intelligence team.		
Local Authority budget for wider tobacco control and enforcement activities, including those to tackle underage sales and illicit tobacco, should be protected. DPH Annual Report 2015/16 Recommendation 6 Commit to support of evidence based sub national Tobacco Programme. DPH Annual Report 2015/16 Recommendation 13	April 2016 - 2017 and ongoing	Budgets protected at 2016/17 levels. 1 year funding commitment 2017/18	Gateshead Council Public Health Gateshead Council Public Health		
Implementation of the findings from 2016 “Clear Thinking: Excellence in	Dec 2016 onwards	Feedback report to H&WB Board.	Gateshead Council, Public Health		

tobacco control" peer Assessment		Review of alliance action plan and dissemination.	Tobacco Alliance lead.		
Link Gateshead Smokefree Tobacco Control Alliance with Regional Networks focussing on specific areas of tobacco control.	Quarterly Forums	Alliance member attendance at Smokefree North East Network meetings, North East Tobacco Regulation Forum and North East Tobacco Commissioners group. Also attendance at the Regional Making Smoking History partnership.	Fresh Gateshead Smokefree tobacco Control Alliance members.		
Ensure regular (as newsworthy issues arise) briefings for the 3 to 4 key people in Gateshead Local Authority area who have been trained in working with the Media so that they are up to date with current tobacco issues. Link to Fresh Media contact and Press Releases from Fresh.	2017/2018 and ongoing.	Number of briefings given to media contacts and outcome of this e.g. Media coverage.	Fresh Gateshead Smoke Free Tobacco Control Alliance partners		
Alliance partner organisations to share Intelligence to support wider	Quarterly	Actions taken on back of intelligence shared by partners or through the	Fresh Gateshead		

tobacco control – *see section 5* "Reducing the availability of tobacco products and reducing supply of tobacco".		"Keep it Out" website	Smoke Free Tobacco Control Alliance partners		
Ensure and report delivery on performance through governance framework. e.g. Council Overview and Scrutiny (OSC)	2017/2018	Oversight from OSC	Alliance lead within Public Health		
Lobby/provide support for a Levy on Tobacco companies, based on local sales volumes, to support Tobacco Control activities in Gateshead. DPH Annual Report 2015/16 Recommendation 4	As this becomes a national issue.	Submissions of support to government in support of Tobacco Levy on tobacco companies' profits.	Gateshead Smoke Free Tobacco Control Alliance partners.		
Supporting the NHS through its local Sustainability and Transformation Plan (STP) to reduce the burden of smoking on the NHS.	2016 onwards	Reducing smoking prevalence a key target in the Northumberland, Tyne and Wear and North Durham Sustainability and Transformation Plan (STP)	Newcastle Gateshead CCG		
Implement Framework Convention for Tobacco Control directive 5.3 (i.e. not	31 March 2017	Partners do not engage / promote tobacco companies in their work.	Gateshead Smoke Free Tobacco		

engaging /promoting tobacco companies in the work of the partners of the Alliance) by March 2017		Gateshead have already signed the local government declaration and NHS Statement of support for tobacco control and these need to be revisit in 2020 and 2025 to look what has been achieved by these.	Control Alliance partners		
Area 2: Reducing exposure to secondhand smoke (SHS)					
Objective	**Milestone End of Quarter**	**Performance measure**	**Lead officer / Delivery partner**	**Performance RAG** 	**Performance**
De-normalise smoking by increasing public support for SF areas e.g. Increase in smoke free outdoor zones in public areas across Gateshead including; pubs and restaurants, playgrounds, school gates and workplace grounds from 01 April 2017 baseline. DPH Annual Report 2015/16 Recommendation 10 & 11	April 2017 onwards	Increase in number of smoke free places across Gateshead. Number of awareness campaigns. Public Survey of support.	Gateshead Smoke Free Tobacco Control Alliance partners Fresh Gateshead		

Support Environmental Health colleagues in maintaining compliance with current smokefree legislation including enclosed public places, workplace vehicles and private vehicles carrying children under 18. Link in with North East Tobacco Regulation Forum on smokefree discussions.	April 2017 onwards	Environmental Health representative on Alliance to inform Alliance members of activity where they can support. Alliance partners linking with Council Environmental Health colleagues on Tobacco control initiatives.	Environmental Health representative. Gateshead Smoke Free Tobacco Control Alliance partners.		
Increase the proportion of homes occupied by adult smokers and dependent children that are smokefree to *% by 2020 **Note:** Need baseline. Continue support for the new law which bans smoking in cars that are carrying children. DPH Annual Report 2015/16 Recommendation 8	April 2017 onwards April 2017 onwards	Percentage of smoke free homes increases year on year. Smoking in Cars that are carrying children becomes socially unacceptable	Gateshead Smoke Free Tobacco Control Alliance partners. Gateshead Smoke Free Tobacco Control Alliance partners.		
Awareness raising of the harms of SHS led by young people from Gateshead.	April 2017	Issue raised by x number of members to x number	Gateshead Youth Parliament		

		of meetings.	Gateshead Young People		
Develop, Deliver and evaluate a programme of training to deliver brief interventions to all smokers in a full range of settings across Gateshead. Ensure programme includes smoking in homes, smoking in Cars and other closed environments. DPH Annual Report 2015/16 Recommendation 8	April 2017 onwards	Number of people trained in delivering brief advice. Number of people delivering brief interventions as a result of training. Number of people accessing support following a brief intervention.	Gateshead Stop Smoking Service. Making Every Contact Count lead.		
Area 3: Supporting smokers to stop "More Smokers to Quit"					
Objective	**Milestone End of Quarter**	**Performance measure**	**Lead officer / Delivery partner**	**Performance RAG**	**Update Reports Quarters One**
Target Stop Smoking Services to disadvantaged groups/communities e.g. people with Mental Health issues, people who are Homeless and people with Long Term conditions, ensuring that smokers	July 2017 – March 2018	Establish process to capture service access by disadvantaged groups and establish a baseline measure for each. Rates of access and success are better in	Public Health Intelligence Public Health Tobacco lead		

receive stop smoking interventions as a routine part of their care. DPH Annual Report 2015/16 Recommendation 3 Evaluate availability and access to Stop Smoking Services to see if offer is equitable.	 July 2018 for 2017 / 2018 delivery.	areas of deprivation/ more deprived groups than less deprived areas/groups. Rates of access and success are better in areas of deprivation/ more deprived groups than less deprived areas/groups.	 Public Health Intelligence Public Health Tobacco lead		
Encourage and support communities to identify and develop initiatives to address tobacco harm at local level. DPH Annual Report 2015/16 Recommendation 17	2017 onwards	Number of initiatives initiated and outcomes delivered.	Capacity Building Service and Public Health.		
Reduce number of women smoking in pregnancy from 2015/16 baseline to 5% by 2025 (see above). Assess all pregnant women for Carbon Monoxide to identify potential smoking and refer for specialist support. Healthcare professionals screen all pregnant women at ante-natal appointments and refer	2016/17 13.2% in 2016 10.5% in 2019 7.8% in 2022 5% in 2025	Support of Baby Clear model implementing NICE Guidance on smoking in Pregnancy. Smoking at time of delivery data Baseline for 2015/16=18.6%	Gateshead Health NHS Foundation Trust		

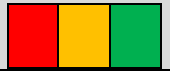
women with elevated levels to specialist services. NICE PH26 DPH Annual Report 2015/16 Recommendation 5					
Newcastle Gateshead CCG to include Stop Smoking support in contracts with secondary care providers and primary care providers Preventing ill health - alcohol and tobacco CQUIN for 2017-19, https://www.england.nhs.uk/wp-content/uploads/2016/12/prevention-cquin-supplmnt-guid.pdf (PHE 2016) DPH Annual Report 2015/16 Recommendation 3	2017/18 onwards	CCG include requirement for stop smoking support in secondary care contracts. Number of smokers successfully supported to stop smoking by QE, NTW staff and Primary Care contractors	Newcastle Gateshead CCG		
Screen and refer smoking patients to stop smoking services in Acute Trusts. Stop smoking support to become a key offer at the Queen Elizabeth hospital in Gateshead including a Stop before the Op Initiative and	2016/17 onwards	Number of smokers successfully supported to stop smoking by QE staff	Gateshead Health NHS Foundation Trust Newcastle Gateshead CCG		

care pathways. Support also available to Gateshead residents in NTW facilities.			NTW		
• CCGs commission NHS trusts to integrate NICE guidance PH48 on smoking cessation into all secondary care pathways. DPH Annual Report 2015/16 Recommendation 14	01 April 2017 onwards	Number of smokers successfully supported to stop smoking by QE staff.	Gateshead Health NHS Foundation Trust Newcastle Gateshead CCG		
• Trusts to implement NICE guidance PH45 “Smoking: Harm reduction” and provide support for temporary abstinence for smokers unready to stop smoking completely or permanently.	01 April 2017 onwards.	Number of smokers successfully supported to stop smoking by QE and NTW staff.	Gateshead Health NHS Foundation Trust. NTW NHS Foundation Trust		
• All patients in secondary care are screened so people who smoke are identified at each episode of treatment and offered advice and referral. Ensure that the care plan at discharge of patients who smoke addresses their tobacco dependence Making Every Contact Count	01 April 2017 onwards.	Number of smokers successfully supported to stop smoking by QE and NTW staff.	Gateshead Health NHS Foundation Trust. NTW NHS Foundation Trust		

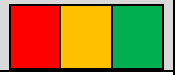
requirement SC8 in the NHS Standard Contract DPH Annual Report 2015/16 Recommendation 14 &16 • Trust staff can use an electronic referral system, to provide automatic referral to local Stop Smoking Services. DPH Annual Report 2015/16 Recommendation 3 • Local Authorities commission local Stop Smoking Services to provide high-quality smoking cessation support to referred patients. DPH Annual Report 2015/16 Recommendation 12	01 April 2017 onwards. 01 April 2017 onwards.	Number of smokers successfully supported to stop smoking by QE staff. Stop smoking services available to local smoking population.	Gateshead Health NHS Foundation Trust. Public Health		
SmokeFree NHS Premises CCGs require acute trusts to implement smokefree policies on estate grounds and support staff to encourage compliance with the policy with staff trained to facilitate smoking cessation.	2017 onwards	No smoking on NHS Trust grounds	Newcastle Gateshead CCG		

Reduce rates of smoking in those people with a Serious Mental Illness (SMI) • Smoke Free premises and grounds	April 2017 onwards	Reduction in the number / percentage of people with a SMI that smoke.	Northumberland, Tyne and Wear NHS Foundation Trust.		
Review any medicinally licensed novel nicotine products and make them available to smokers looking to quit, dependant on efficacy and cost.	December 2016 onwards	Reviews conducted and recommendations made on availability to smokers in Gateshead.	Tobacco commissioning lead in Public Health		
Ensure that key health professionals are equipped to provide accurate, high quality information and advice to smokers about the relative risks of nicotine and all nicotine containing products. DPH Annual Report 2015/16 Recommendation 16	December 2016 onwards • 2 training courses delivered over a calendar year.	Training provision to Active Intervention providers on nicotine containing products.	Tobacco commissioning lead in Public Health		
Consider offering harm reduction approaches to smokers who don't feel able/ready to quit abruptly, following the 4-week quit model. Develop local commissioning metrics for evaluating SSS activity	April 2018	Harm reduction approaches offered to a small number of smokers unable to stop smoking but where benefit outweighs costs.	Tobacco commissioning lead in Public Health		

which falls under this harm reduction approach. NICE Guidance PH45					
Deliver a programme of training in Stop Smoking to a range of professional and community based organisations across Gateshead. DPH Annual Report 2015/16 Recommendation 16	April 2017 onwards	Number of people trained. Number of people referring members of the public for support.	Public Health		
Local Authority budget for Stop Smoking service provision should be protected and services should be provided in a range of settings accessed by those at greatest risk. DPH Annual Report 2015/16 Recommendation 12	April 2017 onwards	Budget protected at 206/17 levels	Director of Public Health		
Ensure that action on smoking is embedded in all other relevant plans e.g. Cancer and Long Term Conditions strategy. DPH Annual Report 2015/16 Recommendation 15	April 2017 onwards	Relevant pathways to include action on smoking.	HWB members. Newcastle Gateshead CCG		
Embed NICE Guidance PH23 “Smoking Prevention	April 2017 onwards	Gateshead schools compliant with NICE	Public Health Team		

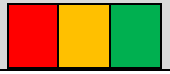
in Schools" across all Gateshead schools DPH Annual Report 2015/16 Recommendation 9		Guidelines PH23.			
Partner organisations on the Gateshead Health and Wellbeing Board should act as exemplars and offer their staff opportunities to access support to stop smoking services, including time to attend appointments.	April 2017 onwards	Numbers of employees in partner organisation that access stop smoking services increases.	HWB Partners		
Area 4: Media, communications and social marketing					
Objective	**Milestone End of Quarter**	**Performance measure**	**Lead officer / Delivery partner**	**Performance RAG** 	**Update Reports Quarter One**

Support all national and regional media and PR activities relating to tobacco control. e.g. *Don't be the 1*, *Smokefree play areas*, *Smokefree cars*, *Stoptober, No Smoking Day*. DPH Annual Report 2015/16 Recommendation 13	Continued support of Fresh, tobacco control office for the North East.	No. of Campaigns supported. Media articles achieved.	Fresh		
Involve young people in tobacco campaigns via youth projects e.g. Promote the adverse effects of illicit tobacco giving young people an easier and cheaper route into addiction, Raise awareness of the promotion of smoking in films and Link campaigns with existing youth and community work and social media.	March 2016	Campaign involvement	Gateshead Youth and Community Service		
Partners of the Health and Wellbeing Board and Gateshead Smokefree Tobacco Alliance to offer advice and opportunities for members of the public to	April 2017 onwards	Stop Smoking support offered in all communications with the public when accessing health related appointments.	Gateshead Smokefree tobacco alliance Gateshead		

stop smoking in stakeholder communication where relevant. E.g. Any health related appointment or communication.			Health and Wellbeing Board.		
Review of stop smoking service communications plan and develop robust marketing plan in partnership with Fresh.	June 2017 onwards	New communications plan developed	Public Health, Stop Smoking Lead, Gateshead Council Fresh		
Ensure implementation of NICE Guidance on smoking prevention and preventing uptake of smoking	March 2017	NICE Guidance being implemented.	Public Health Tobacco Lead		
Develop a bank of client case studies for media purposes	Ongoing	No. of case studies used	Local Gateshead Stop Smoking Services.		
Area 5: Reducing availability of tobacco products and reducing the supply of tobacco "Enforcement"					
Objective	**Milestone End of Quarter**	**Performance measure**	**Lead officer / Delivery partner**	**Performance RAG** 	**Update Reports Quarters One**
Deliver an intelligence led	Enforcement	% failure in test	Trading		

and targeted enforcement programme to reduce availability and supply of tobacco products to children DPH Annual Report 2015/16 Recommendation 7	programme conducted	purchasing. No of complaints No of enforcement actions	Standards, Gateshead Council		
Working in partnership and using local, regional and national intelligence sources to plan and deliver special operations and targeted interventions tackling illicit, counterfeit, bootlegged and smuggled tobacco products. DPH Annual Report 2015/16 Recommendation 7	Annual enforcement programme	No of enforcement actions and quantity of tobacco products seized.	Regional Office of Tobacco Control Trading Standards		
Ensure representation on North East Tobacco Regulation Forum.	Quarterly	Feedback to the Alliance	Trading Standards lead Gateshead Council		
Support National moves / lobbying to introduce a licensing regime to cover the whole tobacco supply chain including manufacturers, distributors and retailers with a bill of responsibility lying on the tobacco	When Fresh / ASH communicate/request requirement for action.	Peter Wright Catherine Taylor	Trading Standards lead Gateshead Council. Gateshead Smokefree		

multinationals DPH Annual Report 2015/16 Recommendation 7			tobacco alliance		
Alliance partner organisations to share Intelligence to support wider tobacco control e.g. Tab houses, Proxy sales, Non-compliance with Smokefree (SF) law, Non-compliance with local policies. Trading Standards to communicate ways to share information.	As and when information becomes available.	Number of reports shared by Alliance partners with Council Trading Standards / Environmental Health Team.	Gateshead Smokefree tobacco alliance members.		
Support the Illicit Tobacco Partnership see www.illicit-tobacco.co.uk	April 2017 ongoing	Attendance at the partnership by member(s) of Gateshead Smoke Free tobacco alliance.	Gateshead Smoke Free tobacco alliance members.		
Promote the Illicit Tobacco reporting line (0300 999 0000)	April 2017 onwards.	Examples of promotion recorded.	Gateshead Smoke Free tobacco alliance members.		
Promote the website/ initiative to tackle Illicit tobacco www.keep-it-out.co.uk	April 2017 onwards	Examples of promotion recorded.	Gateshead Smoke Free tobacco alliance		

			members.		
Deliver a programme of intelligence led and targeted interventions to ensure compliance with legislation e.g. Standardised packaging. DPH Annual Report 2015/16 Recommendation 7	April 2017 onwards	No. of awareness campaigns, visits and enforcement actions.	Trading Standards Gateshead Council. Fresh		
Area 6: Reducing the promotion of tobacco					
Objective	**Milestone End of Quarter**	**Performance measure**	**Lead officer / Delivery partner**	**Performance RAG** 	**Update Reports Quarters One**
Ensure partner involvement in lobbying activity in response to tobacco promotion issues at local, Regional and National level. DPH Annual Report 2015/16 Recommendation 2	March 2017 March 2018 March 2019 March 2020	Submissions from Smokefree Gateshead Tobacco Alliance to all national consultations relating to tobacco.	Smokefree Gateshead Tobacco Alliance Chair		
Exposure of the Tobacco Industry tactics, how they		No. of training sessions offered	All Partners		

promote to young people Use local networks/media/ training opportunities					
Prevent the tobacco industry targeting young people Ensure compliance with tobacco promotions in pubs and clubs - Work with schools	March 2016 onwards	Reporting of any non-compliance	Public Health		
Area 7: Tobacco Regulation					
Objective	**Milestone End of Quarter**	**Performance measure**	**Lead officer / Delivery partner**	**Performance RAG**	**Update Reports Quarters One**
Actions to Support Tobacco Regulation Ensure partner involvement in lobbying activity when required in response to tobacco regulation issues • Support for licensing of tobacco sales (see above) • Tobacco Taxation	Response submitted to each issue which is brought forward by MP's,	Response submitted to each issue which is brought forward by MP's, following ASH'S LEAD Nationally and Fresh's lead Regionally	Smokefree Gateshead Tobacco Alliance Chair.		

above rate of inflation (Annual duty escalator) • Tobacco Levy to support local and Regional Tobacco Control work. (see earlier)					
Area 8: Research Monitoring and evaluation					
Objective	**Milestone End of Quarter**	**Performance measure**	**Lead officer / Delivery partner**	**Performance RAG** 	**Update Reports Quarters One**
Research into equity of delivery and uptake of Stop Smoking Services (see above).	2017 / 2018	Health Equity audit conducted of access to stop smoking services and outcomes.	Public Health, Stop Smoking Lead, Gateshead Council Public health Intelligence.		
Track smoking prevalence of adults, smoking at time of delivery (SATOD) rates	2017 / 2018	Public Health Outcomes Framework.	Public Health, Stop Smoking Lead,		

along with youth rates (15 year olds) - No Young People starting to smoke.		'What about YOUth' survey (Health and Social Care Information Centre)	Gateshead Council Public health Intelligence.		
Monitor any increase in uptake of stop smoking support in secondary care (see above) and Monitor referrals Baseline 2016/17	March 2017 Sept 2017 Dec 2017 March 2018	Number of smokers referred and proportion that go on to set a quit date	Public Health, Stop Smoking Lead, Gateshead Council Public health Intelligence.		

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Framework Convention on Tobacco Control (2003): World Health Organisation http://apps.who.int/iris/bitstream/10665/42811/1/9241591013.pdf?ua=1

Tobacco Control Advocacy toolkit – A guide to Planning Advocacy activity to tackle tobacco: (2011): GASP http://www.gasp.org.uk/

Healthy Lives, healthy People: A Tobacco Control Plan for England (2011): Department of Health: London https://www.gov.uk/government/publications/the-tobacco-control-plan-for-england

Public Health Outcomes Framework (2016) Public Health England: London http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042

Tobacco Control Profile: (2016): Public Health England: London http://www.tobaccoprofiles.info/tobacco-control).

ASH Ready Reckoner: (2015): Action on Smoking and Health (ASH): London ash.org.uk/localtoolkit/docs/Reckoner.xls Updated July 2016

Tobacco control: joint strategic needs assessment (JSNA) support pack; Good practice prompts for planning comprehensive local tobacco control interventions in 2017-18: (2016): Public Health England: London

CLeaR Thinking Excellence in local tobacco control: (2012): Action on Smoking and Health: London

Smoking Still Kills: Protecting children, reducing inequalities: (2015): Action on Smoking and Health: London

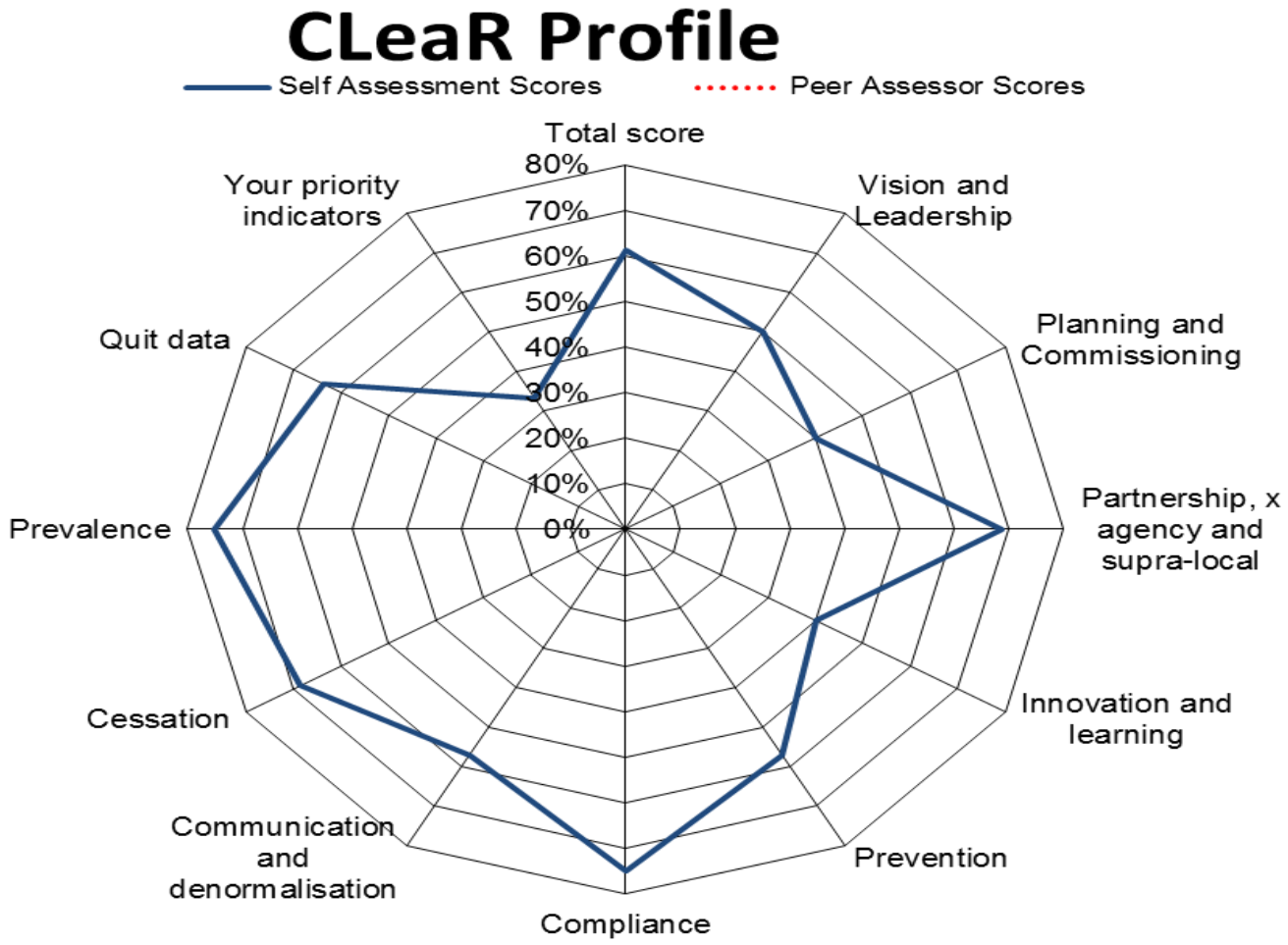
Local Health and Care Planning: Menu of preventative interventions: Public Health England: November 2016

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/565944/Local_health_and_care_planning_menu_of_preventative_interventions.pdf

NHS England Prevention Aide-Memoire,

Tobacco Control: joint strategic needs assessment (JSNA) support packs; Good practice prompts for planning comprehensive local tobacco control interventions in 2016-17 (2015): Public Health England: London:

Appendix 1: Outcome from the 2016 Clear Thinking: Excellence in local tobacco control, peer assessment of July 2016



Gateshead Council

HEALTH AND WELLBEING BOARD

3 March 2017

TITLE OF REPORT: Northumberland, Tyne & Wear and North Durham Sustainability and Transformation Plan

Report by: Joe Corrigan Chief Finance & Operating Officer NHS Newcastle Gateshead CCG

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1. Purpose of the report

1.1 This report updates on the progress to date and next stages in the development of the Northumberland, Tyne and Wear and North Durham Sustainability and Transformation Plan (NTWND STP) since the last meeting.

2. Introduction and background

2.1 The NHS Shared Planning Guidance (December 2015) asked every local health and care system in England to come together to create their own local plan for accelerating the implementation of the Five Year Forward View (5YFV), called Sustainability and Transformation Plans (STPs). These are place-based, multi-year plans built around the needs of local populations.

2.2 STPs will drive genuine and sustainable transformation in health and care outcomes, and will help build and strengthen local relationships, enabling a shared understanding of where we are now, our ambition for 2021 and develop a plan as to how we get there.

3. Key messages

3.1 Feedback on the STP has been received from NHS England and national policy leads following the October submission outlining the national support available for STPs moving forward, with a subsequent commitment from NHS England to support STPs through the alignment of resource locally.

3.2 Work stream workshops have been established at STP footprint level aligned to the transformation areas identified below:

- Prevention, Health and Wellbeing.
- Out of Hospital Collaboration (now called Neighbourhoods and Communities)
- Optimal Use of the Acute Sector.
- The core ambition of the STP is to ensure “no health without mental

health". This will involve the development of an integrated life span approach to the integrated support of mental health, physical health and social need which wraps around the person.

Some of the work streams have held "pre meet" working groups prior to holding wider workshops in January and February.

3.3 Development of the Governance arrangements to support the STP and the system continues, with ongoing conversations with Local Authority and NHS Chief Executive Officers to ensure the right Governance arrangements are in place for the future and to ensure oversight of the implementation of the STP.

3.5 There is an alignment of the STP Governance arrangements and NECA arrangements.

3.6 Phase 1 of the engagement process on the draft STP plan has included:

- a series of engagement events which have taken place across the STP footprint area alongside
- an online survey aimed at feedback from organisations within the footprint
- discussions with Health and Wellbeing Boards
- discussions with organisational boards
- meetings with trade unions
- meetings with Political Leaders
- meetings with local pressure group
- local organisational led meetings with the public

4. What happens next

4.1 The work to date in developing the plan has been to create a case for change, which describes the gaps, challenges and on-going work. We are now working together with partners to take forward this transformation work, via the work stream workshops.

4.2 A report will be published which will contain a detailed analysis of all the key themes and issues arising from all of the engagement work to date including within this an analysis of national feedback from NHS England.

4.3 A detailed timeline for subsequent stages of the consultation process is currently being developed, following which an updated draft plan will be consulted on, which will involve more engagement with key stakeholders and members of the public.

4.4 Once consultation outputs have been collated they will be used to inform a final version of the plan along with updated finances etc. which organisations would then be asked to sign off.

4.5 Any transformational change arising will be led by the relevant organisation with the appropriate consultation processes in place.

6. Recommendations

6.1 It is recommended that the Health and Wellbeing Board:

- notes the progress made in the development of the NTW ND STP and next steps.

7. Background papers

NHS Operational Planning and Contracting Guidance 2017-2019. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

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

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Gateshead Council

Health and Wellbeing Board

3 March 2017

TITLE OF REPORT: Emerging Themes: Development of OSC Work Programmes 2017-18

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1. Purpose of the Report

This report seeks views on the emerging themes for the Council's Overview and Scrutiny Committee (OSC) work programmes for 2017-18.

2. Background

Each year the Council consults its partners on the emerging priority issues for all of its Overview and Scrutiny Work Programmes, to assist the Council in identifying the right priority areas to take forward and help shape the focus of specific areas of work. The Board has previously indicated that it may wish to ask Overview and Scrutiny to examine specific issues on its behalf in future work programmes.

Views are being sought from Gateshead Strategic Partnership and other Partnership Boards and feedback to date will be shared at the meeting.

Overview and Scrutiny Committees are due to agree their work programmes for 2017-18 at meetings scheduled at the end of March/ April 2015. (Appendix 2)

3. Proposals

The emerging themes for all OSCs are set out in Appendix 1. These themes are being put forward following consideration of a range of factors including:-

- Vision 2030
- The Council Plan 2015-20
- The Health and Wellbeing Strategy for Gateshead
- Relevant Legislation
- Performance Information
- Issues of concern to local people
- Issues highlighted by councillors on Overview and Scrutiny Committees
- Public Health Commissioning Priorities
- Clinical Commissioning Group Priorities
- Safer Gateshead Partnership Priorities
- Children Gateshead (the plan for children, young people and families)

4. Recommendation

The views of the Board are sought on:

- the emerging themes for OSCs for 2017-18
- whether the Board considers there are any additional priority issues it would wish to ask Overview and Scrutiny to include in its work programmes for 2017/18 or future work programmes.

Contact: Angela Frisby angelafrisby@gateshead.gov.uk

Emerging Issues for OSCs – 2017-18 **APPENDIX 1**

Care, Health and Wellbeing OSC

Review Topic- Work to address harms caused by Tobacco
Links to
Vision 2030
Council Plan 2015-20
Director of Public Health Annual Report 2015-16

Case Study 1 – Health and Social Care System Wide Work Force Issues (to cover an overview of the current workforce position in Gateshead across the health and social care sector, along with details of system wide actions being undertaken to address the issues and an outline of the areas of risk / mitigation)
Links to
Vision 2030
Council Plan 2015-20

Case Study 2 - Hospital Admissions arising from Alcohol related Harm
Links to
Vision 2030
Council Plan 2015-20
Performance Issue – Target LW13 – Rate in Gateshead significantly higher than NE average and the England rate and provisional data indicates a rise in 2015-16 from 2014-15.

Corporate Resources OSC

It is proposed that this OSC focus on two Case Studies within its 2017-18 work programme as follows:-

Case Study 1 – Procurement of Goods and Services from Local Suppliers (to focus on how the Council procures locally)
Links to:-
Vision 2030
Council Plan 2015-20

Case Study 2 – Impact of Welfare Reform (in light of ongoing implementation of reforms and roll out of key areas such as Universal Credits)
Links to:-
Vision 2030
Council Plan 2015-20

Families OSC

Review Topic – Children on the Edge of Care (to focus on the needs of this group (toxic trio);evidence of the impact of neglect on life chances ;what the council and partners are currently doing; what the gaps are; what we need / are planning to do.)
Links to:-
Vision 2030
Council Plan 2015-20

Case Study 1 - Best Start in Life Outcome of Self -Assessment
Links to:-
Vision 2030
Council Plan 2015-20

Case Study 2– Early Help Strategy / Outcomes Framework / Performance Indicators
Links to:-
Vision 2030
Council Plan 2015-20

Communities and Place OSC

Review Topic – The Council and Partner's Approach to Roads and Highways – to include:-

- road safety / road traffic accidents
- road and pavement repairs / funding
- bus lanes
- traffic congestion

(to focus on current position / challenges/ areas for future action)
Links to
Vision 2030
Council Plan 2015 – 20
Referral from Council – 22 Sept 2017 – Council asked Communities and Place as part of its work programme to review the work of all relevant agencies holding road safety responsibilities due to recent loss of life in road traffic accidents in Gateshead.

No Case study this year – Replaced with four progress update reports on:-

- Development and Extension of the Quality Bus Partnership
- Environmental Enforcement
- Future Direction of Leisure Services
- Housing Growth

Community Safety Sub OSC

Case Study – Impact of Alcohol on Community Safety **Links to:-** **Vision 2030** **Council Plan 2015-20**

Corporate Parenting Sub OSC

Case Study – Performance / Planning / Safeguarding of Care Leavers **Links to:-** **Vision 2030** **Council Plan 2015-20** **LSCB Annual Report and Plans**

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Appendix 2a

DRAFT Corporate Resources OSC 2017/2018	
26 June 17	• Constitution/role/remit • The Council Plan – Year End Assessment and Performance Delivery 2016-17 • Sickness Absence / Health of the Workforce Update • Five Year Target Setting 2017-18 • Gateshead Fund Update • Freedom of Information – Annual Report 2017
4 September 17	• Resilience and Emergency Planning Framework - Progress Update • **Case Study – Procurement of Goods and Services from Local Suppliers**
16 October 17	• Comprehensive Impact Assessments and the Council Plan – Progress Update • Implementation of Gateshead Volunteers Plan – Annual Report • Implementation of Workforce Strategy – Progress Update
27 November 17	• The Council Plan – Six Monthly Assessment of Performance and Delivery 2017-18 • Corporate Asset Management – Delivery and Performance Report • Corporate Complaints Procedure - Annual Report 2016-17 • Annual Health and Safety Performance Report • Sickness Absence / Health of the Workforce
22 January 18	• OSC Work Programme Review • Gateshead Communities Together Annual Update • Support to Voluntary and Community Sector – Progress Update
26 February 18 (5.30pm meeting)	• Information Governance Report • **Case Study – Welfare Reform**
16 April 18	• Resilience and Emergency Planning Framework - Progress Update • Freedom of Information - Annual Report 2017

Issues to Slot in

- **PSP Performance Monitoring**

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Draft Communities & Place OSC 2017/2018	
19 June 17	• Constitution / role and remit • The Council Plan – Year End Assessment and Performance Delivery 2016-17 • Five Year Target Setting 2017-18 • OSC Review- Scoping report
11 September 17	• OSC Review - Evidence Gathering • Monitoring - OSC Review of Impact of Gambling on the Borough • Progress Update – Reducing Carbon Emissions
30 October 17	• OSC Review - Evidence Gathering
4 December 17	• OSC Review - Evidence Gathering • The Council Plan – Six Monthly Assessment of Performance and Delivery 2017-18
29 January 18	• OSC Review - Evidence Gathering • Work Programme Review
5 March 18 **(5.30pm meeting)**	• OSC Review - Interim Report • The Flood and Water Management Act 2010: Annual Progress Report
23 April 18	• OSC Review - Final Report • Monitoring - OSC Review of Impact of Gambling on the Borough • Annual Report of Talisman

Issue to slot in

- Progress Update on Development / Extension of Quality Bus Partnership
- Progress Update on Environmental Enforcement
- Progress Update on future direction of Leisure Services
- Progress Update on Housing Growth

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Draft Families OSC 2017/18	
15 June 17	• The Council Plan – Year End Assessment and Performance Delivery 2016-17 • Five Year Target Setting 2017-18 • OSC Review- Scoping report • Gateshead Child Health Profile • CAMHS – Progress Update • Update- Changing role of LAs in Education
7 September 17	• OSC Review - Evidence Gathering • Annual Report on Complaints and Representations – Children • Ofsted Inspections/School Data – Progress Update • Monitoring – OSC Review of Oral Health • Update - Care Pathway for Foetal Alcohol Spectrum Disorder
19 October 17	• OSC Review - Evidence Gathering – • Performance Improvement Update – Children Presenting at Hospital as result of Self Harm • Safeguarding Children - LSCB Annual Report and Plans • Children and Young People's Plan – Refresh and Commissioning Priorities
30 November 17	• OSC Review - Evidence Gathering • OSC Work Programme Review • The Council Plan – Six Monthly Assessment and Performance Delivery **(LSCB progress update as part of this report**) • Employment of Children within the Borough- Update
25 January 18	• OSC Review - Evidence Gathering • Ofsted – Annual Report • Liaison with Gateshead Youth Assembly • CAMHS Update • Modern Slavery Update
1 March 18	• OSC Review - Interim Report • Annual Conversation with Head Teachers of Special Schools • Update on Healthy Schools Programme
19 April 18 **(5.30pm meeting)**	• OSC Review - Final Report • Monitoring - OSC Review of Oral Health • Closing the Gap – Annual Report

Issues to slot in

- 0-19 Public Health Service Provision – consultation / models.
- Case Study –Early Help Strategy /Outcomes Framework/Performance
- Case Study – Best Start in Life – Outcome of Self- Assessment
- Progress Update –How Adult and Children's Services are working Together.

Draft Care, Health & Well-being OSC 2017/2018	
20 June 17 **(5.30pm meeting)**	• The Council Plan – Year End Assessment and Performance Delivery 2016-17 • Five Year Target Setting 2017-18 • OSC Review- Scoping report • MHA/DOLs Update
12 September 17	• Monitoring - OSC Review of Role of Housing in Improving Health & Wellbeing • OSC Review - Evidence Gathering • Social Services Annual Report on Complaints and Representations – Adults • Annual Report of Local Adult Safeguarding Board and Business Plans –(Chair of Board to attend) • Adult Social Care Account - Video
31 October 17	• OSC Review - Evidence Gathering • Health and Well-Being Board - Progress Update • Gateshead Healthwatch • Quality of Care in Commissioned Services
5 December 17	• OSC Review - Evidence Gathering • The Council Plan – Six Monthly Assessment of Performance and Delivery (incl LSCB update) • New Service Delivery Model for Extra Care Services • Gateshead Care Partnership – Progress Update
23 January 18	• OSC Review – Evidence Gathering • OSC Work Programme Review • Delayed Transfers of Care / Reablement Progress Update • **Case Study 1**– Health and Social Care System Wide Workforce Issues
6 March 18	• OSC Review - Interim Report • Gateshead Healthwatch • **Case Study 2-** Hospital Admissions as result of Alcohol related Harm
17 April 18	• OSC Review - Final Report • Monitoring - OSC Review of Role of Housing in Improving Health and Wellbeing • Health and Well-Being Board – Progress Update

Issues to slot in

- Impact of any health transformations on adult services.
- Quality Accounts - Gateshead Health NHS Trust and NTW NHS Foundation Trust and South Tyneside NHS Foundation Trust
- STP Updates - as appropriate.

Community Safety Sub OSC Work Programme 2017-18 (DRAFT)	
27 June 2017	• The Council Plan – Year End Assessment and Performance Delivery 2016-17 • Five Year Target Setting 2017-18 • Safer Gateshead Partnership Plan 2017-18 • Serious Violence and Domestic Homicide Progress Update • Overview of Probation Services(links between CRC/NPS and enforcement activity
17 Oct 2017 (5.30PM)	• Implementation of Safer Gateshead Priorities – progress update • Prevent – Update on Action Plan • Progress Update – Domestic Abuse including MATAC • Anti – Social Behaviour update – Impact of PSPO's and Vanguard Review
30 Jan 2018	• Progress Update on Families Gateshead • Consultation on Strategic Assessment Priorities • Anti –Social Behaviour update – Tools and Powers / Tasking and Problem Solving • Hate Crime Update – Engagement with local communities/residents
27 March 2018	• Implementation of Safer Gateshead Priorities – end of year performance • Prevent – Update on Action Plan • Safer Gateshead Draft Priorities 2018-19 • **Case Study** – Impact of Alcohol on Community Safety

Issues to slot in:-

- Drug Related Deaths – Annual Report and Audit Findings
- Serious Violence and Domestic Homicide – Additional Progress Update

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Corporate Parenting OSC Work Programme 2017-18 (DRAFT)	
10 July 2017 (1.30PM)	• Fostering Service Annual Report • Regulation 44 Report • SEN and LAC • Support for Disabled LAC
9 October 2017 (4.30PM)	• Health of LAC Annual Report - (incl update on foetal alcohol syndrome) Young Peoples Presentation • Performance Overview (including update on *Ofsted – Specific LAC Improvement Plan)* • Regulation 44 Report
15 January 2018 (1.30PM)	• Missing from Care Annual Report • Education Annual Report (including focus on employment/ training / apprenticeships) • Regulation 44 Report • Support for Care Leavers • Adoption Annual Report - 2017
26 March 2018 (4.30PM)	• Young Peoples Presentation • Performance Overview • **Case Study - Performance/planning/safeguarding of Care Leavers** • Regulation 44 Report

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Gateshead Council

HEALTH AND WELLBEING BOARD
3 March 2017

TITLE OF REPORT: Better Care Fund: 3rd 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 3rd 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 and the Quarter 2 return at its meeting on 2nd December 2016.

Quarter 3 Template Return for 2016/17

4. In line with the timetable set by NHS England, a return for the 3rd quarter of 2016/17 is due to be submitted by the 3rd March. 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 the final quarterly return for 2016/17 is the 24th May 2017. This will be brought to the Board for endorsement at its June meeting.

Proposal

6. It is proposed that the Board endorse the 3rd Quarter BCF return for 2016/17 so that it can be submitted to NHS England (attached as an excel document).

Recommendations

7. The Health and Wellbeing Board is asked to endorse the Better Care Fund 3rd 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 3rd March 2017.

The BCF Q3 Data Collection

This Excel data collection template for Q3 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 & Q3 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 & Q3 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 Q3 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 Q3 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 Q3 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, date 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 9)?	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
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
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)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - 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

4. I&E

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
Income to	Forecast	Yes	Yes	Yes	Yes
	Actual	Yes	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	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
	DTOC	Yes	Yes
	Local performance metric	Yes	Yes
	If no metric, please specify	Yes	Yes
Patient experience metric	Yes	Yes	Yes
	Admissions to residential care	Yes	Yes
	Reablement	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 (mm/yy)	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

Q3 2016/17

Health and Well Being Board	**Gateshead**
Completed by:	Hilary Bellwood/John Costello
E-Mail:	hilarybellwood@talktalk.net
Contact Number:	0191 217 2960
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
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	36
4. I&E	17
5. Supporting Metrics	13
6. Additional Measures	67
7. Narrative	1

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	Q2 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	Yes		
2) Maintain provision of social care services	Yes	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	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	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 Programm
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	Yes		
ii) Are you pursuing Open APIs (ie system that speak to each other)?	No - In Progress	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 developing this joint
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes	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	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	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	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	No - In Progress	31/03/20	Through the STP process there is a recognition that an investment into Out of Hospital services is fundamental to sustainability of the whole system, therefore mod
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	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 Commissionin

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 Car 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 consequenc 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 8 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 2020 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 again 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 informat 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 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 he 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 sho 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 (de 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.

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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	£4,121,962				

Q3 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	£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 Q3 actual differs from the Q3 plan and / or Q3 forecast	

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	£3,586,540	£4,754,540	£4,375,305	£16,487,846	
	Actual*	£3,771,462	£3,586,540				

Q3 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	£4,754,540			

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q3 actual differs from the Q3 plan and / or Q3 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 figures are sourced from the Q1 16/17 collection whilst Forecast, Q1 and Q2 Actual figures are sourced from the Q2 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 below planned levels by circa 923 admisisons or 5% (16,399 against plan of 17,322), CCG QIPP schemes and the Care Homes Vanguard are expected to maintain 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:	Delays in transfer of care were above trajectory during Q3 of 16/17 with 606 days per 100,000 above the target of 536. For the period October to December 2016, there were 1,842 days lost to delays in transfer of care. This equates to 1008 days per 100,000 population aged 18+. This figure is significantly above the BCF target of 536 days.

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 for improved performance, but not to meet full target
Commentary on progress:	The diagnosis rate fell slightly below trajectory to 69.7% (target 70%) during Q3 despite previous improvements to above the target seen earlier in 2016/17. Work continues to further improve and recover previous performance.

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
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:	Aggregate results for the GP practice surveys conducted mid year between July and September 2016 show that 43.8% of patients registered with a Gateshead practice answered Yes, definitely to the question in the last 6 months have you had enough support from local services or organisations to manage your long term condition.If this continues, the 2016/17 target of 48% will be missed but is an improvement on the

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 December 2016, there were 234 permanent admissions into residential or nursing care. This represents 610.4 admissions per 100,000 population (based on 2014 population projections) showing an improvement in performance compared to the same point last year of 308 permanent admissions (814.1 per 100,000 population).

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	0
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 (%)	100%

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	27,584

Please provide a brief narrative on overall progress, reflecting on performance in Q3 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 December 2016, there were 234 permanent admissions into residential or nursing care. This represents 610.4 admissions per 100,000 population (based on 2014 population projections) showing an improvement in performance compared to the same point last year of 308 permanent admissions (814.1 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. It can also be attributed to a growing awareness of Electronic Frailty Index (eFI) and embedding Practice Based Frailty nurses in some practices alongside the Primary Care Navigators.

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

- A&E stabilisation - 1% increase [17 patients], anticipated growth 8.4% [based upon 1415 / 1516 comparison]
- Non elective admission reduction – urine infections, 2.9%, 19 patients Sep 16, average 27 per month 15/16
- Prescribing nutritional supplement reduction – 6.5%, [3259] first two quarters of 16/17 compared to same time period 15/16
- Outpatient appointments reduction – 3.7% [205 saved appointments]

Non elective activity continues to be on plan for Q3 to date. YTD performance is currently below planned levels by 5%, 16399 against plan of 17322. CCG QIPP schemes and the Care Homes Vanguard are expected to maintain activity within planned levels.

Dementia diagnosis has improved throughout 2016/17 despite a slight dip below the 70% target in Q3 to 69.7%. The rate is currently above the national standard and work continues to recover the rate seen earlier in 2016/17 by Q4. In terms of continuous improvement the Care Home Vanguard team have identified from a clinical audit that 62% of people in care homes have a formal diagnosis of dementia, but considering those living with cognitive impairment without a formal diagnosis this figure could be around 72%.

Therefore work is underway to explore the development of a bespoke Dementia diagnosis pathway for Care Home residents

Challenges

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Item 9

HEALTH AND WELLBEING BOARD
3 March 2017

TITLE OF REPORT: **Primary Care (Medical Services) Governance Arrangements**

Purpose of the Report

1. To advise the Health & Wellbeing Board on the revised governance arrangements for Primary Care Commissioning including changes to Committee Terms of Reference.

Background

2. NHS England has responsibility for commissioning primary medical care services. This has been undertaken jointly with Newcastle Gateshead CCG during the last two years. From April 2017, responsibility for commissioning primary medical services will be delegated to Newcastle Gateshead CCG.

3. As part of the nationally agreed arrangements for joint commissioning between NHS England and the CCG, a representative from both Healthwatch and the Health and Wellbeing Board attend the Primary Care Joint Committee. The committee meets in public, unless the business being transacted requires the meeting to be held in private, in accordance with the CCG Standing Orders.

4. To reflect the increased responsibility for primary care commissioning, the CCG will establish a revised Primary Care Commissioning Committee, with effect from April 2017.

Proposal

5. The Newcastle Gateshead CCG primary care commissioning governance arrangements will be in accordance with the national recommendations and draw on experience of areas that have been operating fully delegated arrangements for one or two years.

6. The Primary Care Commissioning Committee will report to the CCG Governing Body and will continue to meet in public. The committee will have a CCG Lay Member as the Chair and a CCG Lay Member as Vice Chair and have an executive (non-medical) majority. A register of interests is maintained and potential or actual conflicts of interest will continue to be managed by the committee Chair, with advice as necessary e.g. from the CCG Conflicts of Interest Guardian.

7. The Committee terms of reference (ToR) are based on the national template, provided by NHS England. The draft committee ToR have been considered by the current Primary Care Joint Committee and by the CCG Governing Body at meetings held in public. The draft Terms of Reference are attached as an appemdix, for information.

8. The representatives of Healthwatch and of the Health and Wellbeing / Wellbeing for Life Board will continue to be invited, in a non-voting capacity, to Primary Care Commissioning Committee meetings held both in public and private. A representative of NHS England will also be in attendance at all meetings.

9. The proposed committee terms of reference as attached are to be presented to the CCG Governing Body at its meeting on 28 March 2017 for formal ratification.

Recommendations

10. The Health and Wellbeing Board is asked to note the revised local arrangements for commissioning primary care medical services from April 2017 and the continued role of the health and wellbeing board representative on the Newcastle Gateshead Primary Care Commissioning Committee.

Contact:

Pauline Fox, CCG Head of Corporate Affairs, direct line (0191) 217 2725

John Costello: (0191) 433 2065

Newcastle Gateshead
Clinical Commissioning Group

Primary Care Commissioning Committee
Terms of Reference

1. Introduction

1.1 The Governing Body has established the Newcastle Gateshead CCG Primary Care Commissioning Committee (the Committee). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers in line with Newcastle Gateshead CCG's Constitution.

2. Statutory Framework

2.1 NHS England has delegated to the CCG authority to exercise the primary care commissioning functions as set out in Schedule 2 in accordance with section 13Z of the NHS Act.

2.2 Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the NHS England and the CCG.

2.3 Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

a) Management of conflicts of interest (section 14O)
b) Duty to promote the NHS Constitution (section 14P)
c) Duty to exercise its functions effectively, efficiently and economically (section 14Q)
d) Duty as to improvement in quality of services (section 14R)
e) Duty in relation to quality of primary medical services (section 14S)
f) Duties as to reducing inequalities (section 14T)
g) Duty to promote the involvement of each patient (section 14U)
h) Duty as to patient choice (section 14V)
i) Duty as to promoting integration (section 14Z1)
j) Public involvement and consultation (section 14Z2)

2.4 The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those in accordance with the relevant provisions of section 13 of the NHS Act:

a) Duty to have regard to impact on services in certain areas (section 13O)
b) Duty as respects variation in provision of health services (section 13P)

2.5 The Committee is established as a committee of the Governing Body in accordance with Schedule 1A of the NHS Act. The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

3 The role of the Primary Care Commissioning Committee

3.1 The Committee has been established in accordance with the above statutory provisions to enable the members of the committee to make collective decisions on the review, planning and procurement of primary care services in Newcastle and Gateshead, under delegated authority from NHS England.

3.2 The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act, as set out in section 4, below.

3.3 In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and Newcastle Gateshead CCG, which will sit alongside the delegation and terms of reference.

3.4 The functions of the Committee are undertaken in the context of a desire to promote increased quality, efficiency, productivity and value for money and to remove administrative barriers.

4 Responsibilities of the Primary Care Commissioning Committee

The responsibilities of the Committee include the following:

a) Decisions in relation to General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Providers of Medical Services (APMS) contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract)

b) To manage the budget for commissioning of primary medical care services

c) Decisions in relation to newly designed enhanced services (Local Enhanced Services and Directed Enhanced Services)

d) Decisions in relation to local incentive schemes, including the design and implementation of such schemes

e) To plan primary medical care services, including Primary Care needs assessments

f) To undertake reviews of primary medical care services

g) Decision making on whether to establish new GP practices in an area

h) Approving practice mergers and de-mergers

i) Decisions on practice closures

j) Planning new primary care estate

k) Making decisions on 'discretionary' payment (e.g. returner/retainer schemes)

l) Responsibility for GP practice contract management and performance

m) Discussions in relation to the management of poorly performing GP practices (excluding any decision in relation to the performers list).

5 Geographical Coverage

5.1 The Committee will comprise the area covered by Newcastle Gateshead CCG

6 Membership of the Committee

6.1 The committee shall have a lay/executive majority. Membership of the committee will consist of:

a) A Lay Member of the CCG (Chair of the committee[1])

b) A Lay Member of the CCG (Vice Chair of the committee[2])

c) The CCG Medical Director

d) The CCG Chief Finance Officer (or designated deputy)

e) The CCG Director of Operations and Delivery

f) The CCG secondary care specialist doctor

g) A CCG GP Clinical Director

In attendance:

a) A representative from NHS England

[1] This cannot be the CCG Audit Committee Chair
[2] This should not be the CCG Audit Committee Chair

b) The CCG Designated Lead for Primary Care

6.2 A standing invitation will be made to specified partners, namely:

a) A representative from HealthWatch (Gateshead)

b) A representative from HealthWatch (Newcastle)

c) A representative from the Health and Wellbeing Board (Gateshead)

d) A representative from the Wellbeing for Life Board (Newcastle)

6.3 These specified partners will be invited to attend in a non-voting capacity but will be an integral part of all discussions. They will be entitled to attend the meeting in private session, unless a conflict of interest prevents them from doing so for a particular item.

6.4 A standing invitation will be made to other specified stakeholders, namely:

a) A representative from the Newcastle and North Tyneside Local Medical Committee

b) A representative from the Gateshead and South Tyneside Local Medical Committee

6.5 These stakeholders will be invited to attend in a non-voting capacity but will be an integral part of all discussions. They will not be entitled to attend the meeting in private session.

6.6 Other CCG Governing Body members, officers, employees, practice representatives and Commissioning Support Unit staff may be invited to attend all or part of meetings of the committee to provide advice or support particular discussion from time to time.

6.7 The membership will meet the requirements of the CCG's Constitution.

6.8 The Medical Director will be the lead officer for the committee, or will nominate a Director to undertake this role.

7 Meetings and Voting

7.1 The Committee shall adopt the Standing Orders of NHS Newcastle Gateshead CCG insofar as they relate to the:

a) Notice of meetings;
b) Handling of meetings;
c) Agendas;
d) Circulation of papers; and
e) Conflicts of interest

7.2 To ensure effective management of actual or potential conflicts of interest, meeting agenda and papers will be circulated to ensure committee members do not receive papers on items on which they are conflicted. Individual members and/or attendees will withdraw from the meeting as requested to do so by the Chair of the committee.

7.3 Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

8 Quoracy

8.1 The quoracy for the committee is 50% of members and including at least one lay member, one Director of the CCG and one GP.

8.2 Where a conflict of interest arises which prevents all of the GPs from being involved in the discussion and/or voting on any matter then the quoracy for that part of the meeting will be at least one lay member and one Director of the CCG.

9 Frequency and operation of meetings

9.1 The committee will meet at regular intervals and not less than 4 times per year.

9.2 In exceptional circumstances, an extraordinary meeting of the committee may be required and can be called by the Chair by providing members with a minimum of five working days' notice. The quoracy for this meeting is the same as that set out above.

9.3 Meetings of the Committee shall:

a) be held in public, subject to the application of 9.3(b) (below);

b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

9.4 Declarations of interest will be a standing agenda item. All potential conflicts of interest will be declared and dealt with in accordance with the CCG's Constitution and CCG policies and procedures for Standards of Business Conduct.

9.5 Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

9.6 The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest..

9.7 The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

9.8 Members of the Committee shall respect confidentiality requirements as set out in the CCG's Standing Orders and Standards of Business Conduct policy.

9.9 The Committee will make decisions within the bounds of its remit. The decisions of the Committee shall be binding on NHS England and the CCG.

9.10 The Committee will present its minutes to the CCG Governing Body and to NHS England (Cumbria and the North East sub region), for information and will also comply with any reporting requirements set out in the CCG Constitution.

9.11 The Committee will produce an executive summary report which will be presented to NHS England and the governing body for information no less than annually.

10 Review of Terms of Reference

10.1 These Terms of Reference will be formally reviewed on an annual basis, or as required reflecting experience of the Committee in fulfilling its functions or changes in guidance or legislation.

Approved by Governing Body: [date to be added]

Due for Review: [date to be added]

Schedule 1 – Delegation [to be added]

Gateshead Council

HEALTH AND WELLBEING BOARD
3 March 2017

TITLE OF REPORT: **Health Protection Assurance Annual Report 2015/16**

Purpose of the Report

1. To provide assurance to the Health & Wellbeing Board on the delivery of the Council's statutory duties regarding health protection assurance.

Background

2. Health protection describes those activities and arrangements that seek to protect the population from risks to health arising from biological, environmental or chemical hazards. It includes:

    - Prevention - screening, immunisation and vaccination schemes to prevent the incidence of diseases
    - Surveillance – systems of disease notification, identifying outbreaks
    - Control – management of individual cases of certain diseases to reduce the risk of spread
    - Communication – communicating messages and risks during urgent and emergency situations).

3. The Director of Public Health (DPH), employed by Gateshead Council, is responsible for the exercise of the local authority's public health functions. This includes those conferred upon the Council by Regulation 8 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 to promote "the preparation of or participation in appropriate local health protection arrangements". This report forms part of those arrangements.

4. The attached report (Appendix 1) provides further detail of those arrangements and activity from ***April 2015 to March 2016***. A brief summary is provided below.

Immunisation

5. NHS England commissions the full range of child and adult immunisation programmes for Gateshead. Key points to note include:

    - Uptake of the routine childhood immunisation programme is amongst the highest in England;
    - By 12 months, 95.2% of children in Gateshead had been immunised against diphtheria, tetanus, pertussis, polio and haemophilus influenza type b (93.6% in England);
    - By 24 months, 92.4% (91.9%) had received measles, mumps and rubella (MMR) vaccine (dose 1);
    - An increase nationally in cases of one type of meningitis (MenW) prompted the addition of a new vaccination to the national programme. The new vaccination, MenACWY, is offered to young people and "freshers" starting university. By the

end of August 2016, 93.6% of Year 9 students in Gateshead had been vaccinated;

- A new vaccine for Meningitis B was introduced to the national childhood immunisation programme;
- In 2015/16, seasonal flu vaccine was offered to:
  - Those aged 65 years and over
  - Those aged six months to under 65 in clinical risk groups
  - All pregnant women
  - All two, three, and four year olds
  - All children in school years 1 and 2
  - Those in long-stay residential care homes or other long stay care facilities
  - Carers
  - Frontline health and social care workers;
- Gateshead continued to pilot flu vaccinations for primary school children in reception and years one to six inclusive;
- Targets for uptake in the adult population were 75% of the eligible population. Ambitions for uptake amongst children were 40-60% of those eligible;
- Headline facts for flu vaccine uptake Gateshead in 2015/16:
  - Uptake amongst those aged 65+ is down locally and nationally and below the 75% target;
  - Uptake amongst those under 65 and at risk is down locally and nationally;
  - There is significant variation between GP practices in uptake amongst those aged under 65 and at risk (37.9 – 60.0%);
  - Uptake amongst pregnant women is down locally compared to last year but still up compared to 2013/14;
  - Uptake amongst children is down locally and nationally;
  - Uptake amongst Gateshead NHS Foundation Trust health care workers is up;
  - Uptake amongst the primary school pilot continues to be good.

Screening

6. The screening programmes, commissioned by NHS England, for which the Director of Public Health has an assurance role are:

   - Cancer screening programmes (breast, bowel and cervical)
   - Diabetic Retinopathy
   - Abdominal Aortic Aneurysm
   - Ante natal and newborn

7. For several programmes, data is not available at the Gateshead level, and/or the most recent data is not for 2015/16. In these circumstances, assurance for Gateshead is limited to the overall assurance we have in respect of the programme or the period for which we do have data.

8. Uptake of the cancer screening programmes continues to be good and comparable with or higher than levels of uptake nationally. There are recognised inequalities in the uptake of cancer screening programmes. Work is underway locally to address some of these inequalities.

9. Data for the Diabetic Eye Screening Programme is unavailable at a Gateshead level. Performance, reported at North of Tyne and Gateshead area level, suggests that uptake exceeds 80%. The Screening and Immunisation Team are also aware

of inequalities in the uptake of the service, with lower uptake amongst younger age groups and those from more deprived socioeconomic areas.

10. Uptake of the Abdominal Aortic Aneurysm screening programme shows a decrease in coverage from 78.2% in 2014/15 to 76.4% in 2015/16.

11. The Antenatal and Newborn screening programme covers six areas:
    a. Fetal anomaly
    b. Sickle cell and thalassemia
    c. Infectious diseases in pregnancy
    d. Newborn infant physical examination
    e. Newborn hearing screening
    f. Newborn bloodspot screening

12. Coverage of the Ante-Natal and Newborn screening programme is high for those areas where data is available, although this does not reflect geographic inequalities within the borough:
    - At the Gateshead Health NHS Foundation Trust, 86.2% of eligible babies received the newborn infant physical examination (NIPE) within 72 hours of birth in 2015/16 (England 94.9%);
    - Newborn bloodspot coverage across the Newcastle Gateshead CCG area continues to be high at 98.0% for 2015/16 (England 95.6%);
    - Newborn hearing screening coverage across Gateshead, South Tyneside and Sunderland continues to be high at 99.1% for 2015/16 (England 98.2%).

    However, data is not available for all key performance indicators for NIPE, and for the remaining areas of the newborn programme as the Gateshead Health NHS Foundation Trust are not able to provide data to meet the national programme standards nor for all the performance indicators.

Surveillance

13. Public Health England's Health Protection Team continues to work with a wide variety of partners to ensure that adequate systems are in place to detect the existence of certain communicable diseases, and to ensure that appropriate agencies are notified.

14. The Council's Environmental Health Team noted increases in the number of cases of food poisoning notified in 2015/16 compared to the previous year.

15. Surveillance of Healthcare Associated Infections showed an increase in rates of E. coli and C. difficile infections.

Control

Tuberculosis

16. Gateshead's population has a low incidence of tuberculosis but the prevalence of the disease per head of population has increased significantly since 2013.

Scarlet fever and invasive Group A Streptococcal infections

17. Cases of scarlet fever rose in the North East from 536 in 2014/15 to 667 in 2015/16. The bacterium responsible for scarlet fever can also cause potentially lethal infections called invasive group A streptococcal infections (IGAS), cases of which in the North East increased from 79 in 2011 to 269 in 2014.

Sexually transmitted infections (STIs)

18. Gateshead Council commissioned a new Integrated Sexual Health Service from 1st April 2015. The service is based in the town centre with clinics across the Borough.

19. Overall 1325 new sexually transmitted infections (STIs) were diagnosed in residents of Gateshead, a rate of 660.8 per 100,000 residents (compared to 767.6 per 100,000 in England):

    - 54% of diagnoses of new STIs in Gateshead were in young people aged 15-24 years (compared to 45% in England)
    - For cases in men where sexual orientation was known, 24.6% of new STIs in Gateshead were among men who have sex with men
    - There were 11 new HIV diagnoses in Gateshead. The diagnosed HIV prevalence was 1.5 per 1,000 population aged 15-59 years (compared to 2.26 per 1,000 in England).

Emergency preparedness, resilience and response (EPRR)

20. Planning for emergency situations, such as extreme weather events, outbreaks or terror incidents, takes place at regional and local levels:

    - The Local Health Resilience Partnership (LHRP) is responsible for ensuring that the arrangements for local health protection responses are robust and resilient. The LHRP works with the Local Resilience Forum (LRF) and multiagency partners, to develop collective assurance of local arrangements.
    - Public Health England co-ordinate the health management of the response to biological, chemical, radiological and environmental incidents, including specialist services which provide management advice and/or direct support to incident responses.
    - The Gateshead Multi-Agency Resilience and Emergency Planning Group brings together different organisations to discuss multi-agency emergency preparedness, response and resilience issues. The group ensures that Gateshead is adequately prepared to respond to disruptive challenges and that there is an appropriate level of engagement from all organisations

21. The Director of Public Health continues to be part of regional on-call arrangements to chair the Scientific and Technical Advice Cell (STAC), convened by Public Health England to co-ordinate such advice in the event of an emergency incident.

Excess winter deaths

22. In Gateshead in winter 2014/15, there were 170 excess winter deaths, compared to 70 in 2013/14. Data for 2015/16 will be available later in 2017.

23. There is significant variation in the numbers of excess winter deaths between different years. It is not always apparent why this is the case. Winter of 2014/15 had the highest number of excess winter deaths in England and Wales since 1999/00 with 41 300 more people dying in the winter months compared with the non-winter months.

24. The majority of deaths occurred amongst people aged 75 and over. There were more excess winter deaths in females than in males in 2014/15, as in previous

years. Respiratory diseases were the underlying cause of death in more than a third of all excess winter deaths in 2014/15.

Air quality

25. Gateshead Council monitors the levels of two pollutants at a number of locations across the Gateshead - nitrogen dioxide and PM2.5 particles.

26. As a result of measured levels of Nitrogen Dioxide (NO_2) exceeding the annual objective level, the council declared an Air Quality Management Area (AQMA) in April 2005 within Gateshead Town Centre. This was extended in April 2008.

27. Since 2011, the levels of NO_2 have fallen below the maximum permitted levels. Gateshead Council does not currently proposing to revoke the Gateshead Town Centre AQMA at this point, although it may be appropriate to do this following the next annual review if levels remain below the objective level.

28. The mean annual concentrations of PM2.5 have been measured at two locations since 2012. Figures indicate that PM2.5 levels have reduced since 2014/15 and remain below Air Quality Objectives, European Limit Values and World Health Organisation guidelines at both monitoring locations.

Communications

29. Communications are a vital element of health protection arrangements. Good communications demonstrate accountability and provide confidence, especially when responding to an incident.

30. A good example of the value of clear communications arose subsequently to an incident in January 2016. Residents living near the Path Head landfill site near Blaydon reported a persistent bad smell in the air. Subsequent investigation of the problem by the Council and the Environment Agency showed that high levels of rainfall in December and January had flooded the site and overwhelmed some of the environmental controls in place. This resulted in low levels of hydrogen sulphide gas being emitted by the site.

31. This gas has a characteristic “bad eggs” smell and can be detected at very low concentrations. Using measurements taken by the Environment Agency, Public Health England confirmed that the levels of the gas present did not pose a risk to health, although the odour itself was likely to make some people feel unwell sometimes.

32. The Council worked with the Environment Agency and Public Health England to make sure that the company responsible for running the site, Suez, worked quickly to re-establish control over gas emissions. Communications proved to be a significant element of the response to concerns raised by local residents.

33. Gateshead Council, PHE and the Environment Agency agreed a clear communications plan to give people concise and regular updates of the impact of the smell on health and wellbeing, and actions being taken to resolve the situation.

Conclusions

34. Existing Health Protection Assurance arrangements are generally working well and have been effective in dealing with all aspects of health protection.

35. There remain specific data issues in the newborn screening programme provided by Gateshead Health NHS Foundation Trust but, having discussed this issue with the Quality Assurance team at Public Health England, I am assured that there are appropriate manual processes and failsafes in place to ensure women are receiving appropriate antenatal screening. Nevertheless, I am concerned at the time that is being taken for NHS England and Public Health England to resolve this with the Trust. I am therefore asking Public Health England to provide me with a report on the action plan, progress to date and outlining the time-scale for this to be addressed.

Recommendations

36. Gateshead Health and Well-being Board are asked to consider and confirm whether this report provides reasonable assurance that the Director of Public Health's responsibilities to protect the health of the local population are being delivered.

Contact: Alice Wiseman, Director of Public Health, (0191) 4332777
alicewiseman@gateshead.gov.uk

Health Protection Assurance - Annual Report 2015/16

Introduction and purpose of the report

This report provides an overview of health protection arrangements and relevant activity in the borough of Gateshead from April 2015 to March 2016. The report supports the Director of Public Health's statutory remit to provide assurance to the Gateshead Health and Wellbeing Board and Gateshead Council in relation to health protection of the local population.

The Board should receive an annual report summarising the local position on health protection issues and priorities (noting the scope of issues set out in the background section of this report).

Background

Health protection describes those activities and arrangements that seek to protect the population from risks to health arising from biological, environmental or chemical hazards. It includes:

- Prevention - screening, immunisation and vaccination schemes to prevent the incidence of diseases
- Surveillance – systems of disease notification, identifying outbreaks
- Control - management of individual cases of certain diseases to reduce the risk of spread
- Communication – communicating messages and risks during urgent and emergency situations).

The Director of Public Health (DPH) is responsible for coordinating the Council's contribution to health protection issues. This includes planning for and responding to threats to the public's health. Public Health England's Health Protection Teams are responsible for the provision of specialist expert functions to respond directly to incidents and outbreaks and to support the Council in understanding and responding to threats. NHS England is responsible for the commissioning of screening, immunisation and vaccination schemes.

The DPH therefore has a local leadership role in providing assurance that robust arrangements are in place to protect the public's health. This means identifying any local issues and issuing advice appropriately. The responsibility and accountability to act upon that advice rests with the appropriate responsible organisation.

Improvements to the quality of local arrangements are achieved through a process of challenge and escalation. This may involve the organisation responsible, their commissioners or the Health and Wellbeing Board.

Arrangements in place to assure the Council that its responsibilities are being delivered

The Health Protection Assurance Working Group was established by the DPH to support her assurance role, as reported in detail in the 2014/15 annual Health Protection report. The Health Protection Assurance Working Group considers all aspects of public health protection.

The performance reports in the attached Appendices demonstrate the level of performance against each activity. Targets are not set for all indicators.

Prevention

Immunisation and screening programmes are commissioned by NHS England. The activity is co-ordinated by Public Health England's Screening and Immunisation Team. A Programme Board for each screening and immunisation meets regularly.

This meeting is attended by a Public Health representative who reports to the regional meeting of the Directors of Public Health. Further assurance is achieved through the attendance of NHS England's Public Health Commissioning Lead at the regional meeting of the Directors of Public Health.

Immunisation
Immunisation programmes help to protect individuals and communities from particular diseases. There are programmes for children and adults.

The national universal childhood immunisation programme offers protection against thirteen different vaccine preventable programmes.

The adult immunisation programme is offered to people reaching a certain age and/or those who may be at particular risk due to underlying medical conditions or lifestyle risk factors.

The full vaccination programme can be found in Appendix A. Performance for Gateshead can be found in Appendix B.

A key point to note for 2015/16 is that uptake in Gateshead for the routine childhood programme is amongst the highest in England:

- By 12 months, 95.2% of children in Gateshead had been immunised against diphtheria, tetanus, pertussis, polio, haemophilus influenza type b (93.6% in England)
- By 24 months, 92.4% (91.9%) had received measles, mumps and rubella (MMR) vaccine (dose 1)

Meningitis
Significant changes to the immunisation programme for meningitis were introduced in 2015.

The MenACWY immunisation was added to the national immunisation programme in August 2015 in response to the rising number of meningococcal W (MenW) cases aimed at teenagers and young adults. Catch-up campaigns were arranged to reach older teenagers and "freshers" at university.

In Gateshead, from September 2015 up to 31 Aug 2016, 93.6% (1839) of Year 9 students (aged 13-14) were vaccinated, and 78.7% (1567) of Year 11 students (aged 15-16). National cumulative MenACWY vaccine coverage at the end of August 2016 for the urgent catch-up cohort (ie. those born between 1 September 1996 and 31 August 1997) in England is 35.2%.

Additionally, in September 2015 a new vaccine against Meningitis B was offered for new babies as part of the routine childhood immunisation programme.

Seasonal influenza
Influenza remains a potentially life-threatening illness, and it is because of this that a national vaccination programme offers flu jabs to older people and to those with other clinical risk factors.

The purpose of the vaccination programme is to reduce the number of cases of severe flu and the numbers of deaths resulting from infection. The programme therefore:

- provides direct protection to recipients, thus preventing a large number of cases of flu, and
- provides indirect protection by lowering flu transmission within the community as a whole

In 2015/16, flu vaccine was offered to:

- those aged 65 years and over
- those aged six months to under 65 in clinical risk groups
- all pregnant women
- all two, three, and four year olds
- all children in school years 1 and 2
- those in long-stay residential care homes or other long stay care facilities
- carers

- primary school aged children in school years 1 to 6 in areas that previously participated in primary school pilots in 2014/15.

Additionally, Gateshead was part of a South of Tyne and Wear (Gateshead, South Tyneside and Sunderland) pilot site for the 2013/14 season which saw flu vaccination offered in primary school to children in reception and years one to six inclusive. The pilot continued in 2014/15 for children in reception and years one to six. The offer of vaccination in school continued to be available for children in years one to six in the former pilot area in 2015/16. Reception age children were offered vaccination through General Practice.

NHS England, which is responsible for the national flu vaccination programme, set out an ambition to immunise 75% of all adults eligible for the vaccine, and 40-60% for all groups of children.

Headline facts for flu jab uptake Gateshead in 2015/16:

- Uptake amongst **those aged 65+ is down** locally and nationally and below the 75% target
- Uptake amongst **those under 65 and at risk is down** locally and nationally
- There is **significant variation between GP practices** in uptake amongst those aged under 65 and at risk (37.9 – 60.0%)
- Uptake amongst **pregnant women is down locally** compared to last year but still up compared to 2013/14
- Uptake amongst **children is down** locally and nationally
- Uptake amongst **Gateshead NHS Foundation Trust health care workers is up**

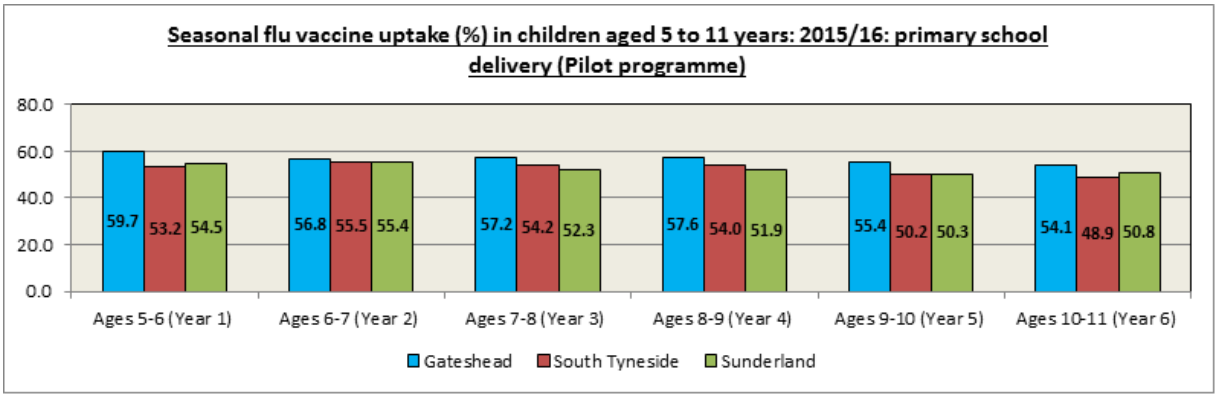
Vaccine uptake - adults

Eligible Group	2013/14 (%)	2014/15 (%)	2015/16 (%)
Aged 65+	74.8	74.9	72.6
Aged under 65 and at clinical risk	57.1	55.1	50.3
Pregnant women	36.9	48.3	46.1
Gateshead FT staff	62.9	55.8	70.6

Vaccine uptake - children

Eligible Group	2013/14 (%)	2014/15 (%)	2015/16 (%)
2 years old	47.8	38.7	40.5
3 years old	45.6	43.3	42.7
4 years old	N/A	51.5	34.4

The 2015/16 pilot programme for ages 5-11 years in primary schools showed uptake in Gateshead to be consistently higher across all of the age groups when compared to Sunderland and South Tyneside.



Screening programmes
Screening is the process of identifying people who appear healthy but may be at increased risk of a disease or condition.

Screening programmes protect the health of the population by carrying out tests on individuals to determine whether they have or are likely to develop particular, often life threatening, conditions. Individuals are selected for screening programmes based on eligibility criteria including age, gender and pre-existing conditions.

The screening progammes which are commissioned by NHS England and for which the DPH has an assurance role are:

- Cancer screening programmes (breast, bowel and cervical)
- Diabetic Retinopathy
- Abdominal Aortic Aneurysm
- Ante natal and newborn

The performance of screening programmes is given in Appendix C. This does not include information for some of the ante natal and newborn screening programmes (HIV, thalassaemia, sickle cell anaemia) as Gateshead coverage data for these for the year 2015/16 remain unavailable.

Cervical Screening
The cervical screening programme is offered to women aged 25 to 49 every three years and to women aged 50 to 64 every five years.

In 2016, 74.8% of eligible women in Gateshead had been adequately screened in the last 3.5 or 5.5 years, slightly down on 2015 (74.8%). This is similar to the North East (75.2%) and higher than England (72.7%).

The national, regional and local trend for uptake of cervical screening has shown a general downward trend since 2010.

Breast Screening
The aim of breast screening is to reduce mortality by finding breast cancer at an early stage when any changes in the breast are often too small to feel.

Screening is offered to women aged 50 to 70 every three years. Women aged over 70 can self-refer.

In Gateshead, the coverage of the breast screening programme increased from 78.5% of eligible women in 2015 to 78.9% in 2016. This is higher than the coverage across the North East (77.3%) and England (75.5%).

In Gateshead, the trend has increased since 2013, while nationally the trend has decreased.

Bowel Cancer Screening
The Bowel Cancer Screening Programme aims to detect bowel cancer at an early stage when treatment is more likely to be effective. It is offered to men and women aged 60 to 74 every two years. Those aged 75+ can request screening.

In 2016, 60.4% of eligible people were screened, higher than across the North East (59.4%) and England (57.9%).

Newcastle Gateshead CCG's Practice Engagement Programme, designed to improve patient outcomes for a range of different indicators, saw 15 Gateshead practices working to increase uptake of bowel cancer screening. The number of eligible adults having a recorded bowel cancer screening result rose by

8.57% since the start of the scheme, which equates to an additional 17,221 results being recorded. Note that this indicator is measured as a rolling 30 month period.

Cancer screening and health inequalities

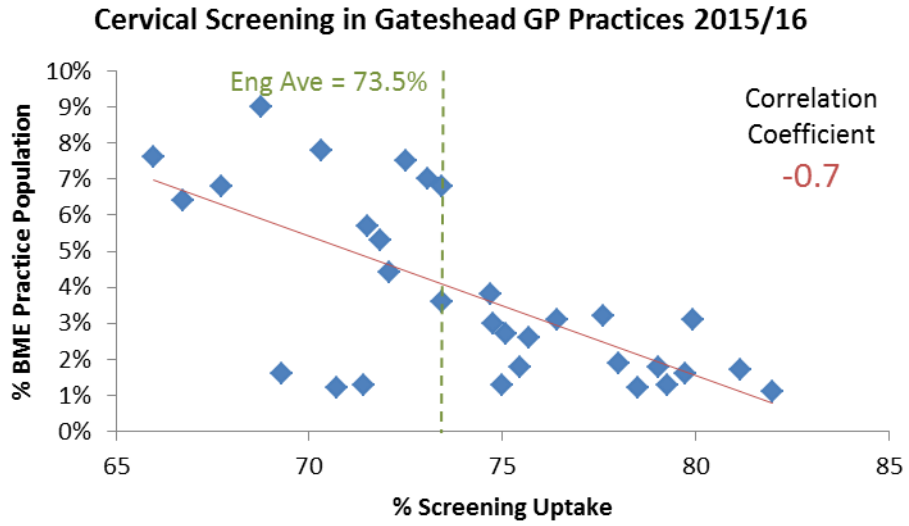
National evidence suggests that there are discernible inequalities in the uptake of cancer screening programmes for different groups. These differ between different programmes and different groups, but broadly, uptake for the three cancer screening programmes (breast, bowel and cervical) tends to be "inversely related" to deprivation and to the proportion of a practice's patients that are from a black or minority ethnic (BME) community.

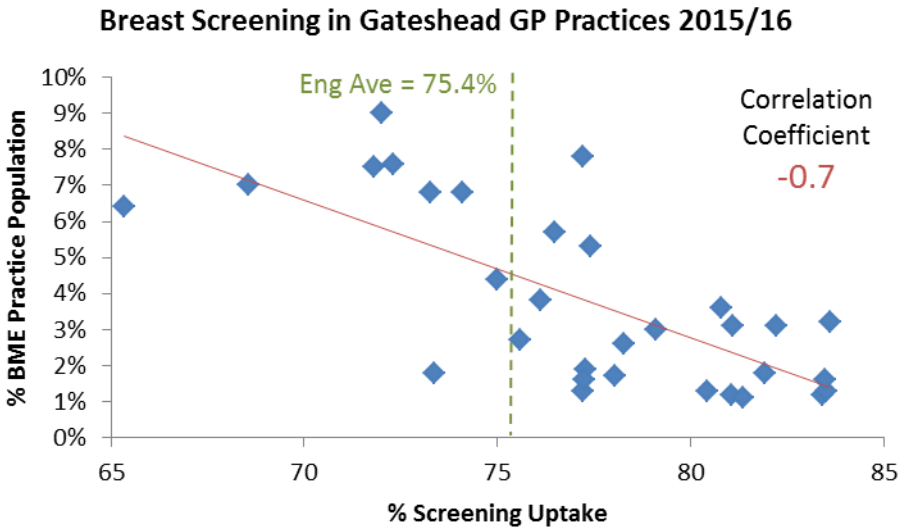
This means that the uptake of cancer screening programmes is generally lower amongst patients of practices in more deprived areas and in practices that have a relatively high number of BME patients. This is true locally, as demonstrated in the scatter plots below. These plot practice screening rates for each of the three cancer programmes by deprivation and by the proportion of their patient list who are from BME communities.

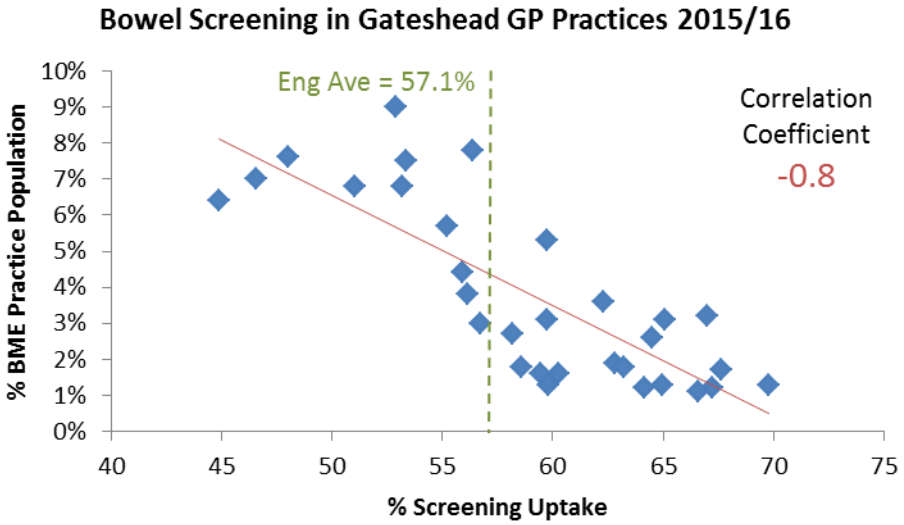
There may be a number of reasons for this, including health literacy (for example lower awareness of the importance of screening), or access to services (for example the cost of travel). The lower uptake amongst BME communities may be explained by deprivation rather than any specific factors related to ethnicity, such as language barriers.

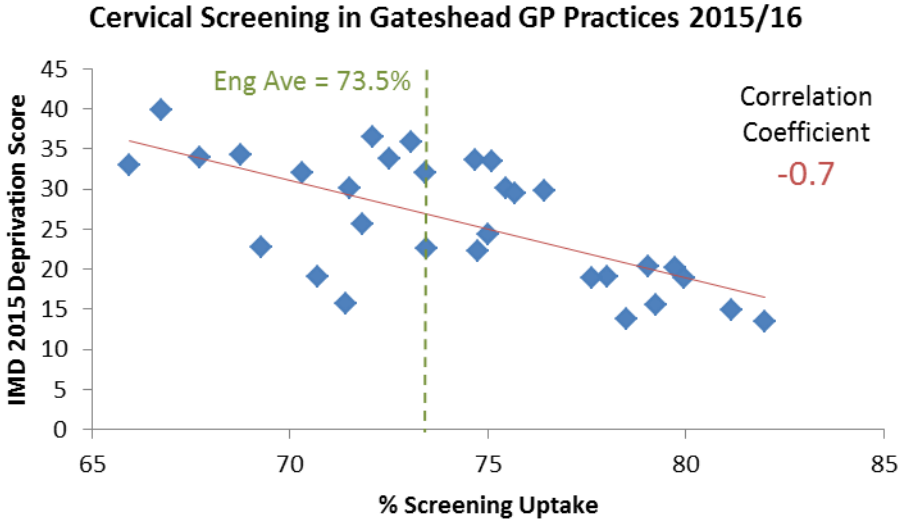
However, it should be noted there are exceptions to this – some practices serving more deprived areas or with high numbers of BME patients manage to achieve uptake levels above the national uptake rates, and at levels similar to practices in less deprived areas and with lower number of BME patients.

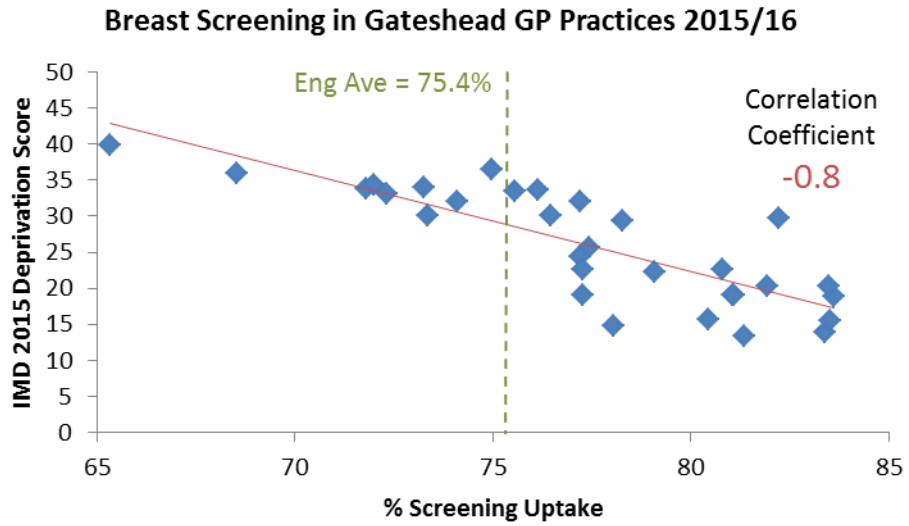
Work is in hand with partners in the NHS, Public Health England and third sector organisations to share good practise and raise uptake of cancer screening programmes across the whole of Gateshead.

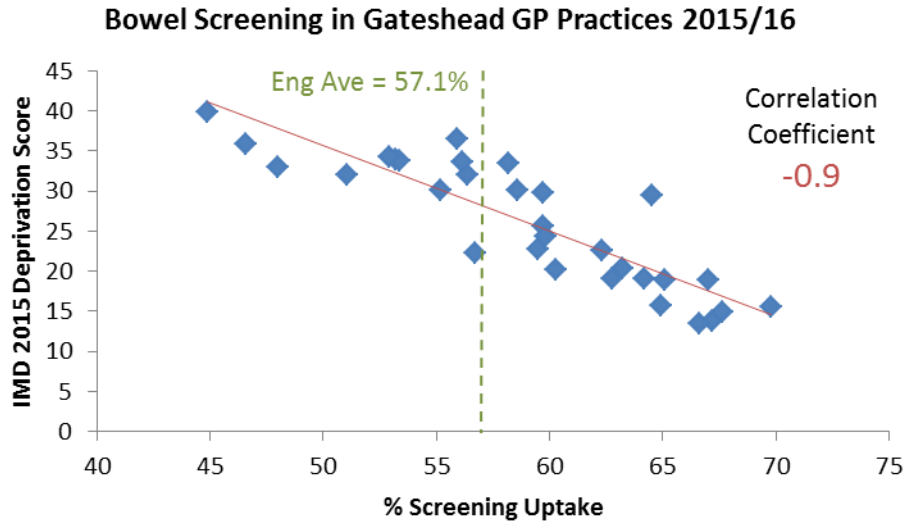



Breast Screening in Gateshead GP Practices 2015/16
Eng Ave = 75.4%
Correlation Coefficient
-0.7
% BME Practice Population
10%
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
65
70
75
80
85
% Screening Uptake


Bowel Screening in Gateshead GP Practices 2015/16
Eng Ave = 57.1%
Correlation Coefficient
-0.8
% BME Practice Population
10%
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
40
45
50
55
60
65
70
75
% Screening Uptake


Cervical Screening in Gateshead GP Practices 2015/16
Eng Ave = 73.5%
Correlation Coefficient
-0.7
IMD 2015 Deprivation Score
45
40
35
30
25
20
15
10
5
0
65
70
75
80
85
% Screening Uptake



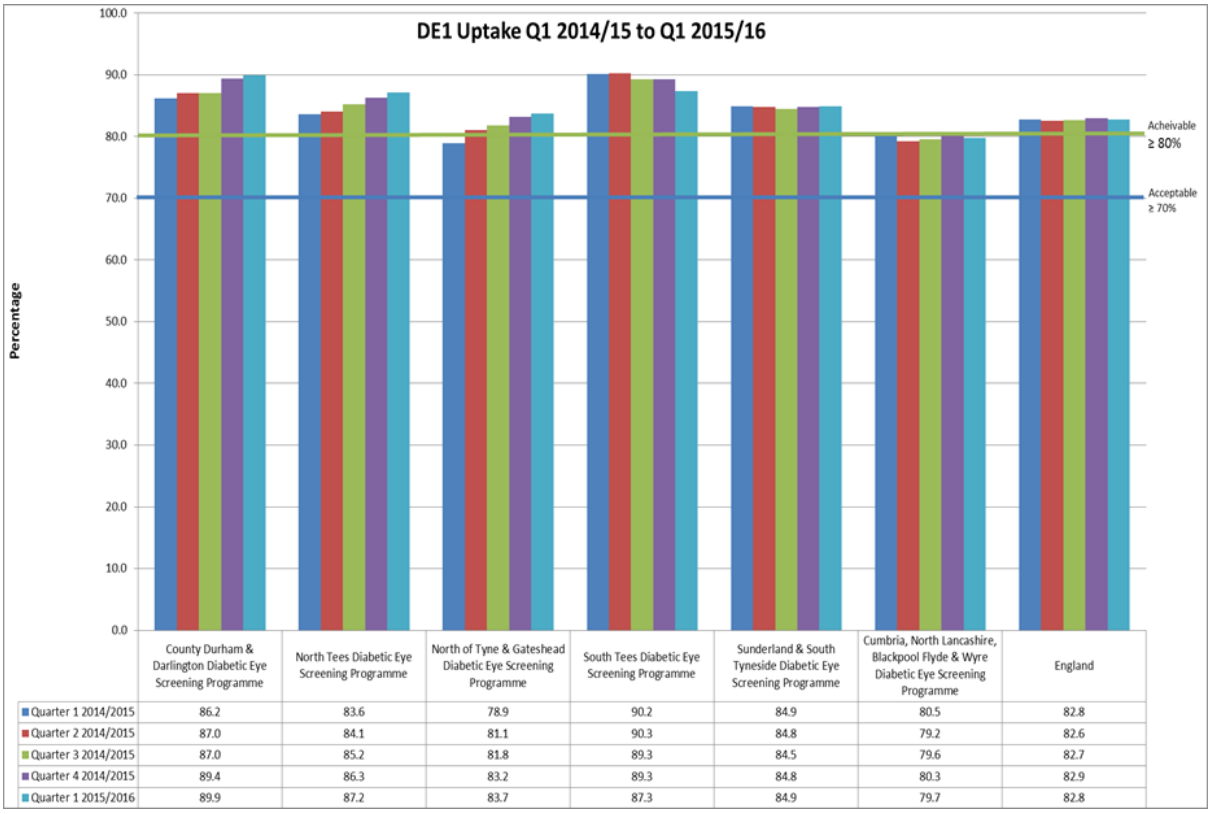


Diabetic Eye Screening

People with diabetes are at risk of damage to their eyes from a condition called diabetic retinopathy. The condition occurs when high sugar levels affect small blood vessels at the back of the eye (the retina). Damage to the blood vessels in a particular part of the retina can lead to a condition (diabetic maculopathy) that can lead to sight loss if it is not treated.

Diabetic retinopathy is one of the most common causes of sight loss among people of working age. The condition does not usually cause noticeable symptoms in the early stages. It can be detected by examining the blood vessels at the back of the eye and, if present, treated.

Early detection and treatment can slow or stop further vision loss. This is why the NHS Diabetic Eye Screening Programme was introduced. Everyone aged 12 and over with diabetes is offered screening once a year. In North of Tyne and Gateshead, diabetic eye screening is carried out by Medical Imaging UK Ltd. (rebranded as EMIS Care from April 2016).



	County Durham & Darlington Diabetic Eye Screening Programme	North Tees Diabetic Eye Screening Programme	North of Tyne & Gateshead Diabetic Eye Screening Programme	South Tees Diabetic Eye Screening Programme	Sunderland & South Tyneside Diabetic Eye Screening Programme	Cumbria, North Lancashire, Blackpool Flyde & Wyre Diabetic Eye Screening Programme	England
Quarter 1 2014/2015	86.2	83.6	78.9	90.2	84.9	80.5	82.8
Quarter 2 2014/2015	87.0	84.1	81.1	90.3	84.8	79.2	82.6
Quarter 3 2014/2015	87.0	85.2	81.8	89.3	84.5	79.6	82.7
Quarter 4 2014/2015	89.4	86.3	83.2	89.3	84.8	80.3	82.9
Quarter 1 2015/2016	89.9	87.2	83.7	87.3	84.9	79.7	82.8

Fig. 1 – Diabetic Eye Screening Uptake

Reporting of uptake of the Diabetic Eye Screening Programme is only available at North of Tyne and Gateshead level. Fig. 1 shows that the North of Tyne and Gateshead programme achieves an uptake of well above the 70% minimum standard and, at the beginning of 2015/16, was starting to exceed the 80% achievable uptake rate. The provider for the service is required to demonstrate a continuous increase in uptake rates.

From the 1st April 2016 service improvements are being implemented to increase the effectiveness of the screening programme. The new service improvements will include:

- More access to screening locations for more people.
- Slit Lamp surveillance screening.
- An increase in clinical leadership.
- Choice-driven appointment booking process.

Areas for further improvement include:

- introducing a CQUIN for local programmes to target the younger diabetics whose uptake is poor
- consideration of issues arising from a Health Equity Audit for all screening programmes

A Health Equity Audit of the North of Tyne and Gateshead programme showed inequalities in uptake of screening between different age groups and between those living in the least and most socioeconomically deprived areas. The Screening and Immunisation Team is working with the recommendations arising from the audit to improve uptake.

Abdominal aortic aneurysm screening

Abdominal aortic aneurysm (AAA) screening is a way of detecting a dangerous swelling (aneurysm) of the aorta – the main blood vessel that runs from the heart, down through the abdomen to the rest of the body.

Screening is a way of detecting an aneurysm early and can cut the risk of dying from an abdominal aortic aneurysm by about half.

This swelling is far more common in men aged over 65 than it is in women and younger men, so men are invited for screening in the year they turn 65.

The most recent data (2015/16) for the programme shows a decrease in coverage in Gateshead compared to the previous year from 78.2% to 76.4%. Uptake is lower than England (79.9%) and the North East (77.6%).

Ante-natal and new born screening programmes
Ante-natal and new borne screening programmes include:

- NHS foetal anomaly screening programme (FASP)
- NHS infectious diseases in pregnancy screening (IDPS) programme
- NHS newborn and infant physical examination (NIPE) screening programme
- NHS newborn blood spot (NBS) screening programme
- NHS newborn hearing screening programme (NHSP)
- NHS sickle cell and thalassaemia (SCT) screening programme

The foetal anomaly screening programme was extended to offer screening for two more anomalies. From April 2015, women are offered screening tests for Edwards' and Patau's syndromes. Children with these syndromes usually die before or soon after birth. The screening test improves the choices available to parents sooner.

Performance data is included in Appendix C for those programmes for which data are available.

Coverage of the Ante-Natal and Newborn screening programme is high for those areas where data is available, although this does not reflect geographic inequalities within the borough:

Key points to note are:

- At the Gateshead Health NHS Foundation Trust, 86.2% of eligible babies received the newborn clinical physical examination within 72 hours of birth in 2015/16 (England 94.9%);
- Newborn bloodspot coverage across the Newcastle Gateshead CCG area continues to be high at 98.0% for 2015/16 (England 95.6%);
- Newborn hearing screening coverage across Gateshead, South Tyneside and Sunderland continues to be high at 99.1% for 2015/16 (England 98.2%).

However, data is not available for all key performance indicators for NIPE, and for the remaining areas of the newborn programme as the Gateshead Health NHS Foundation Trust are not able to provide data to meet the national programme standards nor for all the performance indicators.

Surveillance
Effective surveillance systems ensure the early detection and notification of particular communicable diseases. Public Health England's Health Protection Team obtains data from a wide variety of sources, including healthcare staff, hospitals, sexual health services, local authority environmental health teams, care homes, schools and nurseries. This information is closely monitored to make sure that individual cases of disease are effectively treated and prevented from spreading, and that outbreaks of infections are monitored, analysed and controlled.

Gateshead Council's Environmental Health team are an important resource in identifying and investigating cases and outbreaks of, especially, foodborne infections, including food poisoning.

Throughout the year the Council received notification of 242 cases of campylobacter, an increase of 30 over the previous year. Other food related infectious disease notifications rose by 50 to 153 cases. This includes all cases of Salmonella reported to the Council and four outbreaks investigated throughout the year. The incidence of food poisoning tends to increase during the summer months.

Case Study
In December 2015 the Council was notified of a number of gastro intestinal illnesses in staff across two sites of a children's day nursery within the borough. Investigations revealed the common source was the Christmas Dinner provided to staff and children at the two sites. All affected staff were found to be suffering from Clostridium perfringens. Analysis of staff faecal samples and the suspected food source showed them to be contaminated with C. perfringens from the same source. It was decided to prosecute the company for its failings, but before the case could be finalised the company went into liquidation.

Improvements in the use of DNA analysis of samples has led to an improvement in linking cases together and linking cases to any food recovered during the investigation of a food poisoning outbreak. This could have the result of linking cases across the country, not just locally. It is also having the effect of proving that cases are not linked together, even if the organism is the same species. This has had a significant impact on the investigation of outbreaks.

The Council now records all reported cases of food related infectious disease on a secure electronic database. This enables easier handling of cases and comparison of yearly statistics. It also assists in the early identification of exceedances and links between cases, suggesting possible outbreaks.

Healthcare Associated Infections (HCAIs)
Public Health England (PHE) monitors the numbers of certain infections that occur in healthcare settings through routine surveillance programmes, and advises on how to prevent and control infection in establishments such as hospitals, care homes and schools.

PHE also monitors the spread of antibiotic resistant infections and advises healthcare professionals about controlling antimicrobial resistance.

Trends in rates of infections for the Newcastle and Gateshead CCG are given below:

Rate of infection per 100 000 people	2013/14	2014/15	2015/16
MRSA	1	1	2
MSSA	20.9	18.2	23.4
E. coli	65.6	78.3	81.0
C. difficile	29.3	35.9	40.5

Control – Specific Disease
Tuberculosis (TB)
Tuberculosis (TB) is an infection that can be caught by breathing in bacteria from someone who has infectious TB.

People who live in areas with high levels social deprivation are most vulnerable to developing TB. These include those who are homeless, poor housing, live in poverty or are drug users.

More than 6 500 cases of TB were reported across England in 2014, and of these over 2 500 occurred in London.

Gateshead has small numbers of cases of TB, with a significant rise in cases between 2013 and 2014:

Year	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14
No of TB Cases	7	6	7	6	2	3	8	4	7	14	3	9	12	9	21

Once diagnosed, patients are supported by a Specialist Health Visitor to ensure that they limit their risk of transmitting the infection and to ensure that they comply with and complete their treatment regimen.

Scarlet fever IGAS

Cases of scarlet fever, a common and usually mild childhood bacterial infection, continued to rise for the third season in a row during 2015/16. In the North East, notifications rose from 536 in 2014/15 to 667 in 2015/16.

The bacterium responsible for scarlet fever can also cause potentially lethal infections called invasive group A streptococcal infections (IGAS).

Cases of this more serious infection have also increased across the North East from 79 in 2011 to 269 in 2014. Each case is extensively investigated by the local Health Protection Team with contacts followed up and offered advice and/or treatment as necessary.

Sexually transmitted infections (STIs)

Gateshead Council is responsible for commissioning comprehensive, open access sexual health services.

A new model Integrated Sexual Health Service was commissioned by the Council from 1st April 2015. Based in Gateshead town centre, it is supported by local clinics and outreach services (http://www.gatesheadsexualhealth.co.uk/).

Gateshead data regarding STIs in 2015 (unless otherwise specified) shows that:

- Overall 1325 new sexually transmitted infections (STIs) were diagnosed in residents of Gateshead, a rate of 660.8 per 100,000 residents (compared to 767.6 per 100,000 in England).
- Gateshead has the 119th highest rate (out of 326 local authorities in England) of new STIs excluding chlamydia diagnoses in 15-24 year olds; with a rate of 695.9 per 100,000 residents (compared to 815 per 100,000 in England).
- 54% of diagnoses of new STIs in Gateshead were in young people aged 15-24 years (compared to 45% in England). This includes those tested in specialist sexual health clinics (SHCs) only.
- For cases in men where sexual orientation was known, 24.6% of new STIs in Gateshead were among men who have sex with men (MSM) (specialist SHCs only).
- The chlamydia detection rate per 100,000 young people aged 15-24 years in Gateshead was 1760.9 (compared to 1,887 per 100,000 in England).
- Gateshead has the 46th highest rate (out of 326 local authorities in England) for gonorrhoea, which is a marker of high levels of risky sexual activity. The rate of gonorrhoea diagnoses per 100,000 in this local authority was 69.8 (compared to 70.7 per 100,000 in England).
- In Gateshead, an estimated 8.6% of women and 8.8% of men presenting with a new STI at a specialist SHC during the 5 year period from 2010 to 2015 were re-infected with a new STI within 12 months.
- Among specialist SHC patients from Gateshead who were eligible to be tested for HIV, 68.2% were tested (compared to 67.3% in England)
- There were 11 new HIV diagnoses in Gateshead. The diagnosed HIV prevalence was 1.5 per 1,000 population aged 15-59 years (compared to 2.26 per 1,000 in England).
- In Gateshead, between 2013 and 2015, 42.3% of HIV diagnoses were made at a late stage of infection (CD4 count <350 cells/mm^3 within 3 months of diagnosis) compared to 40.3% in England.

Emergency preparedness, resilience and response (EPRR)

Local health protection arrangements must also plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease, a major transport accident or a terror attack.

Planning takes place at regional and local levels:

- The Local Health Resilience Partnership (LHRP) is responsible for ensuring that the arrangements for local health protection responses are robust and resilient. The LHRP works with the Local Resilience Forum (LRF) and multiagency partners, to develop collective assurance of local arrangements.
- Public Health England co-ordinate the health management of the response to biological, chemical, radiological and environmental incidents, including specialist services which provide management advice and/or direct support to incident responses.
- The Gateshead Multi-Agency Resilience and Emergency Planning Group brings together different organisations to discuss multi-agency emergency preparedness, response and resilience issues. The group ensures that Gateshead is adequately prepared to respond to disruptive challenges and that there is an appropriate level of engagement from all organisations

The Director of Public Health continues to be part of regional on-call arrangements to chair the Scientific and Technical Advice Cell (STAC), convened by Public Health England to co-ordinate such advice in the event of an emergency incident.

Excess winter deaths in 2014/15 and 2015/16

Detailed information on excess winter deaths at a local level is not usually available until the following year. This section of the report will detail what is now known about excess winter deaths in 2014/15, and what is currently known about excess winter deaths in 2015/16.

The ONS standard method defines the winter period as December to March, and compares the number of deaths that occurred in this winter period with the average number of deaths occurring in the preceding August to November and the following April to July:

EWM = winter deaths - average non-winter deaths

The EWM index is calculated so that comparisons can be made between sexes, age groups and regions, and is calculated as the number of excess winter deaths divided by the average non-winter deaths, expressed as a percentage:

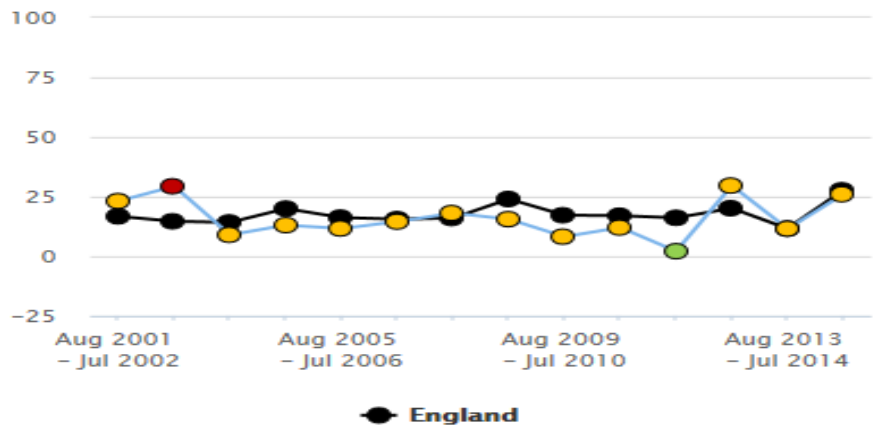
$$\textbf{EWM Index} = \frac{\textbf{EWM}}{\textbf{Average of non-winter deaths}} \times 100$$

In Gateshead in winter 2014/15, there were 170 excess winter deaths, compared to 70 in 2013/14.

There is significant variation in the numbers of excess winter deaths between different years. It is not always apparent why this is the case. Winter of 2014/15 had the highest number of excess winter deaths in England and Wales since 1999/00 with 41 300 more people dying in the winter months compared with the non-winter months.

The majority of deaths occurred amongst people aged 75 and over. There were more excess winter deaths in females than in males in 2014/15, as in previous years. Respiratory diseases were the underlying cause of death in more than a third of all excess winter deaths in 2014/15.

The excess winter mortality index was highest in the South West in 2014/15 and joint lowest in Yorkshire and The Humber, and Wales.



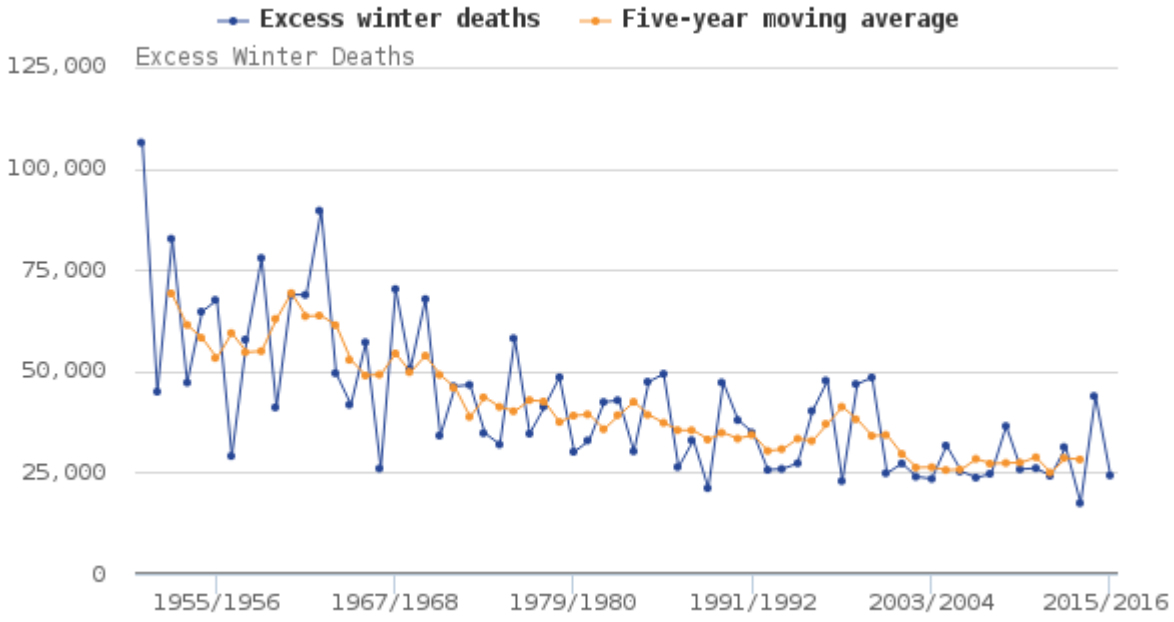
Excess winter deaths index for Gateshead (single year, all ages) (Persons)

Colder temperatures were not the main cause of the increase in winter deaths in 2014/15, as the mean monthly temperature was above average from September through to January and similar to, or slightly below, the average for all other months.

The predominant influenza virus in winter 2014/15 was a strain of flu (H3N2) that had a particularly noticeable effect on the elderly, resulting in numerous care home outbreaks and far higher levels of excess mortality than the last notable H3N2 season of 2008/09. Although uptake of the flu vaccine was close to target amongst people aged 65 and over, the vaccine was less effective.

There is some evidence that those living in poorer quality housing are more likely to die during the winter months. This has been attributed to generally poorer housing standards, being in fuel poverty, and being unable to heat one's home to a reasonable temperature at an affordable price.

Excess winter mortality in England and Wales was back in line with average trends in 2015/16. There were an estimated 24 300 excess winter deaths more than one third of which were caused by respiratory diseases.



Source: Office for National Statistics

Specific figures for excess winter mortality in Gateshead in 2015/16 will be available later in 2017.

Air quality

Poor air quality is associated with a number of adverse health impacts. It is recognised as a contributing factor in the onset of heart disease and cancer. Additionally, air pollution particularly affects the most vulnerable in society: children and older people, and those with heart and lung conditions. There is also often a strong correlation with equalities issues, because areas with poor air quality are also often the less affluent areas.

The Environment Act 1995 requires the Council to review and assess the air quality in Gateshead. There are two pollutants in particular that cause problems with air quality in Gateshead and are related substantially to the use of transport. They are nitrogen dioxide (NO2) and particulate matter less than 2.5 microns in size (PM2.5) - both have short and long term effects on human health.

Gateshead Council monitors these two pollutants at a number of locations across the Gateshead Borough using automatic and non-automatic monitoring arrangements. Some of these monitoring locations represent the worst case scenario of road traffic flows/congestion in Gateshead but in areas where there are residents who are exposed to these pollutants. By monitoring and understanding pollutant concentrations in these locations we can be satisfied that other areas in the borough will be well below air quality objective standards.

As a result of measured levels of Nitrogen Dioxide (NO2) exceeding the annual objective level, the council declared an Air Quality Management Area (AQMA) in April 2005 within Gateshead Town Centre. This was extended in April 2008.

Air pollutants are monitored on a daily basis in Gateshead and the results are reported per calendar year to the Department for Environment, Food and Rural Affairs (DEFRA).

Since 2011, the levels of NO2 have fallen below the air quality annual mean objective and the monitoring data for 2015 shows that NO2 levels continue to remain below the mean objective level of 40µg/m3 within the AQMA. The monitoring data also indicates that there were no exceedances of the annual mean objective outside of the AQMA in 2015/16. Gateshead Council does not currently proposing to revoke the Gateshead Town Centre AQMA at this point, although it may be appropriate to do this following the next annual review if levels remain below the objective level.

The mean annual concentrations of PM2.5 have been measured at two locations since 2012. Figures indicate that PM2.5 levels have reduced since 2014/15 and remain below Air Quality Objectives, European Limit Values and World Health Organisation guidelines at both monitoring locations.

Communications

Communications are a vital element of health protection arrangements. Good communications demonstrate accountability and provide confidence, especially when responding to an incident.

A good example of the value of clear communications arose subsequently to an incident in January 2016. Residents living near the Path Head landfill site near Blaydon reported a persistent bad smell in the air. Subsequent investigation of the problem by the Council and the Environment Agency showed that high levels of rainfall in December and January had flooded the site and overwhelmed some of the environmental controls in place. This resulted in low levels of hydrogen sulphide gas being emitted by the site.

This gas has a characteristic “bed eggs” smell and can be detected at very low concentrations. Using measurements taken by the Environment Agency, Public Health England confirmed that the levels of the gas present didn’t pose a risk to health, although the odour itself was likely to make some people feel unwell sometimes. Even if environmental odours are not directly related to any known hazards to human health, psychophysical well-being can be negatively influenced by exposure. Also, some people may be hypersensitive to chemicals that cause odours. This can induce physical and mental distress, which can in turn affect risk perception.

The Council worked with the Environment Agency and Public Health England to make sure that the company responsible for running the site, Suez, worked quickly to re-establish control over gas emissions. It became clear that regaining control would require substantial works on the site that would take some weeks to complete. This meant that the smell was likely to persist.

Communications proved to be a significant element of the response to concerns raised by local residents. Gateshead Council, PHE and the Environment Agency agreed a clear communications plan to give people concise and regular updates of the impact of the smell on health and wellbeing, and actions being taken to resolve the situation.

Actions extended well into 2016 which led to a significant reduction in complaints about odour from the site.

Reporting

This report will be presented to Cabinet, the Gateshead Health and Wellbeing Board and to the Newcastle/Gateshead Clinical Commissioning Group, to ensure that NHS partners are aware of the Council's Health Protection Assurance role and facilitate and reinforce multiagency cooperation.

The Director of Public Health reports to the Chief Executive of Gateshead Council and is a member of the Health and Wellbeing Board and the CCG Governing Body.

Conclusion

Existing Health Protection Assurance arrangements are working well and have been effective in dealing with all aspects of health protection.

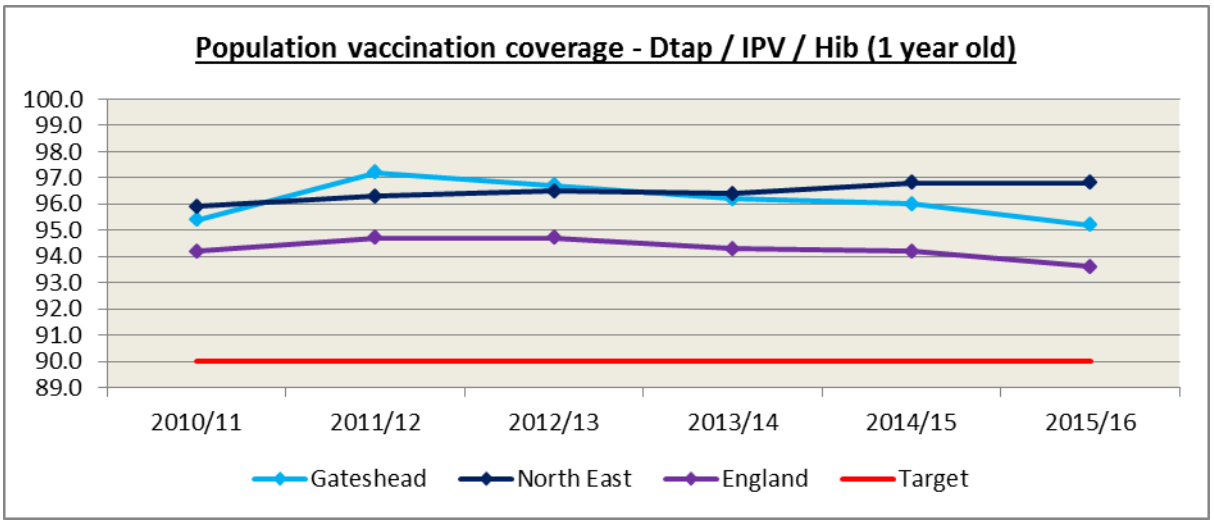
As the changes across the health and social care economy are embedded, it is important to keep the arrangements in Gateshead under review.

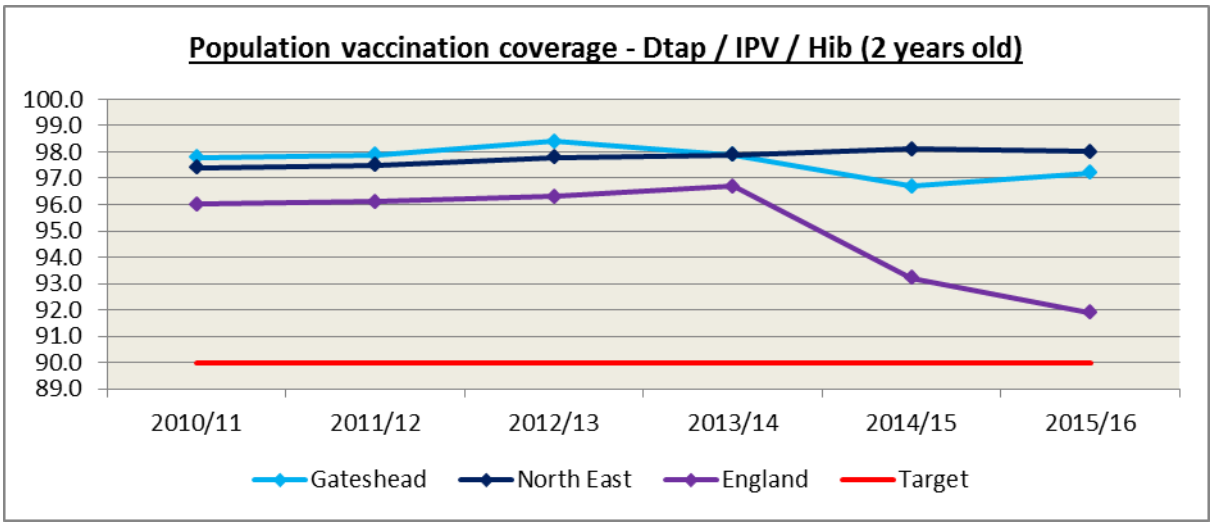
Alice Wiseman
Director of Public Health

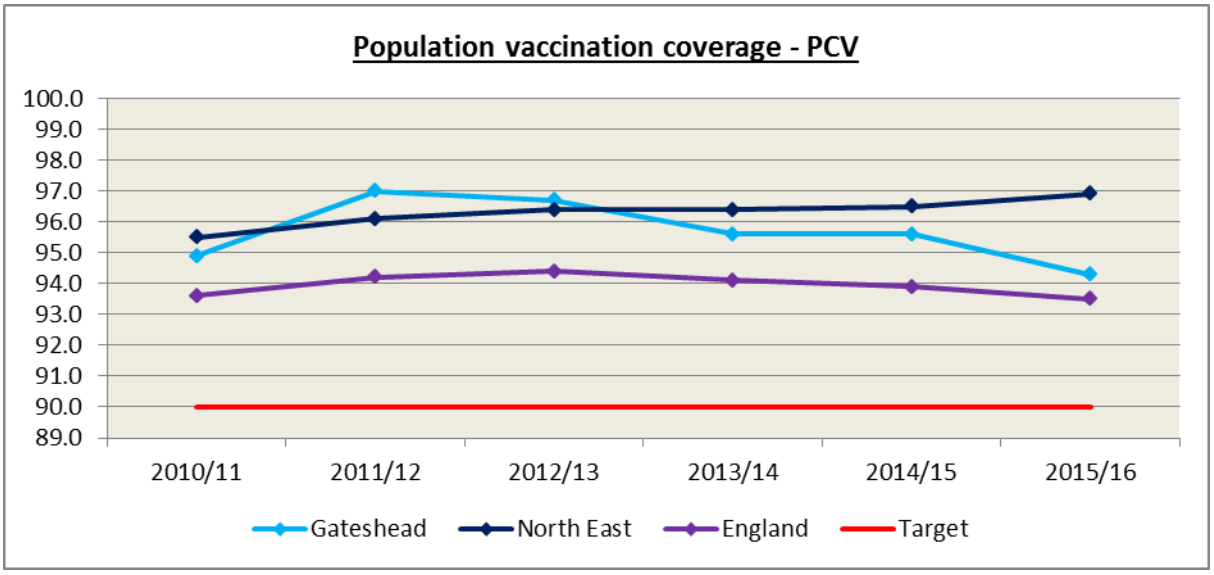
Programme	Organism/disease protected against
Routine programme Pre-school childhood programme (different components given on five occasions)	Diphtheria, tetanus, pertussis, polio, haemophilus influenza type b, pneumococcal disease, meningitis C, meningitis B, measles, mumps and rubella and rotavirus
Routine programme Annual for 2 to 6 year olds (and all children in school years 1 and 2 for winter 2015/16)	Seasonal influenza
Routine programme School-based programme	Booster – tetanus, diphtheria and polio and menACWY
Routine programme School-based programme – girls only	Human papilloma virus (HPV)
At risk programme. Annual. Offered to all people over 65 and those in nationally defined clinical at risk groups	Seasonal influenza
At risk programme. Offered to those over 65, usually on a one off basis, and those in nationally defined clinical at risk groups	Pneumococcal disease
At risk programme. Offered to all people aged 70	Shingles
At risk programme. Offered to all pregnant women who are 20 weeks pregnant	Pertussis (Whooping cough)
At risk programme. Offered to all pregnant women during flu season, at any stage of pregnancy	Seasonal influenza
At risk programme. Offered to babies of mothers found to have Hepatitis B as a result of the antenatal infectious diseases screening programme	Hepatitis B
At risk programme. Offered to babies with a parent or grandparent who was born in a country where the annual incidence of TB is 40/100,000 or greater	Tuberculosis
At risk programme. People in prison	Hepatitis B, other vaccines that are indicated due to health or lifestyle factors, and any missed components of the childhood programme

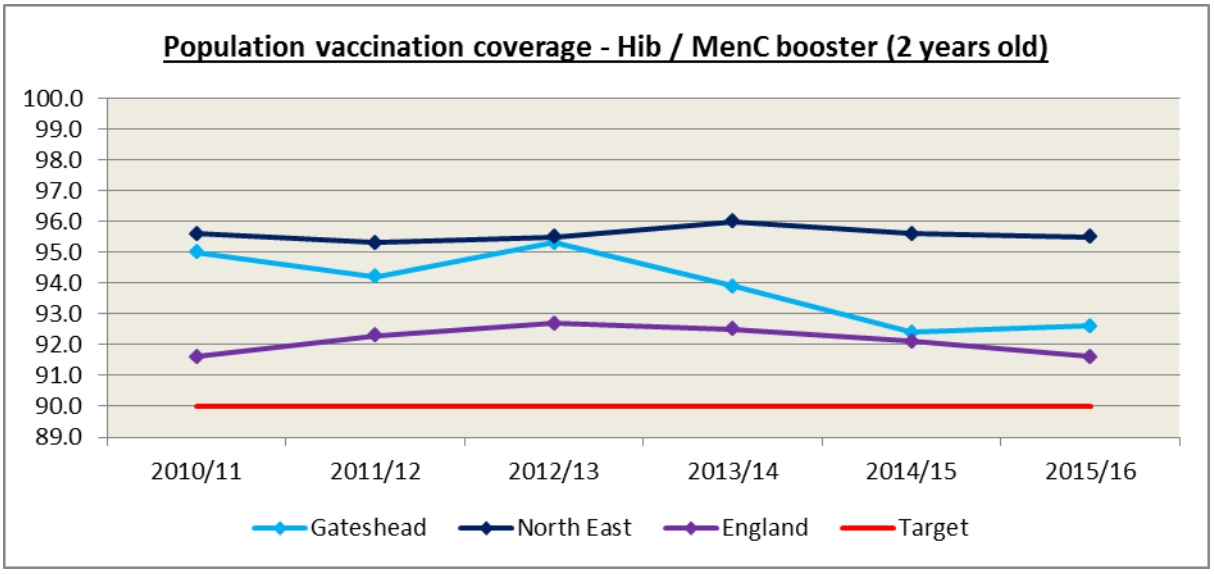
Dtap/IPV/Hib

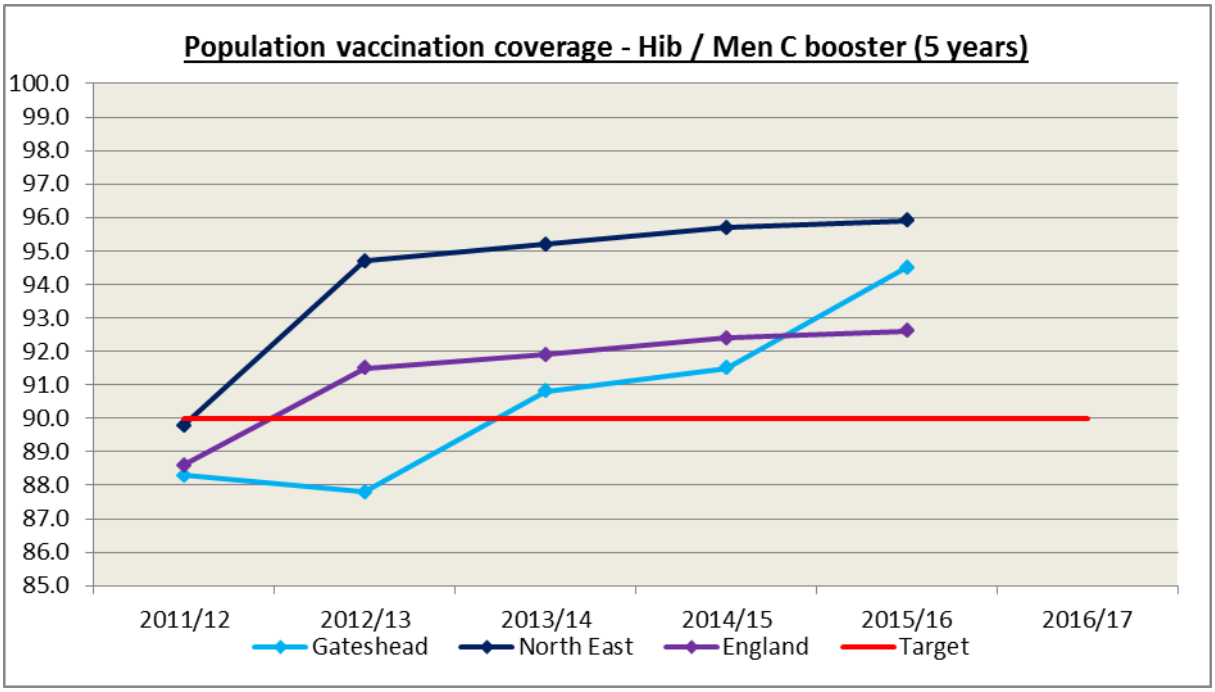
This single jab contains vaccines to protect against five separate diseases:
diphtheria, tetanus, whooping cough (pertussis), polio and Haemophilus influenzae type b (known as Hib – a bacterial infection that can cause severe pneumonia or meningitis in young children)








Population vaccination coverage - Hib / MenC booster (2 years old)
100.0
99.0
98.0
97.0
96.0
95.0
94.0
93.0
92.0
91.0
90.0
89.0
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
Gateshead
North East
England
Target


Population vaccination coverage - Hib / Men C booster (5 years)
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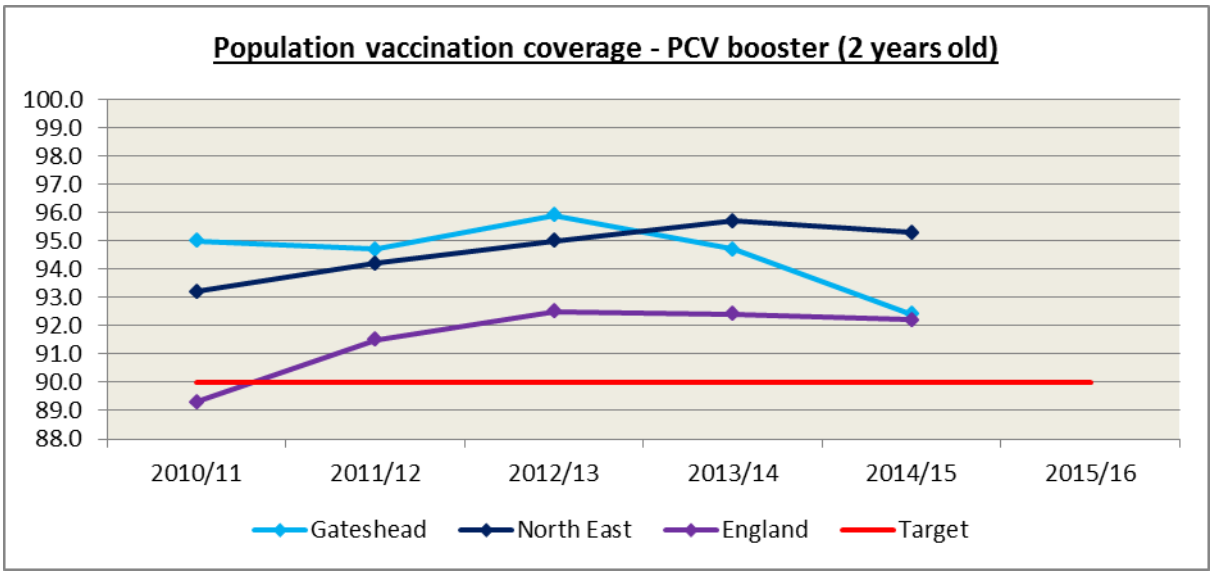
99.0
98.0
97.0
96.0
95.0
94.0
93.0
92.0
91.0
90.0
89.0
88.0
87.0
86.0
85.0
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
Gateshead
North East
England
Target


Population vaccination coverage - PCV booster (2 years old)
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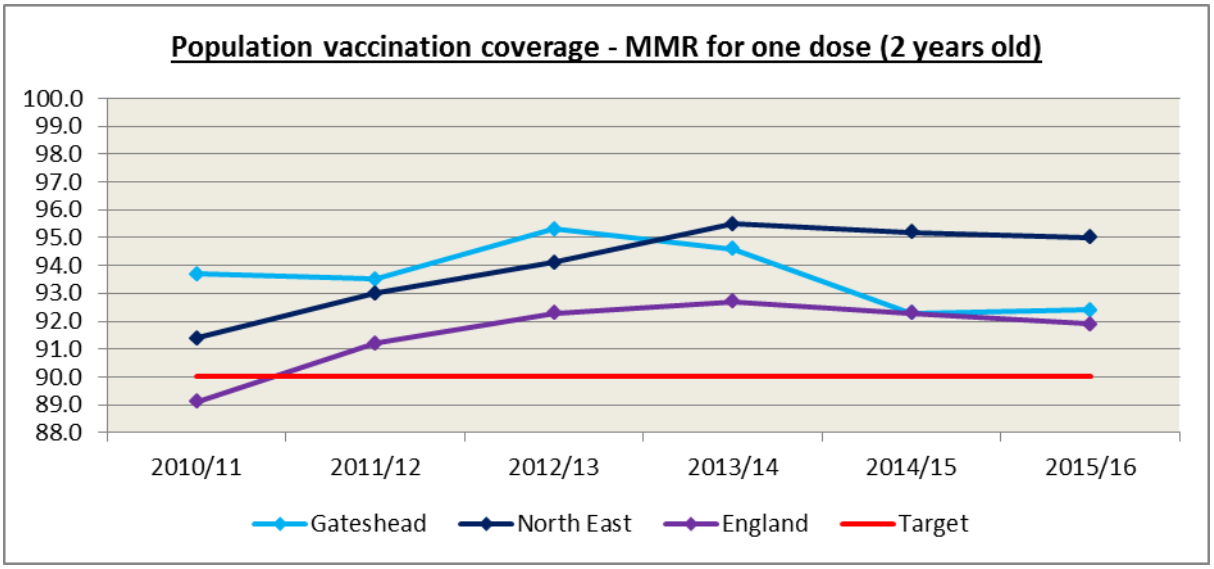
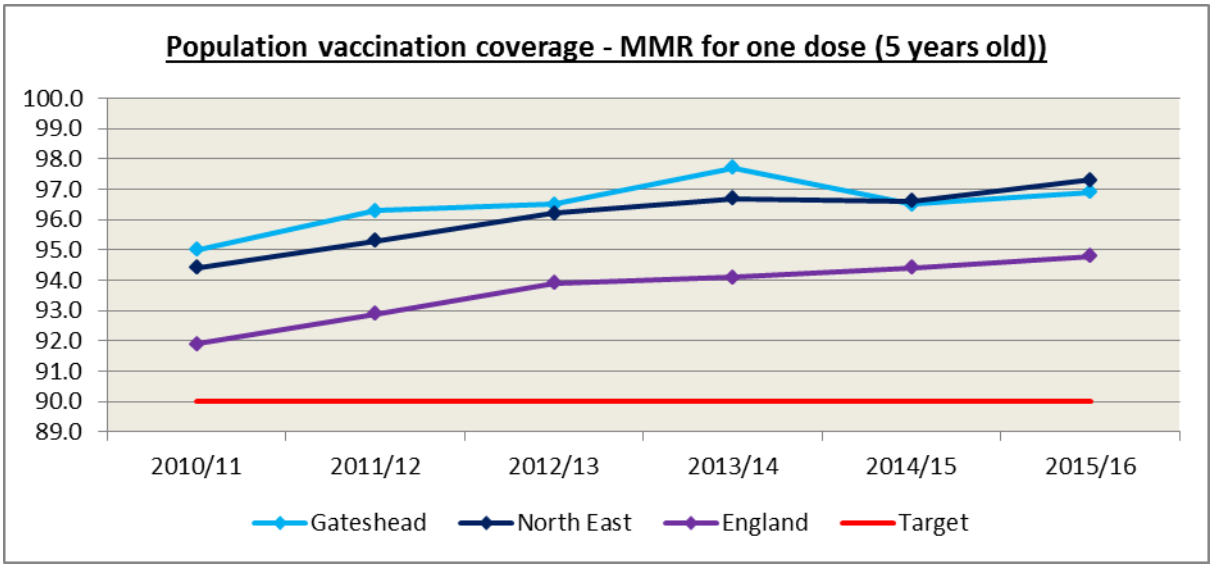
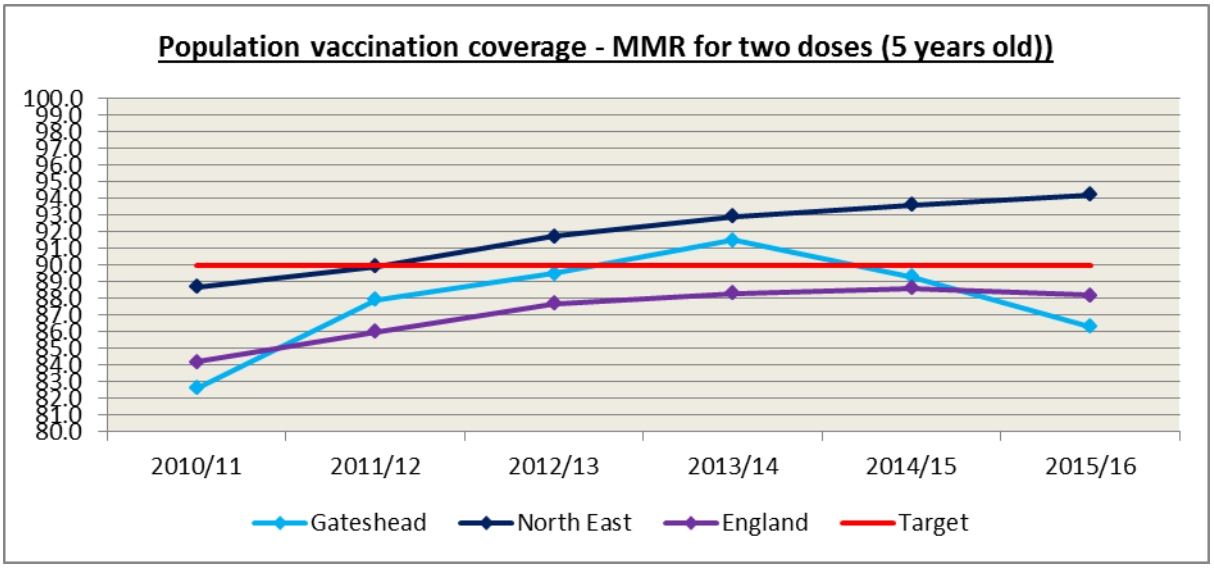
99.0
98.0
97.0
96.0
95.0
94.0
93.0
92.0
91.0
90.0
89.0
88.0
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
Gateshead
North East
England
Target


Population vaccination coverage - MMR for one dose (2 years old)
100.0
99.0
98.0
97.0
96.0
95.0
94.0
93.0
92.0
91.0
90.0
89.0
88.0
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
Gateshead
North East
England
Target


Population vaccination coverage - MMR for one dose (5 years old))
100.0
99.0
98.0
97.0
96.0
95.0
94.0
93.0
92.0
91.0
90.0
89.0
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
Gateshead
North East
England
Target


Population vaccination coverage - MMR for two doses (5 years old))
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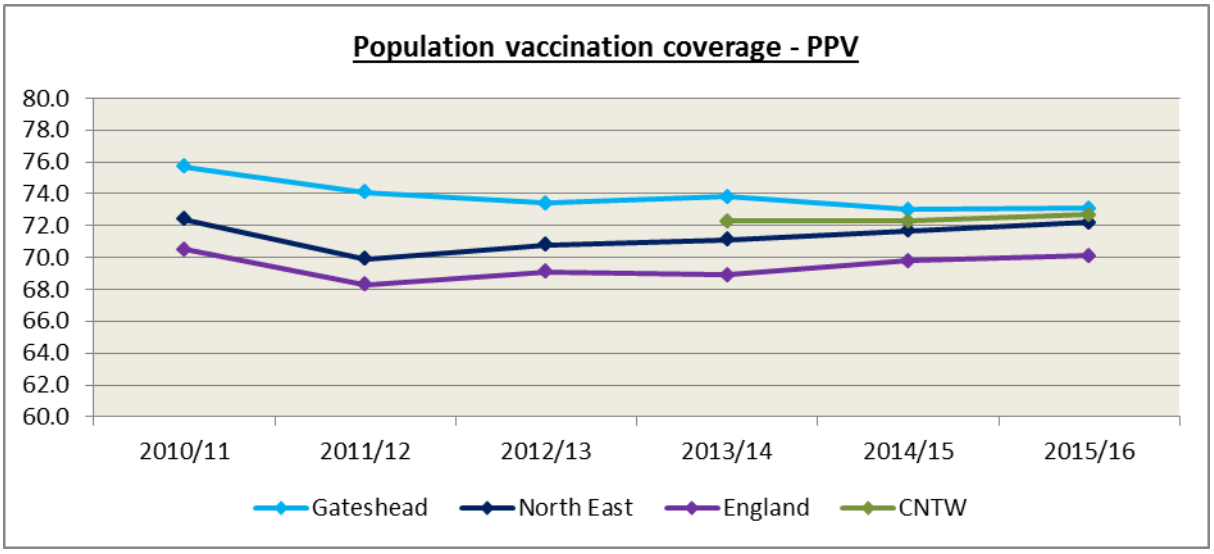
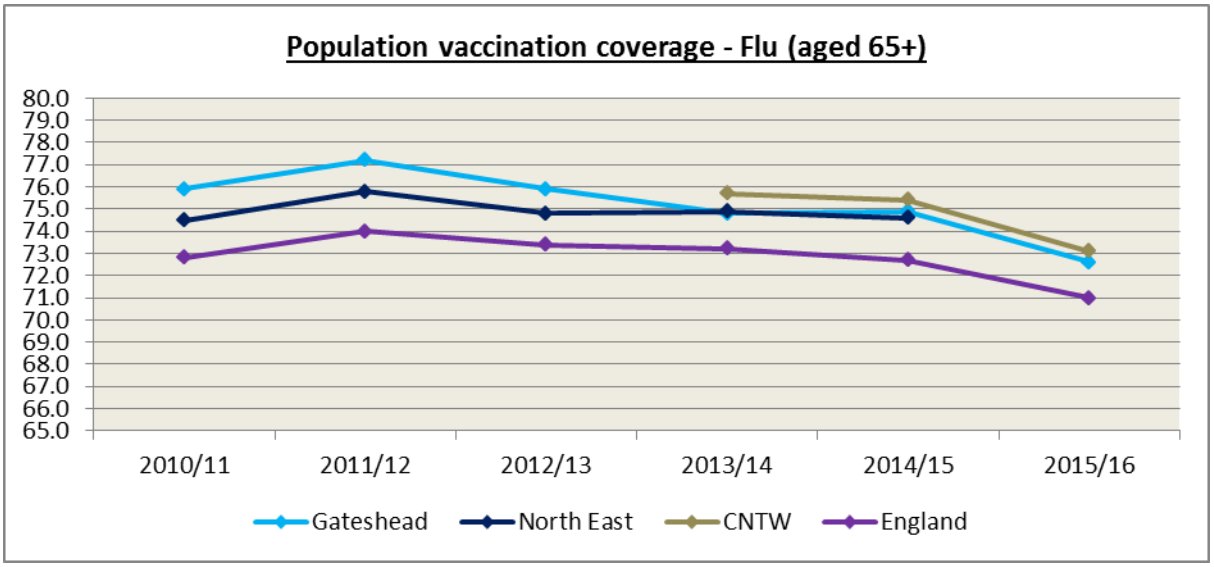
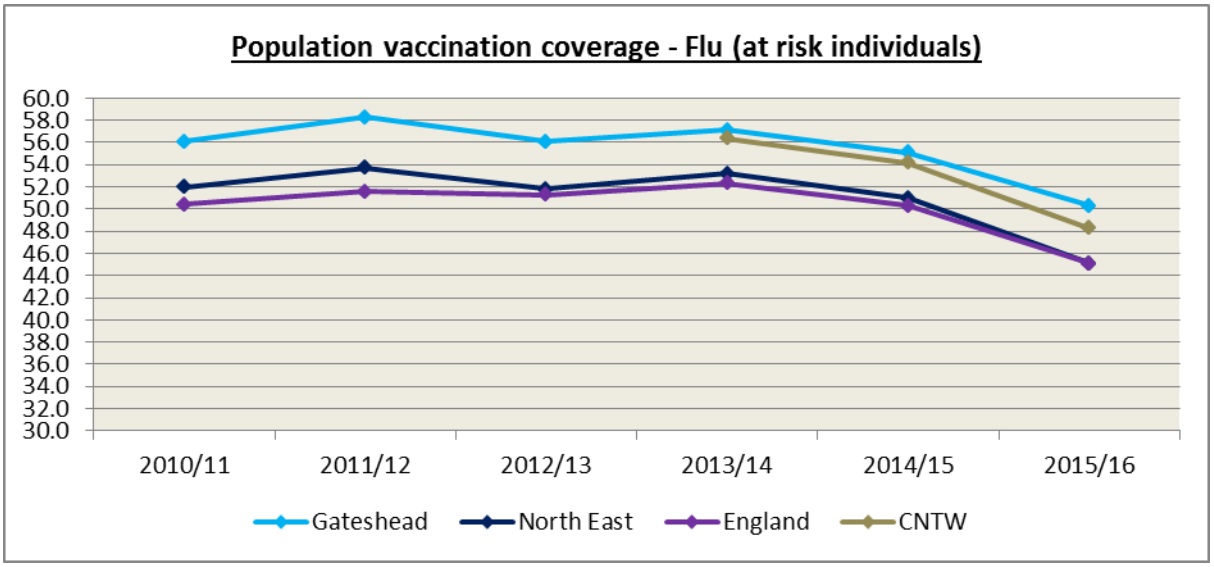
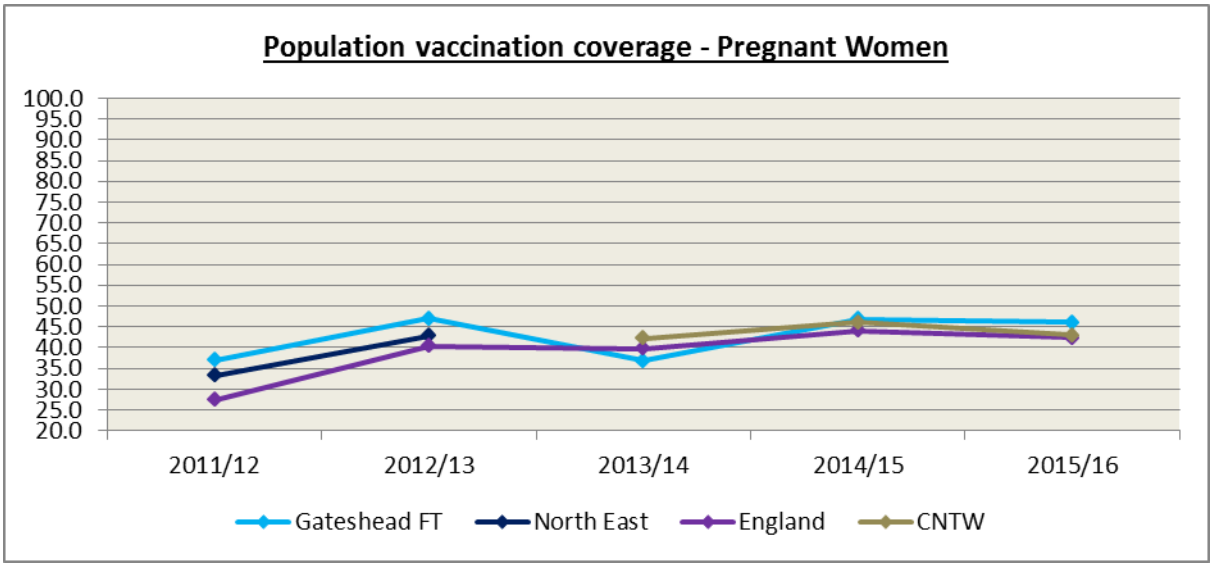
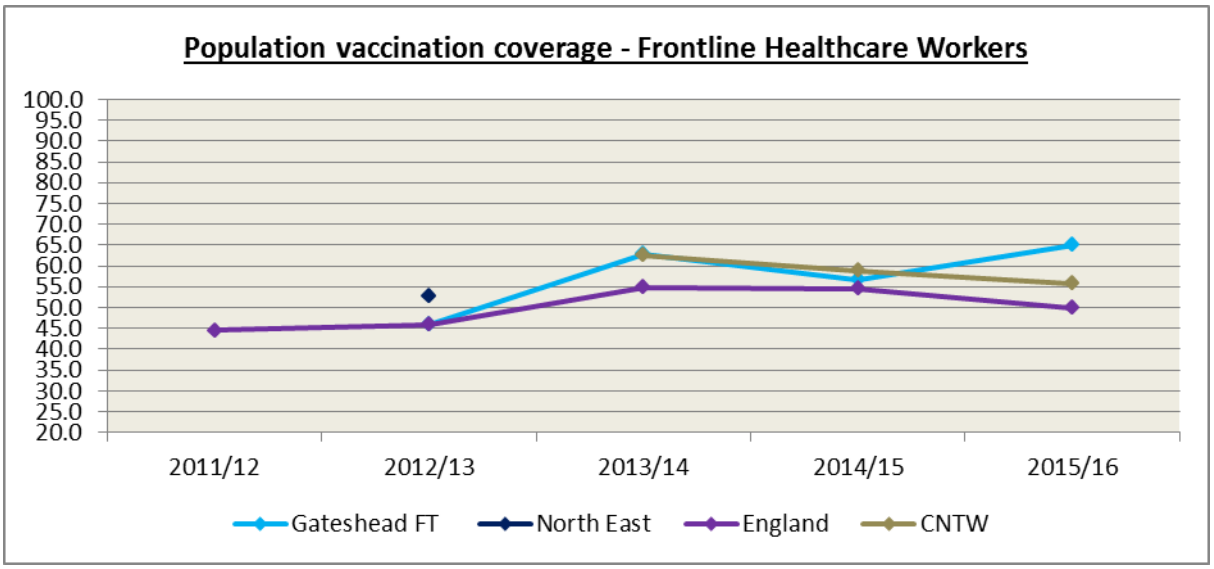
99.0
98.0
97.0
96.0
95.0
94.0
93.0
92.0
91.0
90.0
89.0
88.0
87.0
86.0
85.0
84.0
83.0
82.0
81.0
80.0
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
Gateshead
North East
England
Target

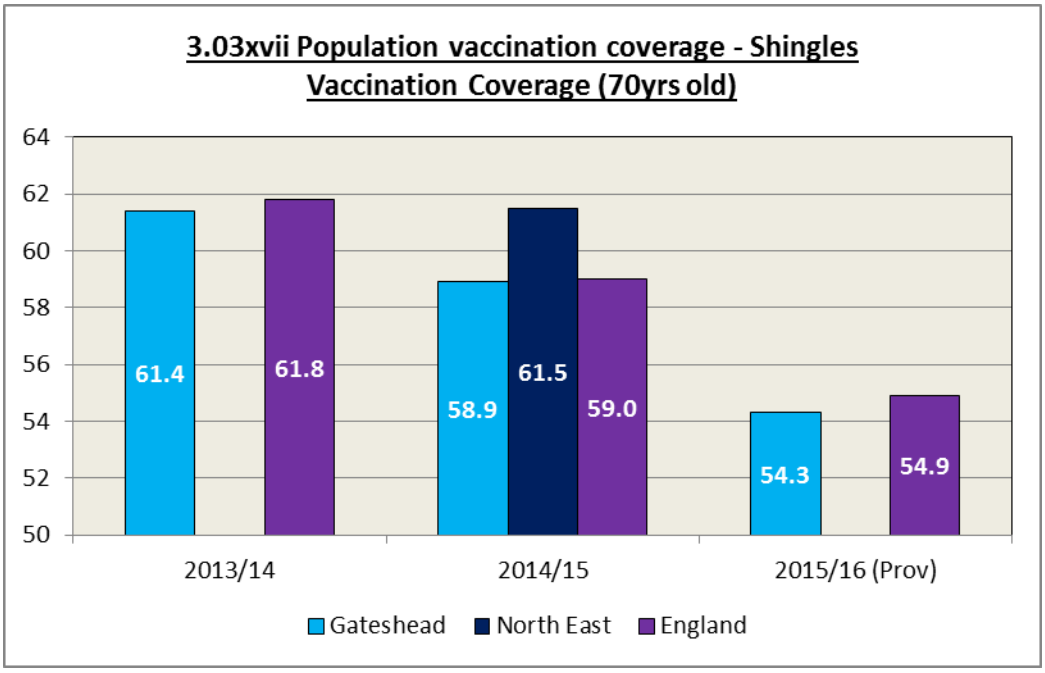

Population vaccination coverage - PPV
80.0
78.0
76.0
74.0
72.0
70.0
68.0
66.0
64.0
62.0
60.0
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
Gateshead
North East
England
CNTW

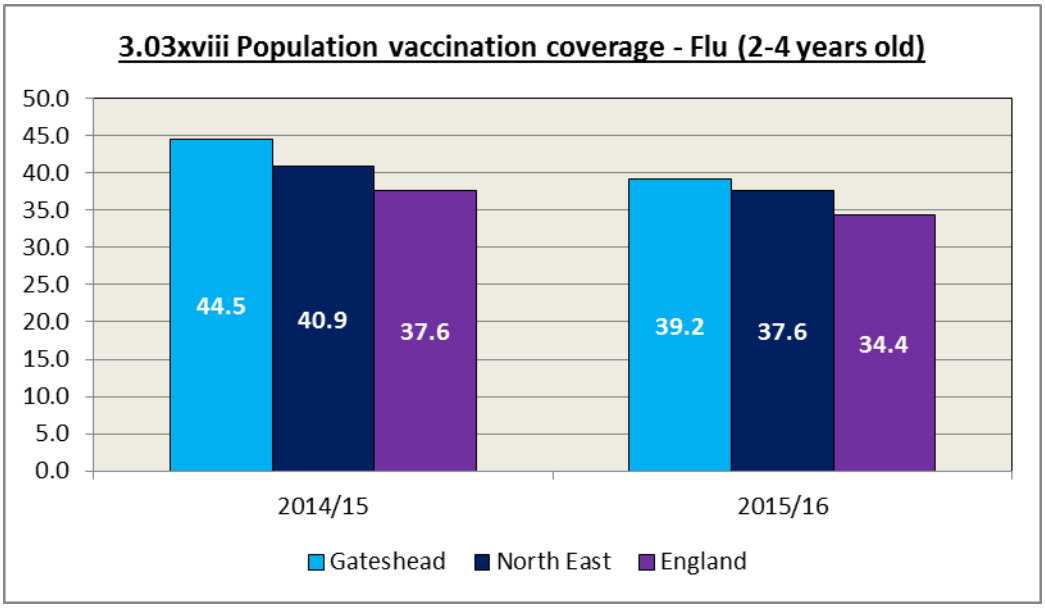

Population vaccination coverage - Flu (aged 65+)
80.0
79.0
78.0
77.0
76.0
75.0
74.0
73.0
72.0
71.0
70.0
69.0
68.0
67.0
66.0
65.0
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
Gateshead
North East
CNTW
England

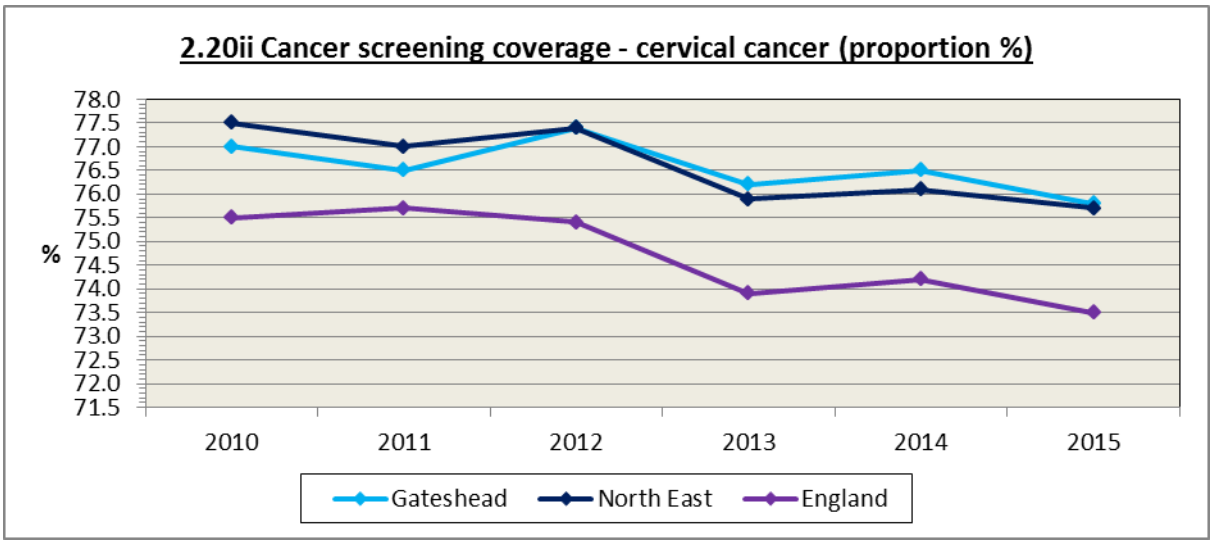

Population vaccination coverage - Flu (at risk individuals)
60.0
58.0
56.0
54.0
52.0
50.0
48.0
46.0
44.0
42.0
40.0
38.0
36.0
34.0
32.0
30.0
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
Gateshead
North East
England
CNTW

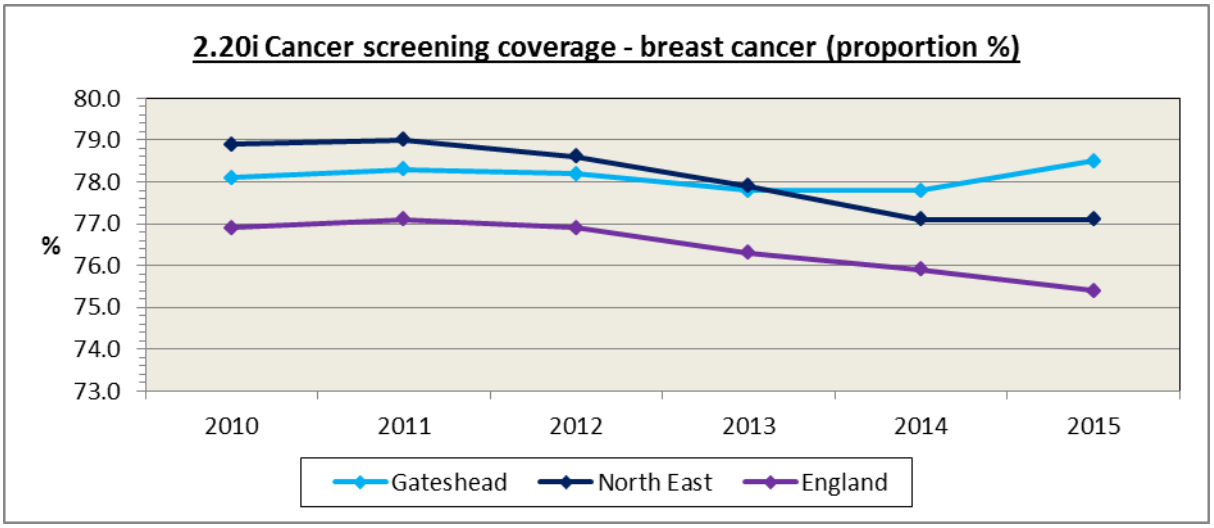

Population vaccination coverage - Pregnant Women
100.0
95.0
90.0
85.0
80.0
75.0
70.0
65.0
60.0
55.0
50.0
45.0
40.0
35.0
30.0
25.0
20.0
2011/12
2012/13
2013/14
2014/15
2015/16
Gateshead FT
North East
England
CNTW


Population vaccination coverage - Frontline Healthcare Workers
100.0
95.0
90.0
85.0
80.0
75.0
70.0
65.0
60.0
55.0
50.0
45.0
40.0
35.0
30.0
25.0
20.0
2011/12
2012/13
2013/14
2014/15
2015/16
Gateshead FT
North East
England
CNTW


3.03xvii Population vaccination coverage - Shingles
Vaccination Coverage (70yrs old)
64
62
60
58
56
54
52
50
61.4
61.8
58.9
61.5
59.0
54.3
54.9
2013/14
2014/15
2015/16 (Prov)
Gateshead
North East
England

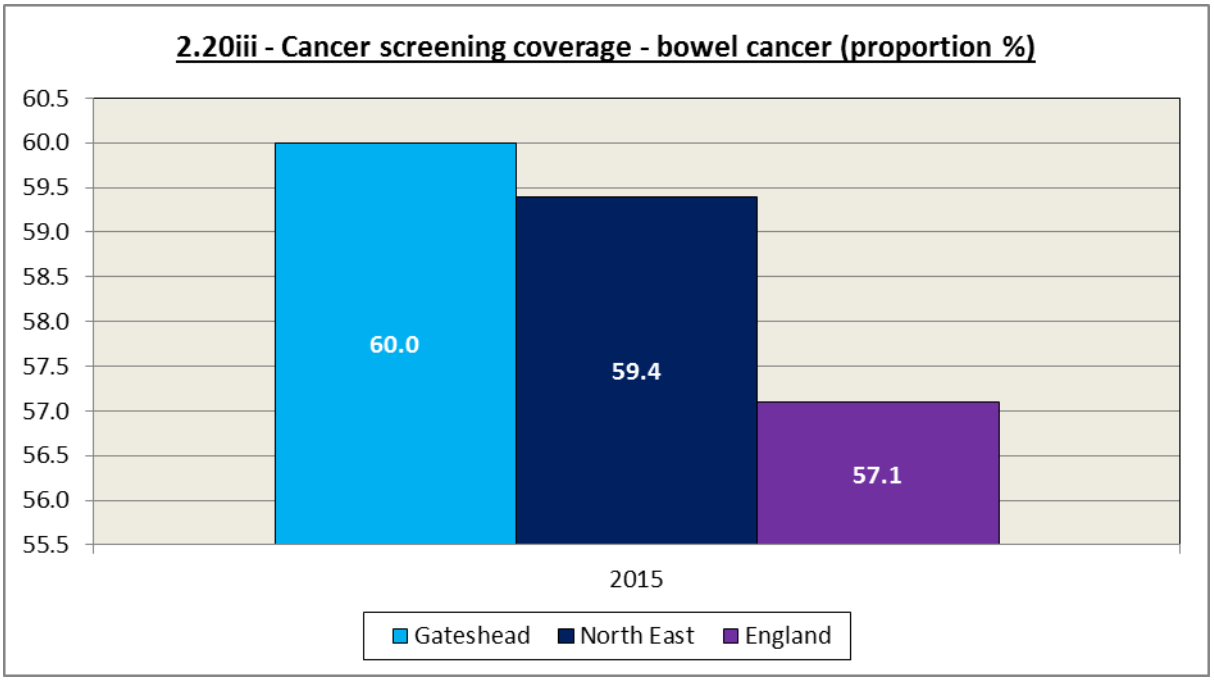

3.03xviii Population vaccination coverage - Flu (2-4 years old)
50.0
45.0
40.0
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
44.5
40.9
37.6
39.2
37.6
34.4
2014/15
2015/16
Gateshead
North East
England



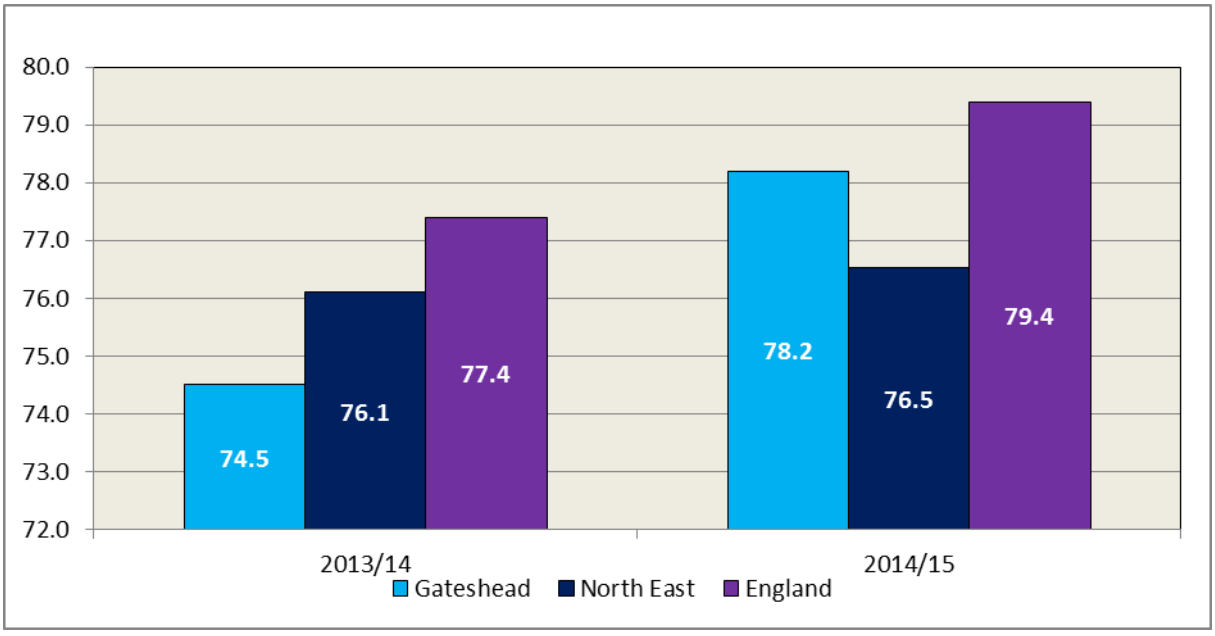


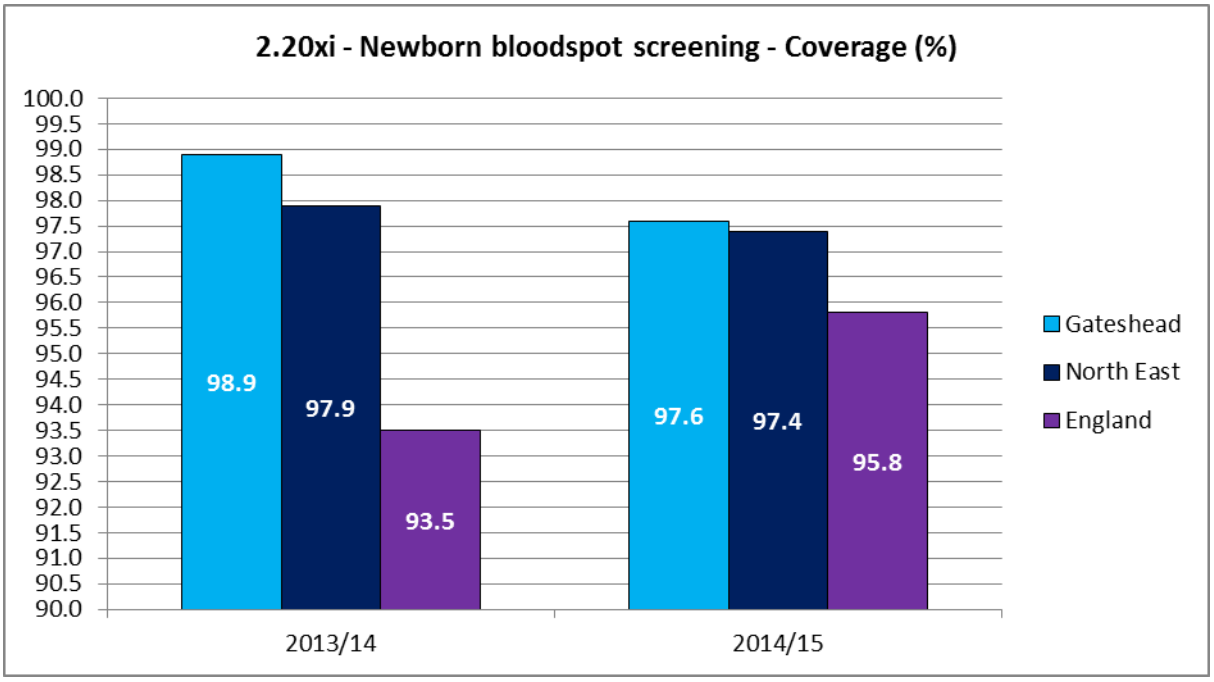
Uptake of the Diabetic Eye Screening Programme 2015-16 (01/04/2015 - 30/06/2015)

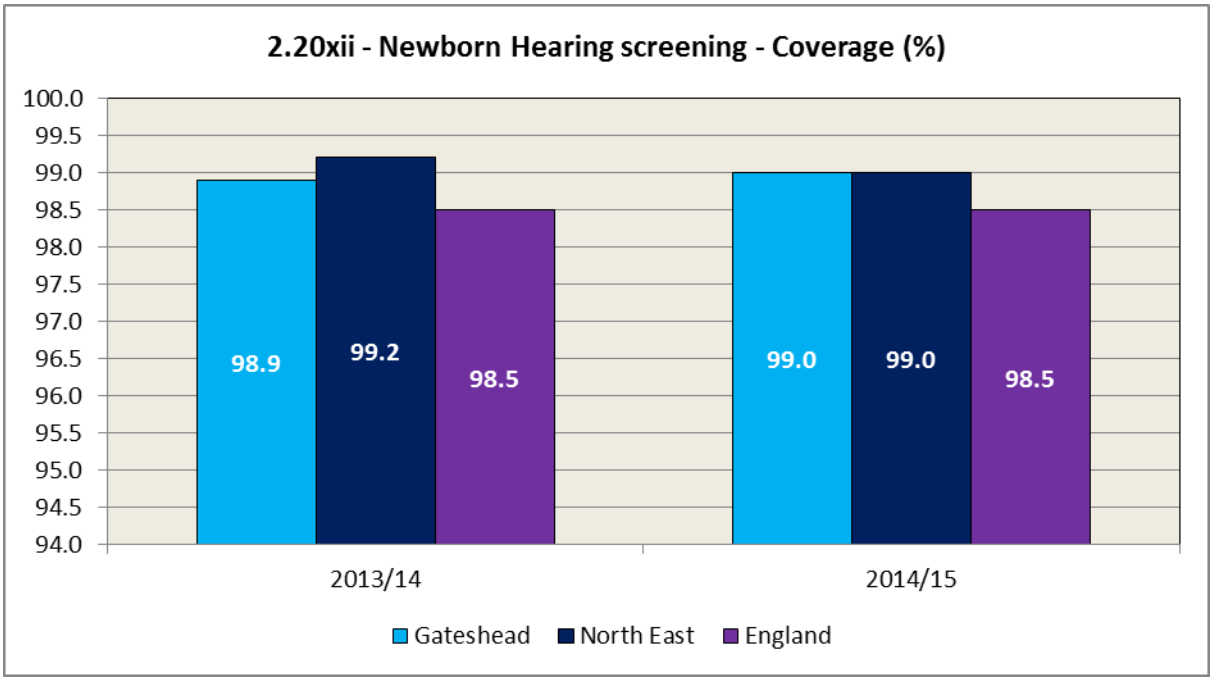
Area	Numerator	Denominator	Percentage (%)
North of Tyne & Gateshead Diabetic Eye Screening Programme	43,299	51,744	**83.7**
Sunderland & South Tyneside Diabetic Eye Screening Programme	20 339	23 953	**84.9**
North East	118,850	138,200	**86.0**



Abdominal Aortic Aneurysm Coverage




2.20xi - Newborn bloodspot screening - Coverage (%)
100.0
99.5
99.0
98.5
98.0
97.5
97.0
96.5
96.0
95.5
95.0
94.5
94.0
93.5
93.0
92.5
92.0
91.5
91.0
90.5
90.0
98.9
97.9
93.5
97.6
97.4
95.8
2013/14
2014/15
Gateshead
North East
England


2.20xii - Newborn Hearing screening - Coverage (%)
100.0
99.5
99.0
98.5
98.0
97.5
97.0
96.5
96.0
95.5
95.0
94.5
94.0
98.9
99.2
98.5
99.0
99.0
98.5
2013/14
2014/15
Gateshead
North East
England

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Gateshead Council

HEALTH AND WELLBEING BOARD
3 March 2017

TITLE OF REPORT: Long Term Conditions Strategy

1. Purpose of the Report

This report is to inform the Health & Wellbeing Board of the publication and content of the Newcastle and Gateshead LTC Strategy, which was approved by the Newcastle and Gateshead CCG's Executive at its November 2016 meeting.

The strategy details the CCG's vision for Long Term Conditions over the next five years. The CCG aims to transform how services are managed, taking a partnership approach both in planning and providing care. It will aim to integrate services further, move care closer to the patient's community and increase the information and support people can access; making use of all the resources available in communities to fully develop the more than medicine approach. It will support the local implementation of priorities identified in the wider STP.

The CCG will work with Primary Care, local FTs, Local Authorities, the voluntary sector and general public to agree and support the development of integrated models of care that will deliver sustainable patient centred services. We will support transformation in Primary and Secondary Care and seek to commission new pathways of care that deliver the aims of this strategy.

The CCG will focus on delivering better value to the public. This will mean tackling unwarranted variation in clinical care, reducing waste and ensuring that quality and safety are at a key priority for all providers involved in the provision of LTC care.

2. Background

2.1 Overview

Long Term Conditions represent a challenge for us all, those who are affected by a Long Term Condition and their carers, as well as commissioners and providers of health and social care.

Newcastle & Gateshead Clinical Commissioning Group uses the following definition of a long term condition:

"***Long Term Conditions (LTCs) are diseases that cannot currently be cured, but are controlled by medication and/or other treatment. They are health problems that require ongoing management over a period of years or decades and are often characterised by acute exacerbations of ill health resulting in repeated admissions to hospital".***

We have ever increasing numbers of people affected by a LTC and new approaches are needed. Over 64,000 people in Gateshead have an LTC; and of

these 7.2% are diagnosed with 2 or more LTCs and 3.8% are diagnosed with 3 or more LTCs.

The Kings Fund report on long-term conditions and multi-morbidity states:

- long-term conditions are more prevalent in older people (58 per cent of people over 60 compared to 14 per cent under 40) and in more deprived groups (people in the poorest social class have a 60 per cent higher prevalence than those in the richest social class and 30 per cent more severity of disease) (1).
- People with long-term conditions now account for about 50 per cent of all GP appointments, 64 per cent of all outpatient appointments and over 70 per cent of all inpatient bed days.
- Treatment and care for people with long-term conditions is estimated to take up around £7 in every £10 of total health and social care expenditure (1).

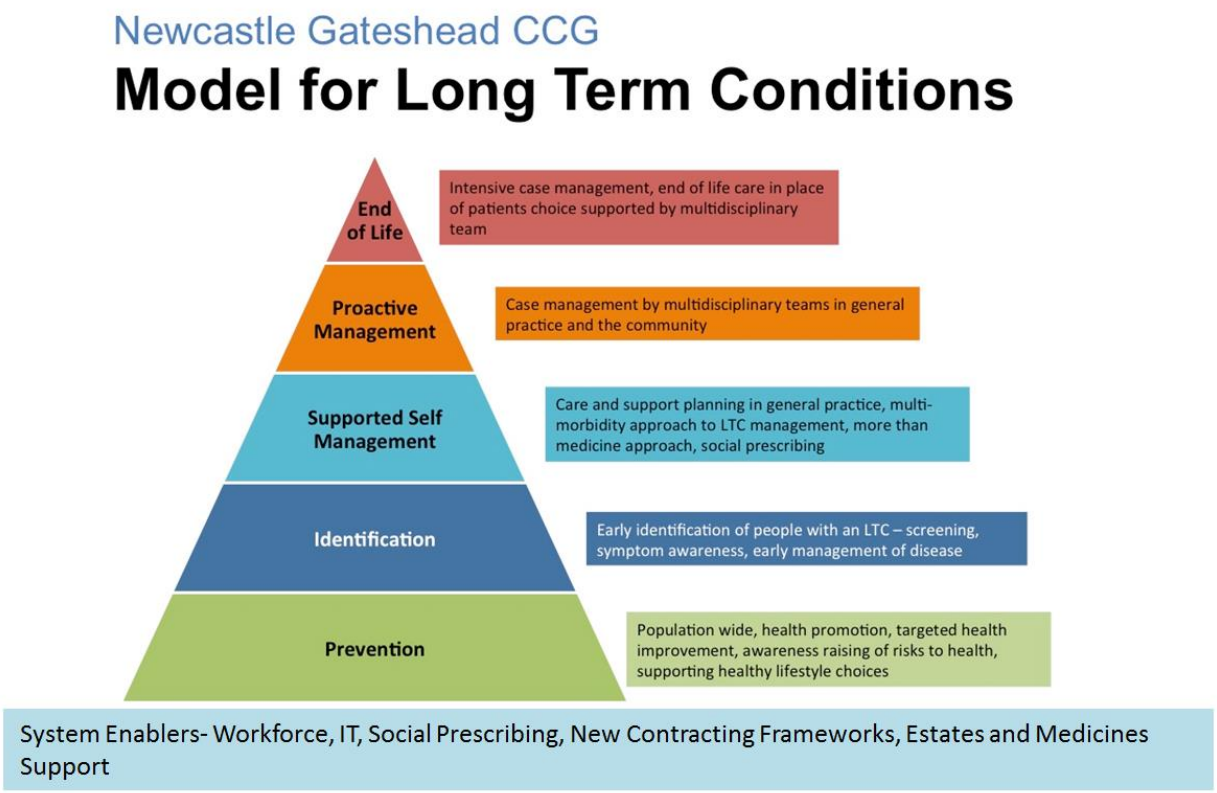
Our local NHS and Social care work together to support those with LTCs to be as healthy as possible. In the last few years we have changed the emphasis of care for those with LTCs from a single disease model to a more holistic personalised, person-centered approach. We know that people with LTCs want a greater say in their care and their ideal would be "*I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."* (2)

The strategy replaces the earlier Gateshead LTC Strategy published in December 2013 and is a new strategy for Newcastle. It was developed in conjunction with:

- The Newcastle & Gateshead CCG LTC Programme Board
- Newcastle upon Tyne Hospitals FT
- Gateshead Healthcare FT
- Newcastle and Gateshead Public Health Departments
- General Practices via engagement questionnaire
- CCG Clinical Leads

Patient and public input into the development of the strategy was informed through close working with the Gateshead Long Term Conditions Patient Reference Group and a survey - "Living with my LTC"- completed by 245 people living with LTCs across Newcastle and Gateshead. The Gateshead Local Engagement Board and Gateshead Patient, User, Carer and Public Involvement Group were also engaged in the development of the Strategy.

The CCG's model for LTCs is summarised in the following diagram:



2.2 Governance

Implementation of the LTC Strategy is assured by the Newcastle and Gateshead Long Term Conditions Programme Board. The Programme Board is underpinned by clinical working groups delivering programmes of work in the following areas:

- Diabetes
- Respiratory care
- Cardiovascular disease
- Cancer
- End of life care
- Liver disease
- Care and Support Planning (The Year of Care)
- Frailty

It will be the responsibility of these working groups to ensure implementation of the LTC Strategy. The working groups are accountable to the LTC Programme Board and provide quarterly updates on delivery of their work plans to the board.

The LTC Programme Board is accountable to Newcastle and Gateshead CCG Executive Committee.

2.3 Initial focus for implementation

In implementing the strategy initial focus will be on the following areas:

- Delivery of the CCG's Quality, Innovation, Productivity and Prevention plan (QIPP)
- Recognition and Management of Frailty as a Long Term Condition
- Delivery of Care and Support Planning for patients with multiple LTCs as a means to improve support for self management

- Development of Social Prescribing
- Diabetes care with a focus upon diabetes prevention and delivery of the standards identified within the CCG's Improvement and Assessment Framework.
- Developing the workforce with a particular focus on management of frailly, development of Primary Care Navigator roles, specialist support to primary care and community services wrapped around general practice
- Implementation of the National Cancer Strategy
- Review of End of Life Services
- Moving Care out of Hospital

The reduction in preventative and lifestyle change support services poses a risk to delivery of the strategy. As a result of this more people may develop long terms conditions and those with existing long term conditions may find it more difficult to achieve lifestyle change.

3. Recommendations

The Health and Wellbeing Board is asked to note the content of the LTC Strategy.

References

1. Department of Health (2012). Report. Long-term conditions compendium of Information: 3rd edition

2 National Voices (2013) "A Narrative for Person Centred Coordinated Care" https://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf NHS England Gateway reference Number 00076

Contact: Samantha Hood (0191) 217 2807

NHS
Newcastle Gateshead
Clinical Commissioning Group

Change	Date	Name	Version
Created	17th August 2016	Sam Hood	1.0
Updated	5th September 2016	Steve Kirk	1.1
Updated	6th October 2016	Deborah Dews	1.2
Reviewed	30th September 2016	Gerald Tompkins	1.3
Updated	18th October 2016	Steve Kirk and Dan Cowie	1.4
Updated	23rd October 2016	Sam Hood	1.5
Reviewed	27th October 2016	Steve Kirk	1.7
Updated	2nd November 2016	Sam Hood	1.8

Strategy for the
care of patients with

Long Term Conditions

2016 to 2021

Contents

Foreword

Long Term Conditions represent a challenge for us all, those who are affected by a Long Term Condition and their carers as well as commissioners and providers of health and social care.

We have ever increasing numbers of people affected by a LTC and new approaches are needed. 130 000 people in Newcastle and Gateshead have a LTC. LTC account for a significant amount of the activity in the health service with about 70% of bed days in hospital and about half of all General Practice consultations relating to LTC.

Our local NHS and Social care work together to support those with LTCs to be as healthy as possible. In the last few years we have changed the emphasis of care for those with LTC from a single disease model to a more holistic personalised person-centered approach. We know that people with LTC want a greater say in their care and their ideal would be "*I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."* (1)

This strategy details our vision for Long Term Conditions over the next five years. We aim to transform how services are managed to a partnership approach both in planning and providing care. We will integrate services further, move care closer to the patient's community, increase the information and support people can access making use of all the resources available in communities to fully develop the more than medicine approach.

Dr Steve Kirk

1. Introduction

1.1 CCG Strategic Vision

This Long Term Conditions strategy is part of a collection of strategies that make up Newcastle Gateshead CCG 'Strategy Framework'. The framework will provide an anchor and 'golden thread' for all key strategic plans and is aligned to the CCG's Vision, Mission and Purpose as set out in our 5year strategic plan. In brief we will do this through:

- **Involvement** of people in our communities and providers to get the best understanding of issues & opportunities
- **Experience** - people centered services that are some of the best in the country
- Our **Outcomes** are focused on preventing illness and reducing inequalities

The following diagram summarises our vision, which is underpinned by the core NHS values.

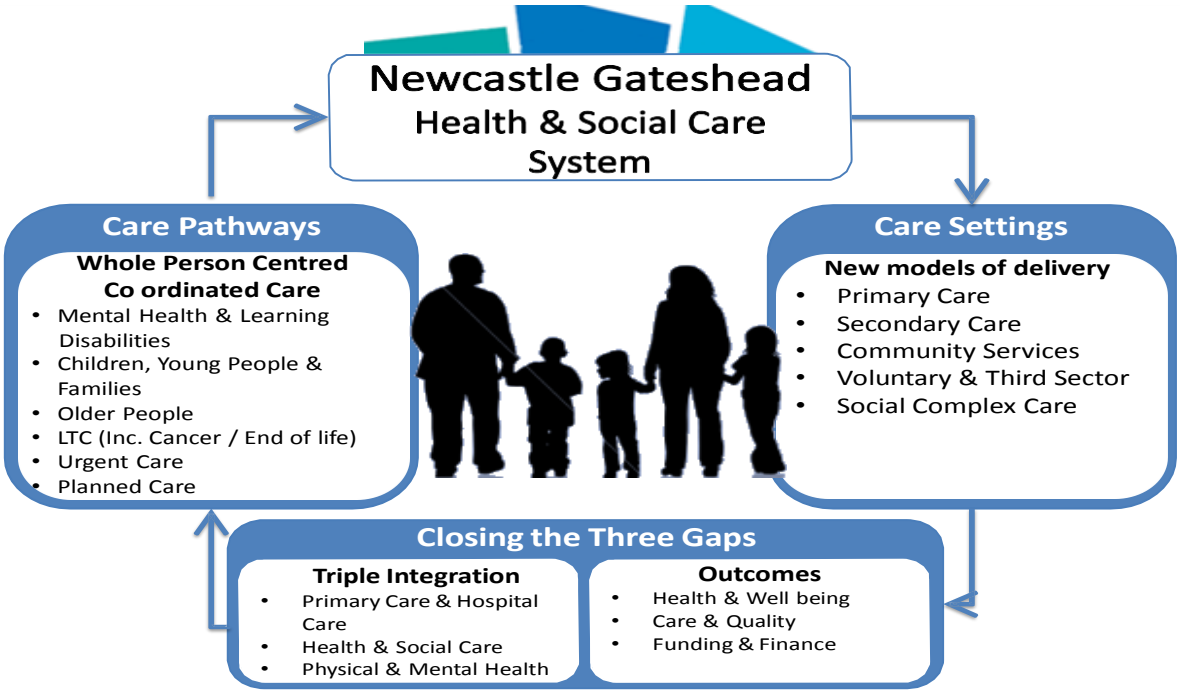
The diagram below represents Newcastle Gateshead CCG strategic approach to deliver our vision. We are focusing on **Care Settings** to enable integration within and between settings as we develop *new models of delivery*. This works with the national

'triple integration' agenda. It also includes the key **3 gaps that we want to close** i.e.:

- variation in health and wellbeing,
- the quality improvements needed
- The challenge of managing the NHS's income and expenditure.

Our **Care pathways** coordinate physical health, mental health and social care through an individual's life journey from Fitness to Frailty. Our Clinical Work Programmes group together many of the CCGs projects to ensure they are coordinated.

Our aim is that through all this we will work with the people of Newcastle and Gateshead to improve the quality and experience of services so that they live *happier, healthier lives, transforming lives together*



The CCG is currently working to develop a single Sustainability and Transformation plan for the Northumberland Tyne & Wear region which will be made up of three local footprints, namely Newcastle Gateshead, North Tyneside Northumberland & Sunderland South Tyneside.

This plan will describe our shared local vision for 2021 regarding care both inside and outside our hospitals underpinned by better integration with local authority services in respect of prevention and social care. It describes how we will close the “3 gaps” identified in the Five Year Forward View.

In Newcastle Gateshead we are committed to the delivery of our STP plan, however we are also aware of the fact that this will require significant changes. We have identified the following three priority areas:

1. Optimal Use of the Acute Sector combined with
2. The complementary redesign of a Collaborative Out-of-Hospital model that promotes care closer to home based on individual and population need, while investing in
3. Prevention, Health and Wellbeing to increase personal and community resilience and reduce future demand on health and care services.

1.2 Background

1.2.1 What are Long Term Conditions?

Newcastle & Gateshead Clinical Commissioning Group (CCG) uses the following definition of a long term condition:

> Long Term Conditions (LTCs) are diseases that cannot currently be cured, but are controlled by medication and/or other treatment. They are health problems that require ongoing management over a period of years or decades and are often characterised by acute exacerbations of ill health resulting in repeated admissions to hospital.

The Kings Fund report on long-term conditions and multi-morbidity states;
long-term conditions are more prevalent in older people (58 per cent of people over 60 compared to 14 per cent under 40) and in more deprived groups (people in the poorest social class have a 60 per cent higher prevalence than those in the richest social class and 30 per cent more severity of disease) (1).

People with long-term conditions now account for about 50 per cent of all GP appointments, 64 per cent of all outpatient appointments and over 70 per cent of all inpatient bed days.

Treatment and care for people with long-term conditions is estimated to take up around £7 in every £10 of total health and social care expenditure (2).

Projections for the future of long-term conditions are not straightforward. The Department of Health (based on self-reported health) estimates that the overall number of people with at least one long-term condition may remain relatively stable until 2018. However, analysis of individual conditions suggests that the numbers are growing, and the number of people with multiple long-term conditions appears to be rising (2).

The 2009 General Lifestyle Survey identified 14% of those aged under forty report having an LTC, and 58% of those aged 60 and over report having an LTC, with 25% of over 60s having two or more. Coupled with a projected national increase in the numbers of people aged 85 and over by 2034 to be 2.5 times larger than in 2009, reaching 3.5 million and accounting for 5% of the population; plans need to be put in place now to address the growing needs of these people. It is clear that the NHS, as currently configured for long term condition care, is not sustainable in the face of this projected future increase in co-morbidity and the level of need predicted (2).

Most individual long-term conditions are more common in people from lower socio-economic groups, and are usually more severe in this group, even in conditions where

prevalence is lower – for example, stroke. General Household Survey data (2006), analysed by the Department of Health, shows those from unskilled occupations (52%) suffer from long-term conditions more than groups from professional occupations (33%

1.2.2 Multi-morbidity and deprived populations

The number of people with three or more long-term conditions is predicted to rise from 1.9 million in 2008 to 2.9 million in 2018 (2).

The ageing population and increased prevalence of long-term conditions have a significant impact on health and social care and may require £5 billion additional expenditure by 2018 (2).

Multi-morbidity is more common among deprived populations – especially those that includes a mental health problem (3) – and there is evidence that the number of conditions can be a greater determinant of a patient's use of health service resources than the specific diseases (4).

There will be rising demand for the prevention and management of multi-morbidity rather than of single diseases (3).

1.3 Interdependent Strategies

This strategy is linked to and supports:

- The Newcastle Gateshead CCG Five Year Plan
- Newcastle and Gateshead Better Care Fund and Care Homes Vanguard
- The Newcastle Gateshead CCG Mental Health Transformation Programme
- The Newcastle Gateshead CCG Urgent Care Strategy
- Newcastle Gateshead CCG Primary Care Strategy
- The Gateshead Community Services Strategy
- The Sustainability Transformation Plan

It will be the role of the LTC Programme Board to ensure there are clear linkages between the above strategies and the LTC Strategy and to assure integrated delivery across these plans in order to improve outcomes for people with LTCs.

1.4 Scope of the Strategy:

The Long Term Conditions Strategy takes a generic approach rather than condition specific. It identifies the framework needed to manage long term physical health conditions based around the individual's life journey that focus on five strategic work programmes for delivery i.e. prevention, identification, support for self management, proactive management and end of life care.

The Kings Fund (2012) states that at least a third of people with long-term physical health conditions also have mental health problems. These can lead to significantly poorer health outcomes and reduced quality of life. The LTC Strategy recognises that care for large numbers of people with long-term conditions can be improved by better integrating mental health support with primary care and chronic disease management programmes, and closer working between mental health specialists and other professionals.

The risk of developing dementia increases with age; as the population ages the numbers of people developing physical LTCs also increases therefore the numbers of patients diagnosed with dementia who are also diagnosed with other LTCs will increase with age. Although dementia is not within the scope of this strategy, the fact that people with dementia are highly likely to have more than one physical LTC means that this strategy will work to ensure that patients suffering from dementia and with other LTCs are in receipt of integrated high quality care that meets all of their health needs.

The work carried out under the scope of the LTC Strategy will therefore work to ensure that an integrated approach is taken to address the health needs of patients diagnosed with dementia, severe mental health issues or other LTCs not specifically identified within this strategy. It is hoped that these patient groups will benefit from the generic, patient centred approach detailed within the five strategic programmes of work detailed later in this strategy.

We will aim to ensure improved management of LTCs in vulnerable groups for example carers and people with learning disabilities living in Newcastle and Gateshead.

LTC Programme Board will ensure clear linkages to the Newcastle and Gateshead Mental Health Programme Board to ensure areas common to both are addressed jointly in order to improve outcomes for all patients living with LTCs.

2. Case for Change

2.1 National Policy Context

The Challenge facing health care systems across the world is how to deliver better quality, safe services at a reduced cost. Fillingham and Weir identified the need to rethink the way care is delivered and coordinated across organisations. In order to achieve this "improving coordination around the needs of the individual will be part of the solution" (10)

The Five Year Forward View published by NHS England in 2014, recognised that Long term health conditions -rather than illnesses susceptible to a one-off cure -now take 70% of the health service budget. At the same time many people wish to be more informed and involved with their own care, challenging the traditional divide between patients and professionals, and offering opportunities for better health through increased prevention and supported self-care.

It talked about closing 3 widening gaps:

1. *The health and wellbeing gap:* if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.

2. *The care and quality gap*: unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.

3. *The funding and efficiency gap*: if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

The Five Year Forward View envisaged a future that empowers patients to take much more control over their own care and treatment; a future that dissolves the divide between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. One that no longer sees expertise locked into often outdated buildings, with services fragmented, patients having to visit multiple professionals for multiple appointments, endlessly repeating their details because they use separate paper records. One organised to support people with multiple health conditions, not just single diseases. A future that sees far more care delivered locally but with some services in specialist centers where that clearly produces better results. One that recognises that we cannot deliver the necessary change without investing in our current and future workforce

It emphasised that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. To support this, the NHS will back hard-hitting national action on obesity, smoking, alcohol and other major health risks; and will advocate for stronger public health-related powers for local government.

It advocated for patients to gain far greater control for their health and that the NHS will become a better partner with voluntary organisations and local communities to support this.

It stated that the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases.

2.2 Local Context

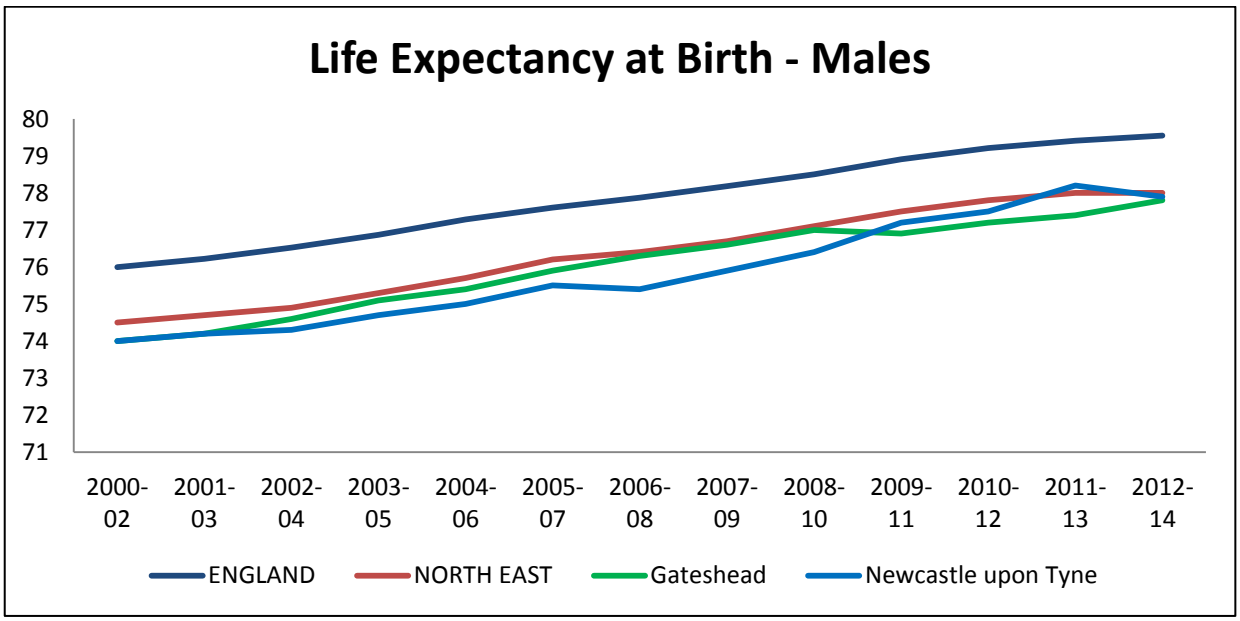
The health of people in Newcastle and Gateshead is generally worse than the England average, with life expectancy for both men and women lower than the England average.

2.2.1 Life Expectancy

In Gateshead life expectancy is 9.2 years lower for men and 7.3 years lower for women in the most deprived areas than in the least deprived areas.

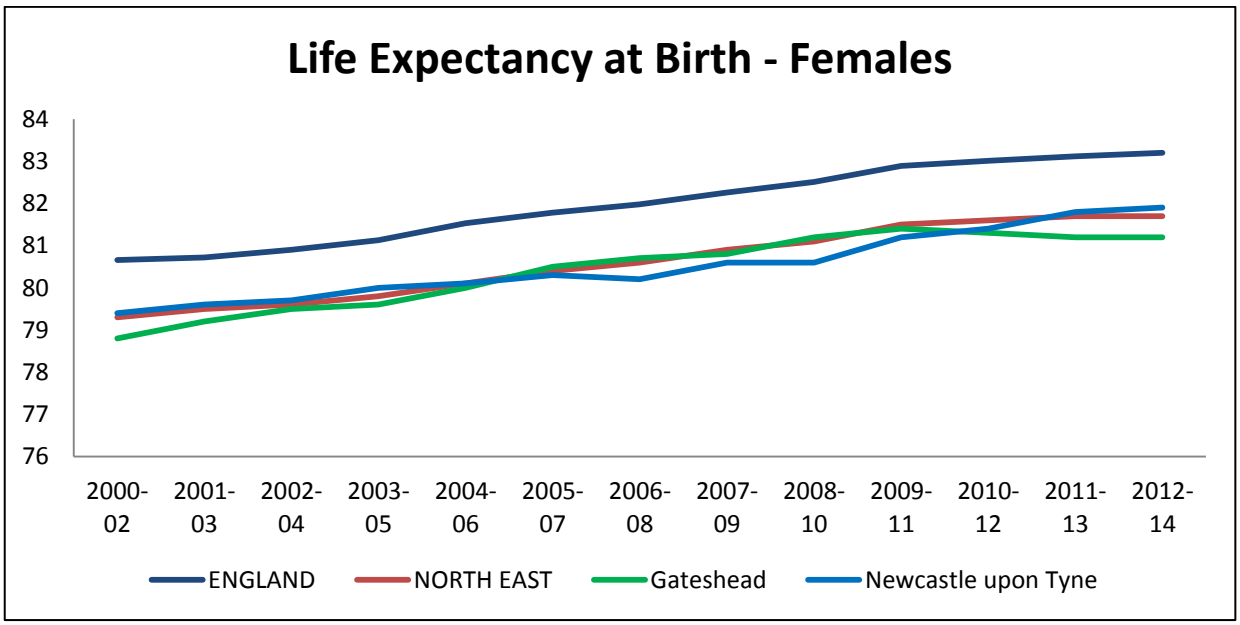
In Newcastle upon Tyne life expectancy is 12.1 years lower for men and 10.1 years lower for women in the most deprived areas than in the least deprived areas.

(Source: Public Health England)



(Source: Health & Social Care Information Centre Indicator Portal)

Male life expectancy in Newcastle upon Tyne has reduced for the first time in 12 years as it has dropped just below the North East average. Previously this was consistently increasing but has now stopped.



(Source: Health & Social Care Information Centre Indicator Portal)

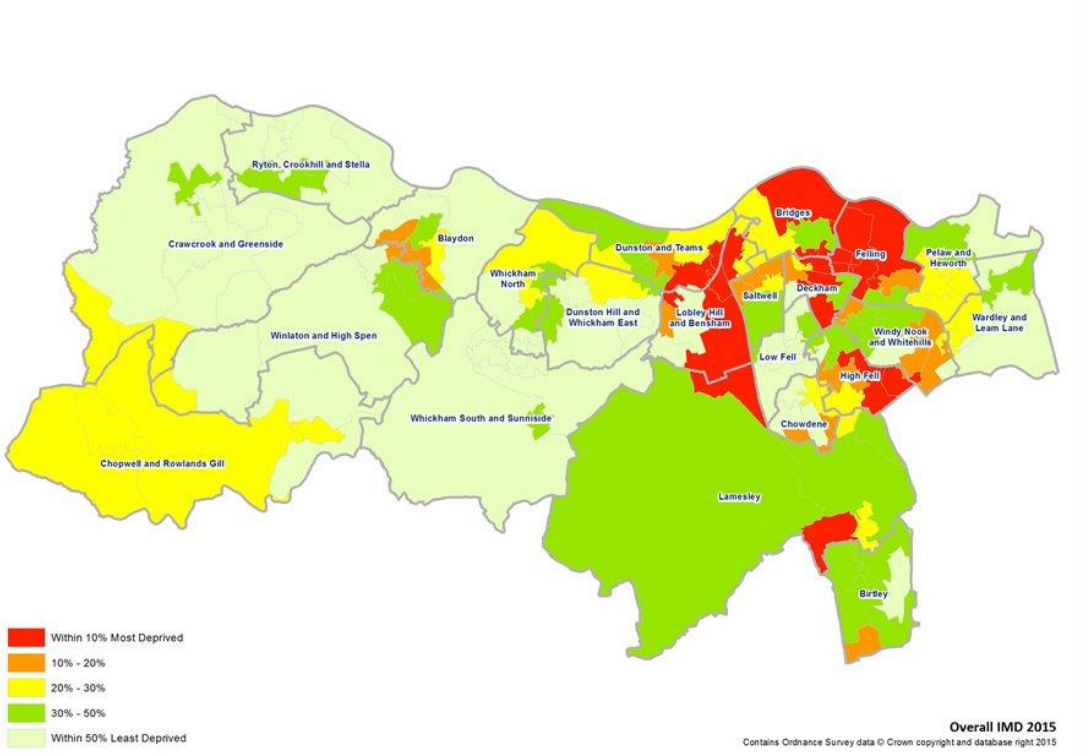
Female life expectancy in Gateshead has been declining since 2009 and is below the North East average. The Gateshead area had previously been hovering around the North East average for female life expectancy but more recently it is under, whereas the life expectancy for females living in Newcastle upon Tyne is just above the North East average.

2.2.2 Deprivation

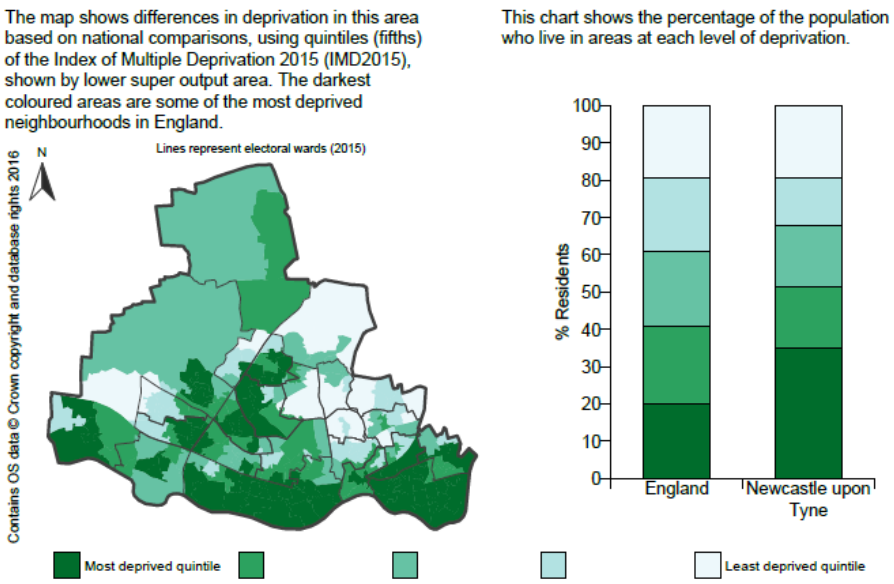
The following maps show differences in deprivation for Gateshead and Newcastle upon Tyne based on national comparisons, using quintiles (fifths) of the Index Multiple Deprivation 2015, shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.

-Public Health England

Gateshead



Newcastle



2.2.3 Lifestyles

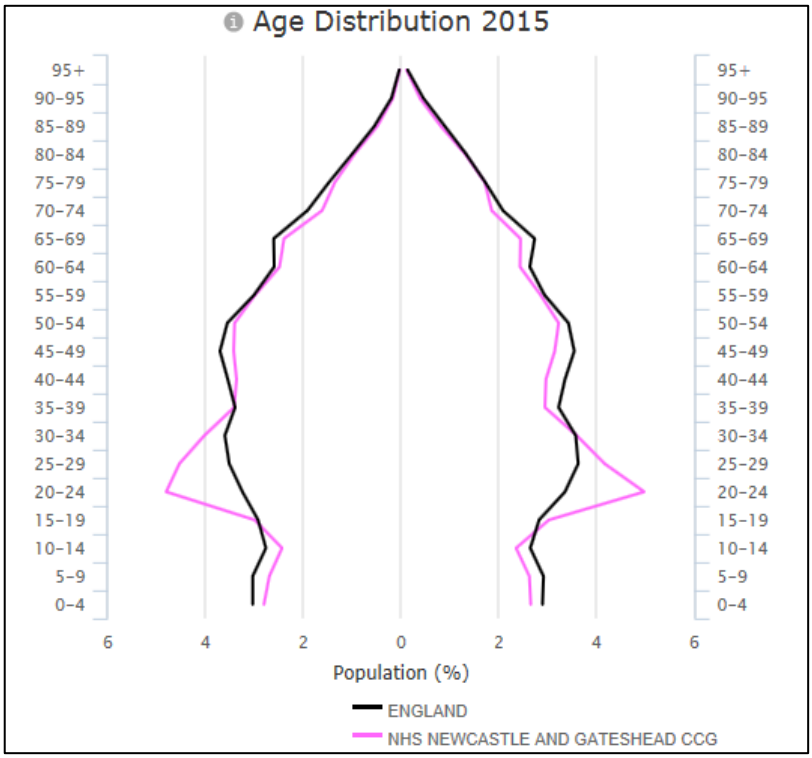
Lifestyle factors can have a significant impact on the prevalence of long-term conditions. In both Newcastle and Gateshead smoking prevalence is slightly higher, but statistically similar to the national rate. In Gateshead, significantly fewer adults are physically active and significantly more adults are overweight or obese than the national average. In Newcastle the rate of physical activity and proportion of adults with excess weight are similar to the national average. In both areas there are significantly more hospital stays for alcohol-related harm than the national average. .

	England	North East	Newcastle	Gateshead
Smoking prevalence	16.9	18.7	18.6	18.3
Percentage of population who are physically active	57.0	52.7	55.7	46.3
Percentage of population who are overweight or obese	64.6	68.6	61.3	68.9
Hospital stays for alcohol-related harm (per 100,000 population)	641	830	927	831

Compared with England:

better	similar	worse

2.2.4 Population



The age distribution chart above illustrates that for Newcastle and Gateshead CCG the elderly population is lower than the national England population.

There is a spike in the 18 to 30 age range for both males (left side of the chart) and females (right side) presumably because of the high student population in Newcastle.

The population is ageing in both Newcastle and Gateshead:

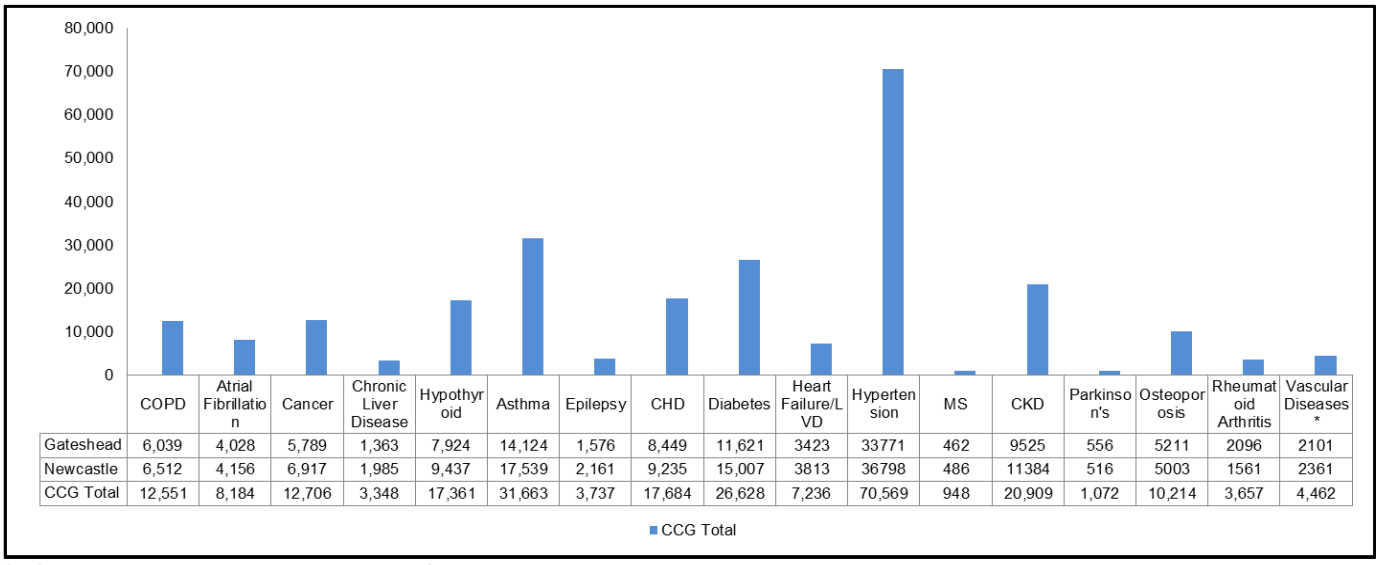
- In Gateshead it is projected that by 2039 there will be an additional 14,400 people aged 65 or older, an increase of 38% from 37,800 in 2014 to 52,200 in 2039, 9,700 of these people will be aged over 85+.

- In Newcastle it is predict there will be a significant increase in people aged over 65 or older, by almost 50% (20,000 people) from 40,700 in 2013 to 60,600 in 2037. A third of these - 6,200 people - are aged over 85+. (Source: ONS)

The older the population the more LTCs they tend to have and the greater the complications arising from these.

2.2.5 Current Numbers of People with Long Term Conditions

The following chart shows the number of Long Term Conditions for the Newcastle Gateshead area as a total, with individual figures for each area:



	COPD	Atrial Fibrillation	Cancer	Chronic Liver Disease	Hypothyroid	Asthma	Epilepsy	CHD	Diabetes	Heart Failure/LVD	Hypertension	MS	CKD	Parkinson's	Osteoporosis	Rheumatoid Arthritis	Vascular Diseases *
Gateshead	6,039	4,028	5,789	1,363	7,924	14,124	1,576	8,449	11,621	3423	33771	462	9525	556	5211	2096	2101
Newcastle	6,512	4,156	6,917	1,985	9,437	17,539	2,161	9,235	15,007	3813	36798	486	11384	516	5003	1561	2361
CCG Total	12,551	8,184	12,706	3,348	17,361	31,663	3,737	17,684	26,628	7,236	70,569	948	20,909	1,072	10,214	3,657	4,462

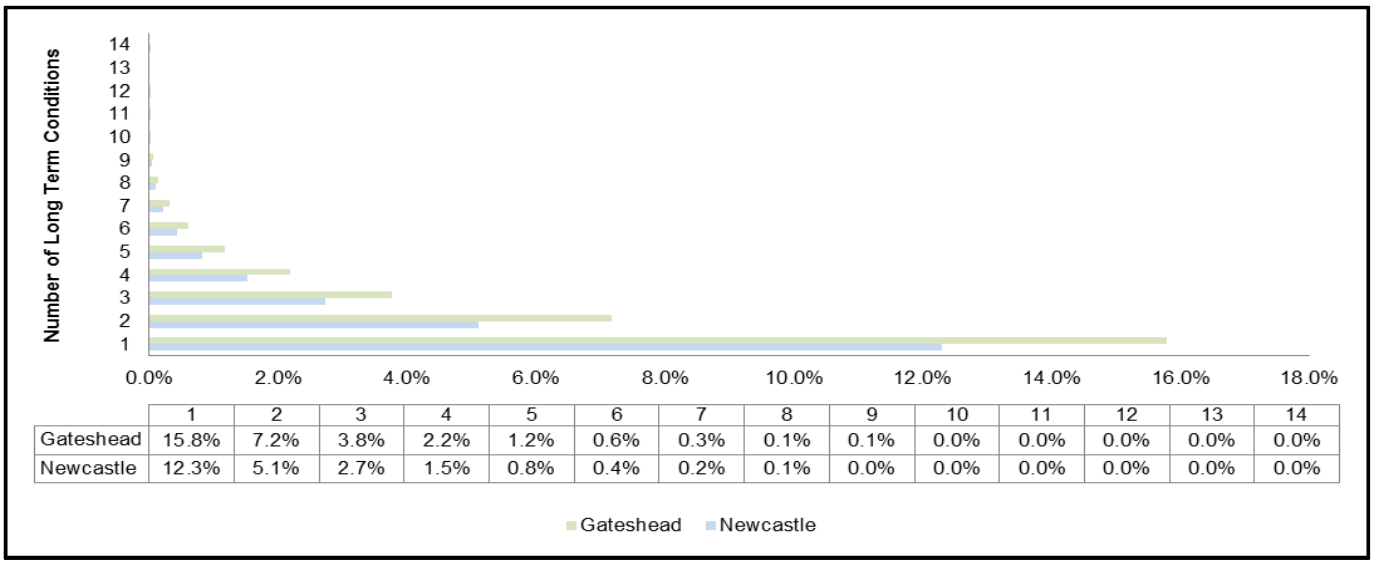
(Primary Care Data as at June 2016)

There are more than 60,000 people in Gateshead currently on disease registers in scope of the LTC strategy.

There are more than 70,000 people in Newcastle upon Tyne currently on disease registers in scope of the LTC strategy.

2.2.6 Co-Morbidities

The following chart highlights the number of patients who have more than one LTC as a percentage of the population of each area:



	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Gateshead	15.8%	7.2%	3.8%	2.2%	1.2%	0.6%	0.3%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Newcastle	12.3%	5.1%	2.7%	1.5%	0.8%	0.4%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

As at 30th June 2016 the Primary Care Data for the whole Gateshead population 7.2% of patients have two or more LTCs and 3.8% of patients have three or more LTCs.

For the same time period, out of the whole Newcastle upon Tyne population 5.1% of patients have two or more LTCs and 2.7% of patients have three or more LTCs.

2.2.7 Frailty

As people age and develop more LTCs their reserves and resilience reduce so that they become increasingly frail. Tools such as the electronic Frailty Index (eFI) have been developed to risk stratify the population for frailty and it is estimated that in our population 23% have mild frailty, 2% have moderate frailty and 0.2% have severe frailty.

Levels of frailty can be defined as follows:

Fit (eFI score 0 - 0.12) – People who have no or few long-term conditions that are usually well controlled. This group would mainly be independent in day-to-day living activities.

Mild frailty (eFI score 0.13 – 0.24) – People who are slowing up in older age and may need help with personal activities of daily living such as finances, shopping, transportation.

Moderate Frailty (eFI score 0.25 – 0.36) – People who have difficulties with outdoor activities and may have mobility problems or require help with activities such as washing and dressing.

Severe Frailty (eFI score > 0.36) – People who are often dependent for personal cares and have a range of long-term conditions/multi-morbidity. Some of this group may be medically stable but others can be unstable and at risk of dying within 6 - 12 months.

2.3 Demographic and Operational Challenges

We know the NHS is facing a period of unprecedented challenges which are not unique to NHS Newcastle Gateshead CCG. These challenges are driven by the following:

An ageing population	• Anticipated significant growth in over 85 year olds • Currently more than 40% of people admitted to hospital are over 65 years • Unplanned admissions for people over 65 years account for more than 70% of hospital emergency bed days • When they are admitted to hospital, older people generally stay longer and are more likely to be re-admitted • Increased complexity as an aging population is associated with increased multi-morbidity,
Lifestyle factors	• 80% of deaths in England are from major diseases (e.g. Cardiovascular Diseases and Cancer) many of which are attributable to lifestyle risk factors e.g. excess alcohol, smoking, poor diet • 46% of men and 40% of women will be obese by 2035
Budgetary constraints	• Although NHS budgets are protected in real terms, current forecasts point to a £30bn gap in funding by 2020/21. • Local Authority budgets are being cut in real terms
Increasing long term conditions	• It is predicted that there will be 550,000 additional cases of diabetes and 400,000 additional cases of stroke and heart disease nationally • 25% of the 15 million people in England with a long term condition currently utilise 50% of GP appointments and 70% of the total health and care spend in England.
Public expectations	• Patients and the public rightly have the high expectations for the standards of care they receive. There are increasing demands for access to latest therapies, greater information requirements and more involvement in decisions about their care.
Increasing pressure on existing health services	• General Practice is at saturation point and unable to take on additional work without major changes to primary care infrastructure and workforce • Reduced provision of services by Local Authorities resulting in pressure on health services and health budgets

In response to the challenges set out in the previous table, our collective ambition is to maintain high quality and sustainable health and care services for our public and patients which we will achieve through:

- Ensuring our citizens are fully engaged
- Wider primary care provided at scale
- A modern model of integrated care
- Access to highest quality urgent and emergency care
- A step change in the productivity of elective care
- Specialised services concentrated in centres of excellence.

2.4 Workforce:

There are a number of challenges facing the local workforce that have the potential to impact upon the provision of LTC care:

- There is an ageing workforce in Primary care – in both GPs and Practice Nurses which necessitates the need for succession planning. This is addressed in the CCG's Primary Care Strategy.
- Skills in primary care workforce for LCT disease management – we will aim to ensure consistency of standards and skills across all practices in the provision of care to patients with LTCs. In addition we will support the development of new skills that support the move to multi-morbidity such as coaching for behavior change, shared decision making and motivational interviewing techniques.
- We will work closely with the Primary Care Transformation teams to support the development of new roles in primary care such as health care navigators; and explore the expansion of existing roles to support delivery of LTC care e.g. practice pharmacists.
- In the community there is a need to ensure closer integration of these staff into general practice to support delivery of LTC care for example optimising the role district and community nursing teams have to play in the care of housebound patients with LTCs.
- The over 65s are the biggest consumers of health and social care and their needs can be hugely challenging to address. While traditionally the most experienced workforce would have sat in specialist secondary care services there has been a move to develop more creative and innovative posts in community and primary care services in recent times e.g. practice based frailty nurses. However much more needs to be done if we are to have a workforce able to respond to the needs of those most frail and complex. As long as we continue to consider long term conditions as single system diseases we will never have the workforce ready and able to proactively manage older people living with multiple conditions or frailty.

2.5 Patient Experience

To inform the Long Term Condition Strategy, the CCG wanted to find out about individual patient experiences of being diagnosed with an LTC, the impact of living with one or more conditions and discover what would help patients manage their conditions as effectively as possible.

This was undertaken by carrying out a review of recent consultations; holding focus groups and one to one discussion with patients (which resulted in the development of a number of case studies); an online survey promoted widely across Newcastle and Gateshead resulted in 245 responses and discussions with the Gateshead LTC Patient Reference Group.

A comprehensive report detailing all responses and findings has been developed as a supporting document to this Strategy. The main points raised are summarised in the following sections together with implications that should be considered in the implementation of this strategy:

2.5.1 Receiving a diagnosis

For many people, being diagnosed with an LTC is a shock, even if it has been a progressive illness. If the onset is sudden, the impact can be greater than recognised by health care professionals and patients are left floundering. If the condition evolves more slowly, people often still require time to accommodate their new circumstances and talk through the implications. Some people have indicated that they did not share their worries with practice staff or with their family because of concern about being a burden.

There is evidence from the case studies that when people are able to come to terms with the diagnosis and learn more about their condition, they are able to make choices to improve their health.

Implications for strategy

- Emotional support offered at time of diagnosis
- A need to ensure people are supported to understand and learn about their condition

2.5.2 Relationship with GP Surgery staff

This relationship is vital for patients with a long term condition. When there is a reliable and trusting relationship with their practice things go well but often patients do not have confidence in the care that they will receive.

Implications for strategy

- Continuity of care for patients with LTCs
- Consultation skills of practice staff to take a holistic approach to the needs of LTC patients during consultation (i.e. to unearth and address MH issues and identify needs for support beyond traditional medical model of care – Social Prescribing)

2.5.3 Understanding and agreeing future plan of care

One key issue that emerged from patients was uncertainty about future appointments and follow up by General Practice. Often patients were unsure if they had to continue taking medication, if they would get called for follow up or if they had to request an appointment. In addition, people were unsure if some new symptoms or a change in

their condition required an urgent appointment. Clarity about long term management is essential for patients.

Implications for strategy

- Ensure systematic approach to LTCs undertaken in general practice and communicated clearly to patients so they know what to expect
- Care plans developed and agreed with patients, where appropriate to cover all LTCs a patient has.
- Ensure patients have a clear understanding of their medication and treatment.
- Patients understand what to do in an emergency or if their condition worsens.

2.5.4 Support to remain in employment

The Gateshead Patient Reference Group raised several problems associated with working. These issues were explored further in the LTC survey. Patients were asked if staff understand and are supportive and helpful about work issues. Similar results were obtained for primary and hospital care and showed that more can be done to assist patients in or looking for employment.

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2.5.5 Finding out about information, services and support that might help patients

For patients, information is the key to be able to manage their condition well and needs to come from a variety of sources. The survey asked 'Do you know where to go for the information you need, such as finding out about how to manage your conditions or what treatments might be right for you?' Although 48% of responders (108 people) knew where to access information, a further 38% know where to go for some things but not others and 14% are confused about where to start to get the information. Discussion with patients raised the following points.

- Information needs to be tailored to the needs of the particular patient and his/her family
- Leaflets and written information are not enough for most people. Word of mouth and personal recommendation is how people engage with activities that can inform and support them.
- People learn about good ways to manage their conditions from others in a similar position.
- Few patients are signposted to the main health charities' advice lines, websites and local peer support
- Most people are not offered courses about their condition. However those that have attended courses to learn more about their condition found them valuable.

Implications for strategy:

- Development of support for self-care needs to ensure information in provided in ways that meet individuals preferred methods of communication – link to care and support planning
- Ensure where required there is personalized support for people to engage in activities that can support them to improve their health outcomes e.g. the role of health care navigators to connect people, use of practice champions to engage patients in activities
- Consider the role of peer support when developing services that support self-care

- Consider how the CCG and partners can work better with the Charity sector to deliver support for self-care
- Commissioning of structured education for patients with LTCs – ensure systematic referral to these courses for patients with LTCs; and consider how to improve uptake of these amongst people with LTCs.

2.5.6 Learning from others in a similar position

Community group classes for those with cardiac, pulmonary or reduced mobility are popular and attendees are very clear about the positive benefits to help them manage their long term condition. They work so well because patients feel safe and are able to work at their own pace but also encouraged to progress. They offer the opportunity to talk to and learn from others in a similar position and offer the camaraderie that helps people to cope. This model seems particular effective at helping patients cope with quite major ill health. The demand outstrips supply and people find out about them in a haphazard way.

Implications for strategy:

- Recognise the importance of community based programmes for patients with LTCs and ensure strategies in place to ensure ongoing commissioning of these.
- Ensure systematic awareness and referral to these courses by general practice
- Ensure services are commissioned at appropriate level to meet demand

2.5.7 Multiple long term conditions

Patients who have several long term conditions face increased problems. Most of these center around getting advice that takes account of all of their conditions, this is particularly important for people who see many different specialists. In addition increased medication increases the complexity for the patient.

Implications for strategy:

- Ensure holistic (as opposed to disease specific) approach to care of patients with multiple LTCs – ensure this happens in both primary and specialist services
- Consider how care and support planning to deliver patient focused care can be used across the health economy.
- Establish an approach that includes comprehensive assessment, problem identification and care planning
- Consider how care and support planning to deliver patient focused care can be used across the health economy, including identified key workers and case managers that interface with secondary care and out of hours services especially
- Look beyond the medical model so support patients to live with their LTCs
- Support a change in the patient professional relationship to empower patients to care for themselves and promote shared decision making

2.5.8 Taking medicines

Patients report that it is getting easier for them to take control of their medication as simpler ways to order repeat prescriptions and advice from their local pharmacist really do help.

In the survey 68 % of patients (n=207) wished that they did not take as many medicines that they do. On the whole respondents felt that they understood their medication (68%) and could work out what to take and when (89%). 36% of respondents find it confusing when they are given a different brand of the same drug

and 33% felt that they had significant side effects of the medication. Managing side effects can be problematic as judgements need to be made. Are the side effects sufficiently serious to seek medical attention or do they just stop taking them? If so will this matter? Who can they get advice from?

Implications for strategy:

- Improve medicines management advice for patients with multiple LTCs

2.5.9 Worry about the future

Every patient is unique and this is reflected in how they cope with thoughts about the future. Some are sanguine, some worry, and others do not want to consider or plan for the future.

2.5.10 Conclusions

Patients living with long term conditions have to make frequent decisions about their health. Informed and supported patients have greater confidence to make effective choices to stay well and seek medical attention when required. This can be maximised by effective relationships with health care professionals, encouraging peer support and health education delivered in a variety of formats to enable people to select the most suitable programme for them.

3. Local Vision and Strategic Priorities

3.1 Models of Care

The Kings Fund paper "Delivering better services for people with long-term conditions Building the house of care" (5) advocated that "the management of care for people with long-term conditions should be proactive, holistic, preventive and patient-centred" The report describes a co-ordinated service delivery model – the 'House of Care' – that incorporates learning from a number of sites in England that have been working to achieve these goals. This forms the basis for Newcastle and Gateshead CCG's approach to care for patients with LTCs.

The house of care model differs from others in two important ways:

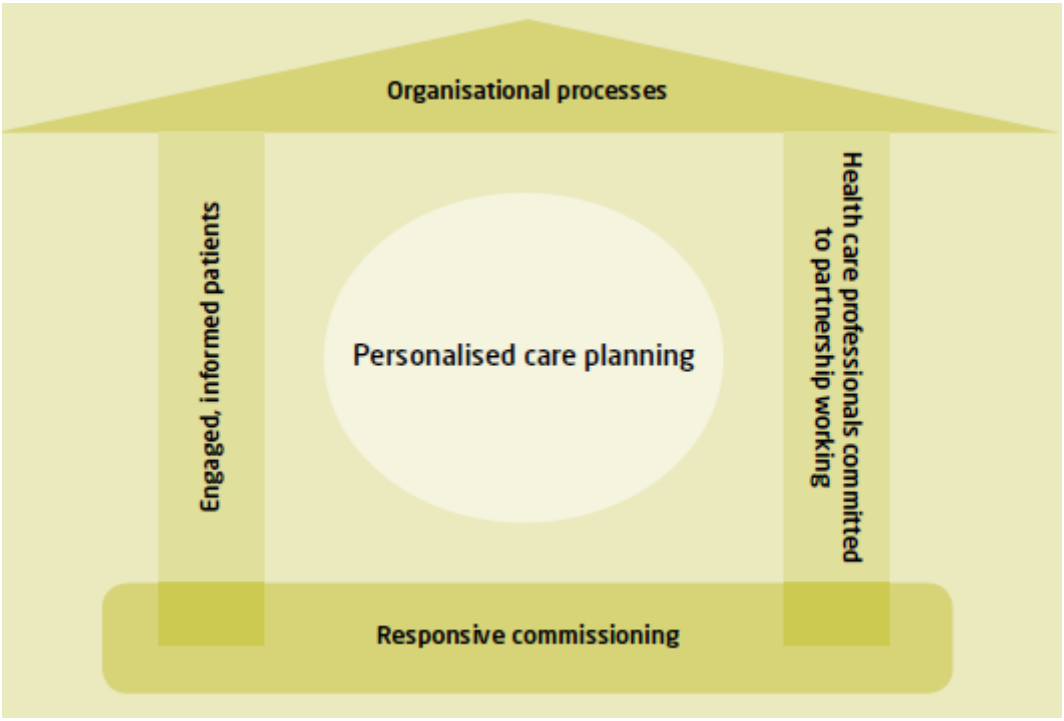
- it encompasses all people with long-term conditions, not just those with a single disease or in high-risk groups;
- it assumes an active role for patients, with collaborative personalised care planning at its heart.

Implementing the model requires health care professionals to abandon traditional ways of thinking and behaving, where they see themselves as the primary decision-makers, and instead shifting to a partnership model in which patients play an active part in determining their own care and support needs.

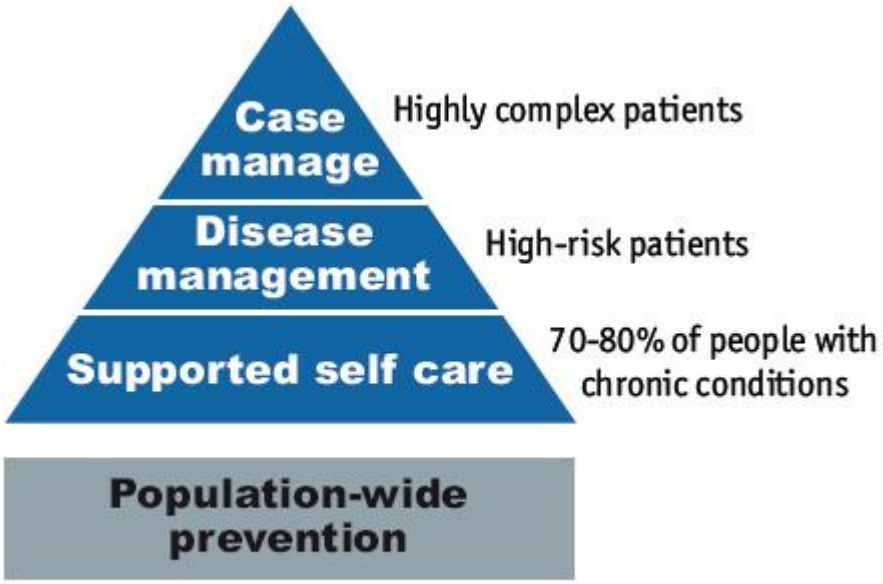
In personalised care planning, clinicians and patients work together using a collaborative process of shared decision-making to agree goals, identify support needs, develop and implement action plans, and monitor progress. This is a continuous process, not a one-off event.

An important feature of the approach is the link between care planning for individuals and commissioning for local populations; it aims to make best use of local authority services (including social care and public health) and community resources, alongside more traditional health services.

The house of care metaphor is used to illustrate the whole-system approach, emphasising the interdependency of each part and the various components that need to be in place to hold it together. Care and support planning is at the centre of the house; the left wall represents the engaged and informed patient, the right wall represents the health care professional committed to partnership working, the roof represents organisational systems and processes, and the base represents the local commissioning plan.



A number of models have been developed to identify the most effective ways to deliver services for people with Long Term Conditions. One model that is useful in illustrating the approach Newcastle and Gateshead CCG has to LTC care is the "Kaiser Triangle" as described by Chris Ham (6). This model focuses on integrating services and removing distinctions between primary and secondary care and represents the differing levels of need for people with LTCs as illustrated below:



Source: NHS and University of Birmingham.

This shows that most - 70-80 per cent - of people with long term conditions can care for themselves, and need minimal input from health and social services. They represent the bottom layer of the pyramid.

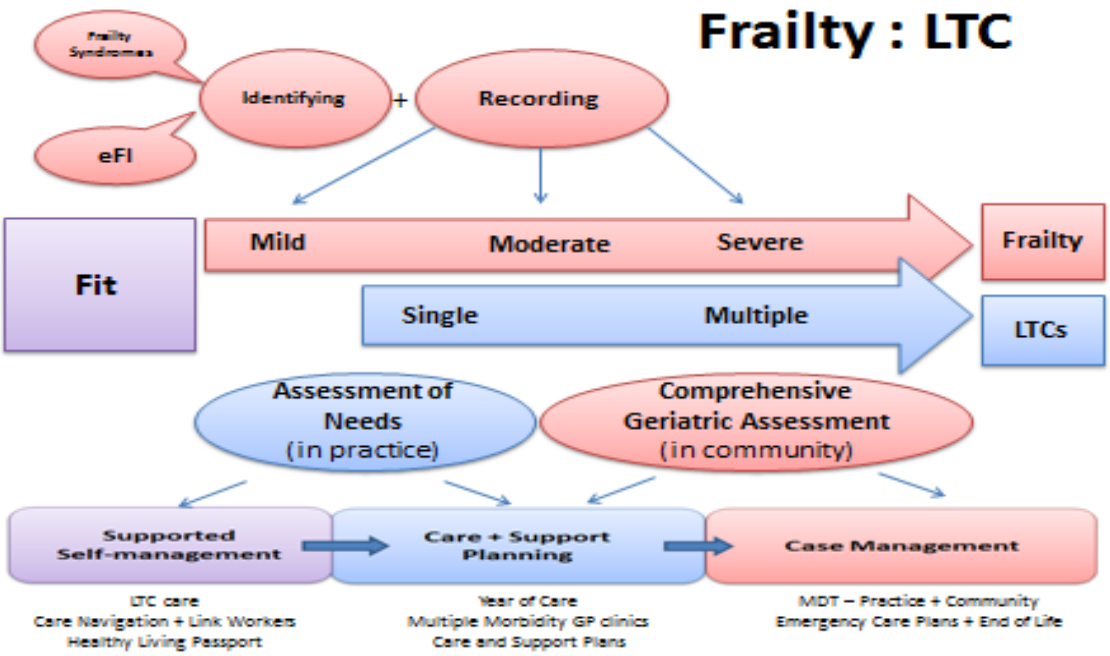
In the middle layer are ‘high risk patients’ – people who need more active disease and care management from professionals.

Finally, in the top level, are the patients with highly complex needs. These patients represent a small proportion of the population, but account for a large number of emergency admissions.

The model assumes with the right information, advice and support, most people are able to manage their own conditions the majority of the time. However, the intensity of co-ordination and support required will vary according to the morbidity, dependency and complexity of the conditions involved.

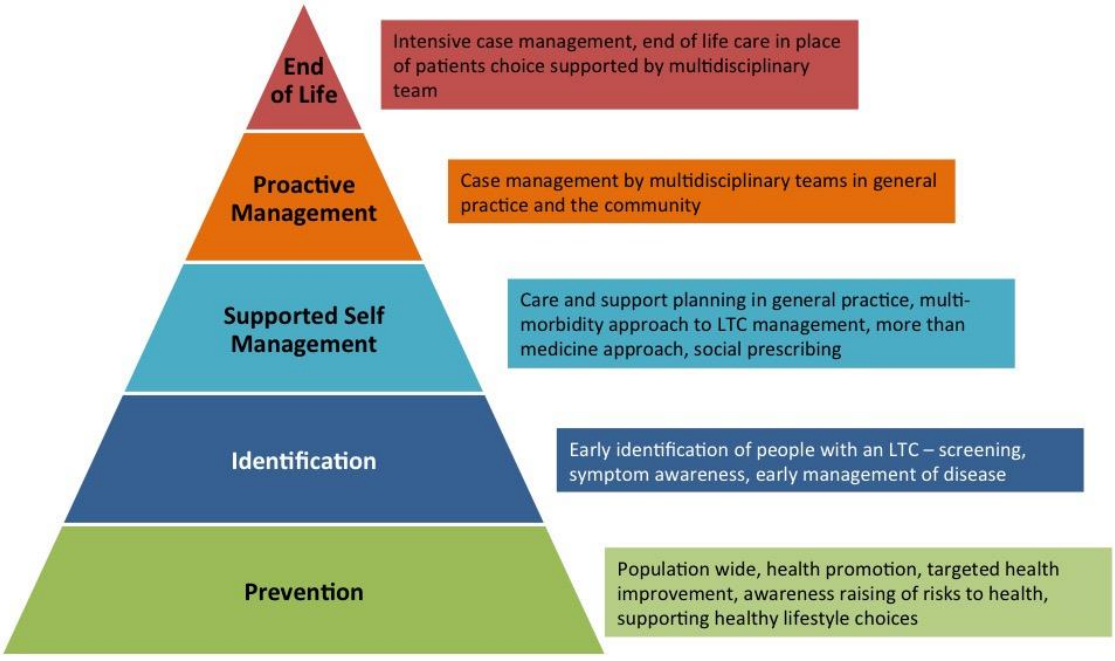
The model is based on a foundation of population-wide prevention, health promotion and targeted health improvement activity, through action to prevent disease, raise awareness of risks to health and support healthy lifestyle choices. This is essential given the high prevalence of long term conditions which are preventable, and the health inequalities associated with living with long term conditions. Supported self-management is where people with long term conditions are given the information and other practical support they require to manage their own conditions in a way that helps them use this information to their own benefit. Disease management is provided when a greater level of professional support is required to help avoid complications or slow the progression of disease; and care management is provided for those with particularly complex needs who require a more intensive level of care - a coordinated and proactive approach to improve health and help them avoid being admitted unnecessarily to hospital.

This strategy recognises the emerging evidence for managing frailty as a long term condition. The following model illustrates how frailty fits within the above model for it’s management as a long term condition:



Newcastle Gateshead CCG

Model for Long Term Conditions



System Enablers- Workforce, IT, Social Prescribing, New Contracting Frameworks, Estates and Medicines Support

3.2 Our Vision, Principles and Strategic Goals

3.2.1 Our Vision - *what we want achieve*

N&GCCG is committed to improving the health of our population over the next 5 years by systematically tackling the effective management of LTCs. Newcastle and Gateshead CCG will work to ensure that all partners are engaged and working in an integrated manner to achieve this vision. This strategy will complement the wider CCG's vision of seamless care, improved quality and patient and carer involvement.

The CCG's vision for LTCs is to reduce the numbers of people developing LTCs and for those who do develop LTCs ensure that they lead a healthier, happier life.

3.2.2 Principles - *the rules within which we will work to achieve our vision*

- We will promote health, wellbeing and prevention
- Ensure the provision of patient centered personalised care.
- Recognise patients and carers as active participants in their care; who are informed and fully involved in decision making about their care
- We will foster a culture of support for self-management.
- Organisations will work in partnership to ensure a system wide approach to the provision of care to achieve the best outcomes for our local population
- As a health care system we will recognise the assets that already exist in our local communities in order to enhance care we provide and improve outcomes for individuals
- We will take a holistic approach to care in order to manage patients' conditions as a whole person rather than looking at individual diseases

3.2.3 Strategic Goals – *how we are going to deliver it in the long-run*

- We will work with our local authorities and other partners to ensure that prevention remains a priority across the health economy
- Patients will be informed about their condition and have access to specialist advice when appropriate.
- Services will be provided locally by multidisciplinary teams who will use clear pathways of care.
- We will work to reduce variation in care
- We will ensure the provision of proactive and structured care based on clear evidence of effectiveness;
- We will ensure clinical pathways and services deliver best value within the funding available
- Care will be provided closer to patient's homes
- We will support people to manage and understand their own conditions with a focus on support for self-management and care and support planning, involving advocates and family carers when necessary

3.3 The Role of the CCG

The CCG will work with Primary Care, local FTs, the Local Authorities, the voluntary sector and general public to agree and support the development of integrated models of care that will deliver sustainable patient centered services. We will support transformation in Primary and Secondary Care and seek to commission new pathways of care that deliver the aims of this strategy.

The CCG will focus on delivering better value to the public. This will mean tackling unwarranted variation in clinical care, reducing waste and ensuring that quality and safety are at a key priority for all providers involved in the provision of LTC care.

4. Strategic Approach

Our Strategic Approach to ensure delivery of the LTC Strategy is made up of five programmes of work based around the individual's life journey (fitness to frailty); each of which identify key strategic actions necessary to ensure delivery of the overall strategy. These are detailed in the following section.

4.1 Prevention

4.1.1 How will this look for the patient?

"*I will be supported to make appropriate life choices for my health and wellbeing by all health care professionals and the choices made available to me in the wider community which I live in"*

4.1.2 Local Context

N&GCCG has a high numbers people who have unhealthy lifestyle behaviors increasing their risk of developing LTCs. There are currently gaps in provision and uptake of secondary prevention services

Key factors that increase the risk people developing an LTC include smoking, diet, alcohol consumption and weight.

Smoking

- As at June 2016, 23.3% of the non- LTC Gateshead patients aged 15+ were smokers.
- As at June 2016, 21.8% of the non- LTC Newcastle upon Tyne patients aged 15+ were smokers.

The following smoking age heat table is for patients **with** a Long Term Condition:

Smokers With A LTC	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
Gateshead CCG	0.9%	2.3%	2.6%	3.7%	4.7%	6.2%	9.4%	12.5%	12.7%	12.9%	12.1%	8.5%	6.4%	3.3%	2.0%
Newcastle CCG	0.9%	2.8%	3.4%	3.8%	4.7%	6.5%	9.6%	12.9%	13.1%	12.7%	11.7%	7.5%	5.7%	2.8%	1.8%
CCG Total	0.9%	2.6%	3.0%	3.8%	4.7%	6.4%	9.5%	12.7%	12.9%	12.8%	11.9%	7.9%	6.0%	3.0%	1.9%

The following smoking age heat table is for patients **without** a Long Term Condition:

Smokers With No LTC	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-69	80-84	85+
Gateshead CCG	2.8%	10.2%	14.2%	14.2%	12.8%	11.0%	11.1%	9.5%	6.3%	3.6%	2.3%	1.1%	0.4%	0.2%	0.1%
Newcastle CCG	3.4%	15.6%	17.1%	14.8%	11.8%	9.8%	8.9%	7.7%	5.2%	2.8%	1.6%	0.7%	0.3%	0.1%	0.1%
CCG Total	3.2%	13.5%	16.0%	14.6%	12.2%	10.3%	9.8%	8.4%	5.6%	3.1%	1.9%	0.9%	0.3%	0.2%	0.1%

It can be seen from the two previous tables, the majority of smokers with a LTC are in the age range 50-69. For both Gateshead and Newcastle the % of smokers in these age ranges is above 10% and therefore represents the largest age group of smokers with LTCs. In contrast the majority of smokers without a LTC are in the age range 20-49.

The greatest scope for prevention of long term conditions is in this younger age group

Obesity

- As at June 2016, 25.1% of the non-LTC Gateshead patients aged 16+ were classed as obese or morbidly obese
- As at June 2016, 19.8% of the non-LTC Newcastle upon Tyne patients aged 16+ were classed as obese or morbidly obese.

The following BMI age heat table is for patients **with** a Long Term Condition:

Obese / Morbidly Obese Patients With A LTC	16-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	76-80	81-85	85+
Gateshead CCG	0.7%	1.1%	1.6%	2.2%	2.9%	5.4%	8.0%	11.1%	12.0%	13.5%	14.9%	10.8%	8.7%	4.9%	2.1%
Newcastle CCG	0.7%	1.3%	2.1%	2.6%	3.2%	5.7%	7.9%	11.6%	13.4%	13.1%	14.1%	9.7%	7.7%	4.8%	2.1%
CCG Total	0.7%	1.2%	1.9%	2.4%	3.1%	5.5%	8.0%	11.4%	12.7%	13.3%	14.5%	10.2%	8.2%	4.8%	2.1%

The following BMI age heat table is for patients **without** a Long Term Condition:

Obese / Morbidly Obese Patients With No LTC	16-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	76-80	81-85	85+
Gateshead CCG	4.4%	9.3%	12.3%	12.6%	10.2%	12.8%	12.1%	9.8%	6.8%	4.1%	3.3%	1.5%	0.6%	0.2%	0.1%
Newcastle CCG	6.3%	13.2%	15.2%	14.9%	11.0%	10.6%	9.2%	7.7%	5.0%	3.4%	2.2%	0.8%	0.4%	0.1%	0.1%
CCG Total	5.4%	11.4%	13.9%	13.8%	10.7%	11.6%	10.5%	8.6%	5.9%	3.7%	2.7%	1.1%	0.5%	0.1%	0.1%

From the BMI LTC age heat table you can see that the majority of patients who are classed as obese or morbidly obese are in the age range 51-75. In contrast, for patients who do **not** currently have a LTC patients are at risk of developing a LTC because obesity is prevalent in a younger age group (21 onwards).

If advice in regards to lifestyle, exercise and healthy eating is offered to the younger patients who do not currently have a LTC there is a chance that they can avoid developing a LTC in future.

Alcohol

- As at June 2016, 13.2% of the non-LTC Gateshead patients aged 18+ drink a hazardous amount of alcohol and 3.5% of non-LTC patients aged 18+ drink a harmful amount of alcohol.

- As at June 2016, 9.7% of the non-LTC Newcastle patients aged 18+ drink a hazardous amount of alcohol and 2.6% of non-LTC patients aged 18+ drink a harmful amount of alcohol.

The following alcohol age heat tables are for patients **with** a Long Term Condition:

Gateshead CCG LTC	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
Hazardous	0.1%	0.4%	0.6%	0.8%	2.0%	4.1%	7.2%	11.1%	13.8%	14.9%	17.6%	13.2%	8.7%	4.1%	1.6%
Harmful	0.2%	0.2%	1.1%	2.7%	3.4%	7.3%	9.7%	14.8%	17.2%	15.1%	13.0%	9.0%	4.1%	1.5%	0.7%

Newcastle CCG LTC	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
Hazardous	0.2%	1.3%	0.7%	1.1%	1.9%	3.6%	6.5%	10.7%	13.6%	16.1%	17.4%	12.4%	7.5%	4.5%	2.5%
Harmful	0.2%	0.6%	0.9%	1.6%	3.0%	6.2%	10.8%	13.7%	14.6%	17.7%	14.2%	9.9%	4.0%	1.8%	0.8%

Total CCG LTC	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
Hazardous	0.1%	0.9%	0.7%	1.0%	2.0%	3.8%	6.8%	10.9%	13.7%	15.5%	17.5%	12.8%	8.1%	4.3%	2.1%
Harmful	0.2%	0.4%	1.0%	2.1%	3.2%	6.7%	10.3%	14.2%	15.8%	16.5%	13.6%	9.5%	4.0%	1.7%	0.7%

The following alcohol age heat tables are for patients **without** a Long Term Condition:

Gateshead CCG Non-LTC	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-69	80-84	85+
Hazardous	0.6%	3.9%	5.4%	6.5%	6.6%	13.3%	15.6%	15.8%	12.3%	8.6%	6.9%	3.3%	0.9%	0.2%	0.0%
Harmful	0.2%	3.7%	5.7%	8.9%	12.1%	13.5%	17.4%	14.5%	11.5%	5.9%	4.1%	1.5%	0.7%	0.2%	0.0%

Newcastle CCG Non-LTC	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-69	80-84	85+
Hazardous	2.9%	17.4%	6.3%	6.8%	5.5%	9.0%	12.0%	13.0%	10.8%	7.5%	5.6%	2.2%	0.8%	0.2%	0.1%
Harmful	1.8%	9.3%	7.2%	9.2%	10.9%	10.1%	13.8%	16.2%	10.1%	6.1%	3.4%	1.5%	0.6%	0.0%	0.0%

CCG Total Non-LTC	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-69	80-84	85+
Hazardous	1.7%	10.7%	5.8%	6.6%	6.0%	11.1%	13.8%	14.4%	11.6%	8.0%	6.2%	2.7%	0.9%	0.2%	0.1%
Harmful	1.0%	6.5%	6.5%	9.0%	11.5%	11.8%	15.6%	15.3%	10.8%	6.0%	3.8%	1.5%	0.6%	0.1%	0.0%

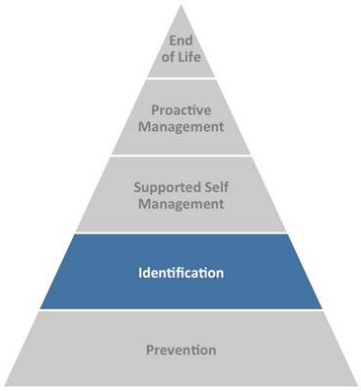
For the non-LTC patients, the hazardous and harmful drinkers vary depending on the area. This is because Newcastle has a student population, evident from the 17.4% of patients who are drinking a hazardous amount of alcohol on a weekly basis. Whereas in Gateshead from age 40 to 59 is the target group for hazardous drinkers and from age 40 to 59 is the target group for harmful drinkers. Contrast this with those that already have a Long Term Condition and for both areas the age range is 50-74 for both drinking groups.

4.1.3 Intention

The CCG will work with interested parties including our Local Authorities and Public Health to minimise the number of people who develop a LTC and reduce the impact for those that do. Identifying patients who are at higher risk of developing a LTC will be followed up with a clear explanation for the patient about this risk and discussion about possible options to reduce risk. It is recognised that health care professionals need to listen to, understand and respond to all the factors that influence a person's health and wellbeing and together with the individual make a shared plan to address them.

4.1.4 Strategic Actions

- We will work with our Local Authorities, to enable people to access support to improve health
- We will work with our Local Authorities, in particular Public Health, to make sure that services meet the needs of individuals and enable them to take steps to improve their health e.g. Stop Smoking Services
- We will support people with LTCs to help them reduce the risk of deterioration in their LTC e.g. reducing the risk of developing complications in people with type 2 diabetes by providing advice and support on a healthy diet
- Support our local populations to address the wider determinants of health by ensuring a more than medicine approach is taken when planning developing health services.
- Develop services for those at highest risk of developing Diabetes to help them reduce their risk.
- Work with Practices to ensure that patients at high risk of stroke because of other medical problems are offered treatments to reduce their risk
- Work with Providers to identify other opportunities for prevention at scale



4.2. Identification

4.2.1 How will this look for the patient?

"If I do develop a long term condition, it will be identified early and I will be supported through diagnosis"

4.2.2 Local Context

The number of people diagnosed with an LTC in Newcastle and Gateshead is lower than expected when compared to estimated numbers, suggesting that we have not identified the whole population. Unknown patients imply unmet need, increased use of local health services and increased chance of people suffering unnecessarily and dying early, compared to England averages

The following table highlights for the disease groups Hypertension, CHD, Stroke, COPD and Diabetes what the prevalence is and also what the expected rate is for each area:

	CCG List Size	Gateshead 208,050	Newcastle 324,714
Hypertension	No. With	33,771	36,798
	Prevalence	16.2%	11.3%
	Expected	32.3%	27.3%
CHD	No. With	8,449	9,235
	Prevalence	4.1%	2.8%
	Expected	6.7%	5.3%
Stroke	No. With	3,048	3,709
	Prevalence	1.5%	1.1%
	Expected	2.8%	2.2%
COPD	No. With	6,039	6,512
	Prevalence	2.9%	2.0%
	Expected	5.2%	4.4%
Diabetes	No. With	11,621	15,007
	Prevalence	5.6%	4.6%
	Expected	7.5%	7.0%

4.2.3 Intention

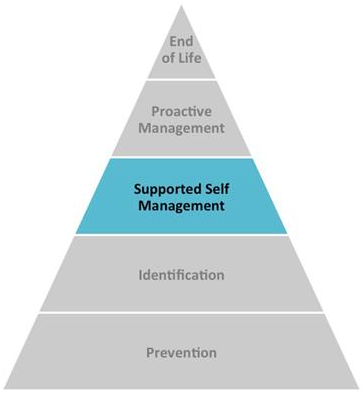
The CCG will work with our partners to increase uptake of screening and awareness of symptoms that need investigation and as a result of this improve the early identification of patients with Long Term Conditions.

4.2.4 Strategic Actions

We will begin to address this by:

- Maximising the uptake of the NHS Health Checks Programmes through participation in local and national campaigns
- Improving the identification of people with COPD through maximising opportunities to note smoking status and standardising the use of risk assessment tools.
- Implementing the NICE suspected cancer guidelines to ensure earlier diagnosis of cancer
- Working with General Practice to ensure systematic approaches to idenitifying those who have developed conditions such as Diabetes or Hypertension.
- Working with General Practices to identify people at risk of osteoporosis

- Improve identification of heart failure through improving the Heart Failure Pathway.
- Maximse uptake of cancer screening programmes



4.3. Support for Self-Management

4.3.1 How will this look for the patient?

"I will be able to understand and manage my own condition, with support from health care professionals when I need it."

4.3.2 Local Context

NGCCG, has an ageing population, high levels of deprivation and an increasing prevalence of patients with LTCs who have a high use of secondary care services. A recent frailty census undertaken in one of our hospitals identified that over 70% of inpatients [excluding children's and maternity services] were frail with 30% of those people found to be severely or very severely frail using the Rockwood frailty tool.

Most people with LTCs spend just a few hours per year with healthcare professionals and more than 99% of their lives managing their conditions themselves. As such, they need to become experts in their own health and will make all the day-to-day decisions which affect their own health. In terms of healthcare this means that the system needs to support individuals to develop the knowledge, skills and confidence to manage their own care. Additionally, healthcare professionals may also need support to develop new knowledge and skills from time to time and this can include learning from expert patients and their families.

Support for self-management recognises that people with long term conditions (LTCs) are in charge of their own lives and are the primary decision makers in relation to the management of their condition. This means the role of the clinician moves from doing things 'to' the person, to supporting people's confidence and competence to manage the challenges of living with their condition. This also includes supporting family carers to lead on self-management when necessary, given that such people are often the reason those with LTC are able to remain living in their community rather than being admitted to hospital in a crisis or live in an institutional setting in the longer term.

There is an extensive evidence base for the effectiveness of interventions which support self-management and their cost effectiveness. The Chronic Care Model (11) describes how better outcomes for people with LTCs can be achieved when there is partnership working between an 'engaged', 'empowered' or 'activated patient' and an organised proactive healthcare system. It has been suggested that the most important element of this complex intervention is support for self-management.

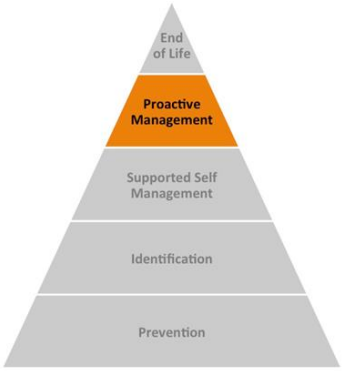
4.3.3 Intention

Our aim is to make sure patients are aware of what is available to them, to help them to manage their own conditions effectively, using services which support individuals and their carers. This can include a range of services and groups, with peer and emotional support, (such as social prescribing, peer support groups and referral to community psychological therapies)

4.3.4 Strategic Actions

We will achieve this by:

- Working with General Practices and the wider health care system to ensure delivery of the Year of Care approach for LTCs – a way services can provide personalised, coordinated care for all LTCs through care and support planning.
- Work in partnership to enable the development of services to support patients to live with and understand their condition e.g. developing patient support groups such as Breathe Easy Groups (British Lung Foundation), providing training to help patients better understand and manage their condition; ensuring effective rehabilitation services are in place; developing service to support patients who have survived cancer
- Contributing to the development of the social prescribing system to ensure it addresses the needs of people living with LTCs or at risk of developing them.
- Using technology to help people to live with and manage the impact of their LTC
- Making sure patients and health care professionals are aware of the services available locally to support them.
- Offer support for carers of those with LTC ensuring carers are able to access the full range of support available to them



4.4. Proactive Management

4.4.1 How will this look for the patient?

"I will be supported by an identified team to manage the impact of my conditions on my wellbeing and make sure there are plans in place for when I need them."

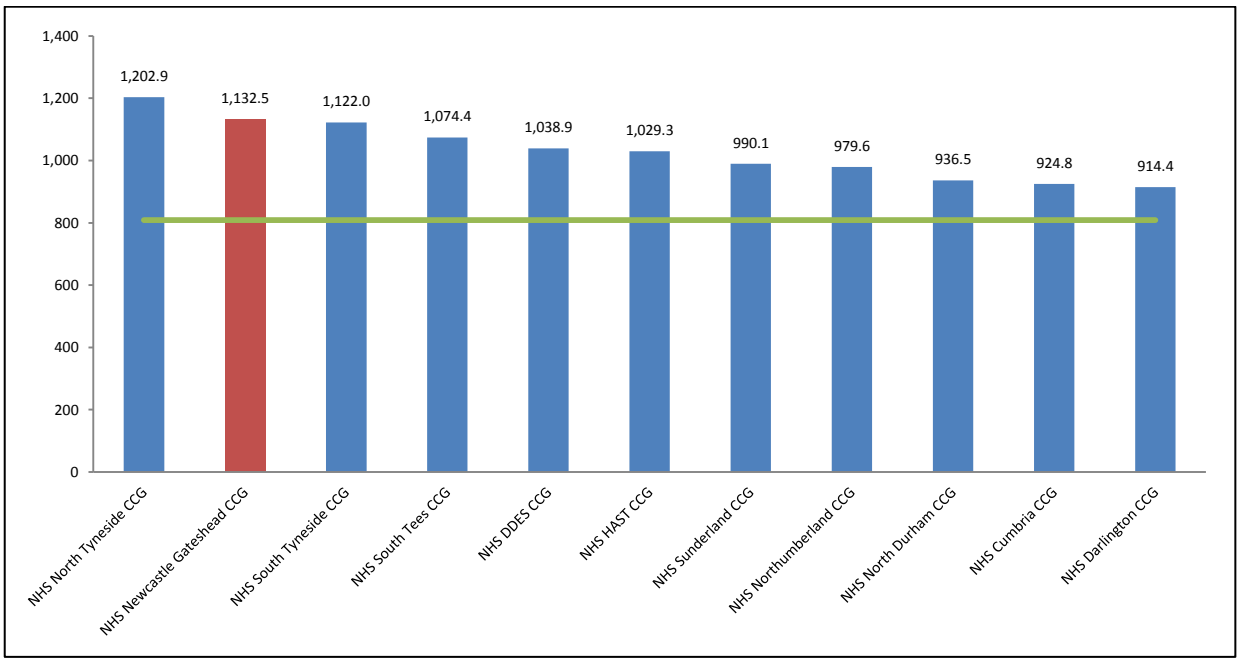
4.4.2 Local Context

Each year more people with one or more LTC are identified and the population of frail elderly people with multiple LTCs is increasing.

The population is ageing and life expectancy is increasing each year. This is a success for society brought about by improvements in public health, welfare and increasingly effective management of patients with long-term conditions. However, not everyone remains healthy and active as they age. Most older people live with at least two long term conditions that affect their health and wellbeing. The National Institute for Health and Care Excellence (NICE) (2015) suggested that, on average, a man of 65 will live a further 17.6 years but will face 7.7 years of ill health and 7.4 years with a disability towards the end of life. On average, a woman of 65 will live a further 20 years but will have 8.7 years of ill health and nine years with disability. This time spent in ill health and disability can be attributed in some cases to frailty (8).

Frailty is a distinctive late-life health state in which apparently minor stressor events are associated with adverse health outcomes. Frailty shares the key features of a long-term condition but is not currently conceptualised as such. Individuals living with frailty could benefit from frailty being managed as a long-term condition as this would allow for the development of primary care-based registers, the application of chronic disease models and a more coordinated team based approach to management (9).

Newcastle Gateshead CCG has the second highest rate in the North East for unplanned hospitalisation for chronic ambulatory care for all ages. Overall in England, Newcastle Gateshead CCG is above the England average and is also in the significantly higher group, giving a high rate of unplanned admissions for Chronic Ambulatory Care conditions.



Clinical experience and medical research suggests that older people have better health outcomes when their care is comprehensive, co-ordinated, multidisciplinary and expert. Approaches to assessment and care based on single or episodic illnesses, or single diseases, are not suitable for many older people who are living with multiple conditions. Their requirement is for holistic, person-centred care and in practice the wellbeing of many older people is compromised by gaps in assessment and by failures in the diagnosis, treatment and management of conditions such as frailty, dementia, arthritis, foot health, chronic pain, mobility problems, visual and hearing impairment, incontinence, malnutrition and oral health. These people need an approach to care ensuring comprehensive assessment, personalised care plans and long-term follow-up(12). Hence the need for multi-morbidity clinics in primary care that are integrated with community teams providing accompanying case management when necessary.

4.4.3 Intention

Each year more people with one or more LTC are identified and the population of frail elderly people with multiple LTCs is increasing. Providing good quality, proactive care is a priority to guide patients and their carers in the right direction. We are working to change services to improve joined up care to benefit those living with LTCs and their carers.

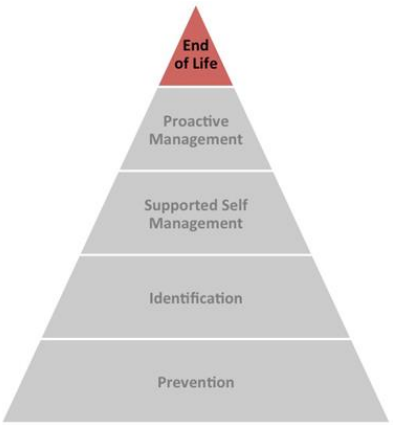
4.4.4 Strategic Actions

We will achieve this by:

- Working with hospital teams to support the development of frailty services that recogise the long relationship patients and their families have with primary care and community services so that liaison and co-working starts early in the inpatient journey
- Working with general practices to enhance the services they provide for people with specific LTCs
- Working with local health services to identify those patients with LTCs who need

more complex care plans developed to support them.

- Working with general practices to ensure care for people with LTCs is based on the person and not the condition
- Linking to work in the wider CCG, to develop a model for risk profiling the population both at a CCG level to inform allocation of resources; and at a practice level to inform identification of patients suitable for Case Management
- Ensuring that intermediate care services, commissioned by NGCCG, recognise and meet the needs of those patients with LTCs.
- Working with providers to reduce follow up in secondary care, and move to a system that allows patients to be seen on the basis of need.
- Increasing support for General Practices to manage people with LTCs, including support from specialist secondary care teams.
- Analysing General Practice data, and ensuring the use of guidelines, best practice and the use of data to identify variation in practice, to help General Practices address this and implement best practice.
- The integration of care pathways to join up in and out of hours care, especially in terms of shared care plans
- The development of multidisciplinary teams that work closely with primary care teams making transition of care and case management seamless
- The identification of frailty, using standard tools to promote active management and care delivery that seeks to delay progression through the spectrum
- Building on new models of care such as the Enhanced Health Care for Care Homes [EHCH] given it's success in shifting from a reactive to a proactive model
- Working with partners in the local health economy to meet the goals in the National Cancer Strategy on faster diagnosis, faster access to treatments and improved cancer survival rates



4.5. End of Life Care

4.5.1 How will this look for the patient?
"As I approach the end of my life, care and support will be planned so that I can die where I choose, in comfort and with dignity."

4.5.2 Local Context
Nationally we know that on average approximately 1% of a given population will be expected to die in an average year. The CCG wants to ensure that this part of our population can be identified to ensure that they receive coordinated, high quality, appropriate care during this period in their life. Currently across Newcastle and Gateshead we know that only 0.33%% of our population are identified as being on General Practice's Palliative care registers.

For this population we want to ensure that they have had an active role in developing clear plans together with the people involved in providing their care that reflects how they would like to be cared for at this point in their life which will be written in an Advance Care Plan. Currently only 27% of patients in Gateshead and 42% of patients in Newcastle have an Advance Care Plan in place.

It is understood that older people living with frailty, especially those over 85 years old, are less likely to access palliative care than younger adults (13). We want to be mindful of this and seek to ensure that a targeted approach is taken e.g. all those living in care homes will have end of life discussions and be considered for inclusion on the practice palliative care register.

When people are approaching the end of their life we want to ensure that services are able to work together closely to coordinate the person's care to ensure the last stage of their life is as good as possible. In Newcastle and Gateshead we need to work with all services to ensure consistency of care and sharing of information to enable this to happen.

4.5.3 Intention
To Develop systematic ways of improving care for people approaching the end of their life with LTCs. To improve coordination of care and ensuring sharing of information, enabling patients and their cares to have a voice in the care they wish to receive.

4.5.4 Strategic Actions

We will achieve this by:

- Promoting the use of palliative care standards in general practice with a focus on developing palliative care registers and increasing the use of Advance Care Plans.
- Developing an electronic palliative care record
- Implementing guidelines for prescribing in palliative care
- Reviewing hospice and palliative care services primarily in Gateshead but followed by Newcastle
- Ensuring services are in place to enable facilitated discharge both in and out of hours and sees coordination between health and social care teams
- Ensuring professionals involved in end of life care are confident and skilled to have difficult conversations with patients and their cares by the provision of relevant training

5. System Enablers

5.1 Workforce Development

A significant amount of long term conditions care in General Practice is carried out by the practice nursing team and it is recognized that there is a pool of skilled and experienced nurses in the CCG practices.

It is essential that all members of the team have the opportunity to access education and training to support them to deliver patient focused care that is effective, evidence based and facilitates self-care. The CCG will link with other local, regional and national work to ensure that education is appropriate to the needs of learners, their employers and patients.

The CCG recognises the need to develop the nursing workforce for the future who will provide care as part of multi-disciplinary teams and will work with providers to minimize variation and maximize interdisciplinary working.

The emerging roles of Primary care navigators and Community Link Workers are increasingly involved in helping and supporting patients with LTCs. We need to ensure that staff in these and other new roles are involved in delivering the aims of this strategy and that their work is effectively evaluated and developed in line with national policy.

Innovative roles such as the recently introduced practice based frailty nurse posts will be robustly evaluated and explored further for widening to all practices.

Patients have told us that some of their key concerns involve medication; understanding what they are for, how to use them and understanding what side effects they should watch out for. Pharmacists have a key role in supporting those with long term conditions and the CCG will support the new roles being developed for pharmacists in practices.

We recognise the needs of our future workforce and will work with partners to promote the principles outlined in this strategy so that the Health Care Professionals of the future are equipped to adopt a patient-centered approach in managing Long Term Conditions

5.2 IT

Our digital vision is to deliver the best seamless care by ensuring:

- Secure real time access to agreed relevant health and social data is available to the practitioner wherever and whenever they are legitimately involved with the service user
- Rapid, efficient and effective transfer of relevant information relating to service users across organisations
- Easy electronic access to organisational support materials/resources for professionals (including resources to be able to signpost service users)
- Patients, their families and / or their carers or other patient proxy have access, where appropriate, to their records

Plans to deliver a paperless NHS system and ensure delivery of the above vision

have been documented in the Newcastle Gateshead Local Digital Roadmap. This includes plans for developing:

IT infrastructure so systems are able to work together seamlessly, with an increased use of mobile technology

- Information sharing solutions so information can be safely shared across organisations
- Digital solutions to enable patients to self care, including use of telehealth and Apps

The Great North Care Record is an initiative which is developing a regional approach and solution to information sharing, this will deliver a system where:

The ***population*** (the patients, customers and citizens we serve) will be safer, more in control, and more involved in decision-making. They will have a well-founded confidence that the professionals who are listening to their story have the whole picture, in so far as they have chosen to share it. Health outcomes and measures of wellbeing will improve. The Great North Care Record will accelerate the diffusion and implementation of solutions, particularly those which enable people to interact with their own records and manage their own care.

The ***staff*** (the health and social care practitioners employed in health and care organisations) will have more efficient and enjoyable working lives. They will be able to make decisions with more certainty and less risk. Because record keeping will be more productive, they will spend less time on administration and paper-work, and more time offering care. Job satisfaction will increase and frustration will decrease. Time will be better spent. The people who lead and organise services (managers) will see value for money improve and waste reduce. This will happen because process costs will fall, in the same way as they have in other industries. It will be easier to launch new services, because the information needed to operate safely will already be available.

Commissioners (the people who plan and fund services) will be able to target services with more precision at the people who need them. Because information moves safely and securely across organisational boundaries, transfers of care are safer and more seamless. Because interoperability is built in from the start, reconfiguration of services is quicker, cheaper and safer. Use of expensive, disruptive, stressful and risky unplanned care will decrease. Over time, commissioners will develop an increasingly rich understanding of the way in which their populations access and interact with services. And because The Great North Care Record offers a holistic picture of services, it is a tool for understanding how changes and interventions interact and combine to alter outcomes.

5.3 Using new models of contracting to change the provision of LTC Care

The emerging contractual models for General Practice offer opportunities for practices to work together to pool skills and expand the skills available in primary care to manage those with LTCs and Multi-Morbidity.

Outcome based contracts also provide new ways of delivering care that is delivers the outcomes needed by those with LTC.

The CCG will work together with providers to ensure that these contracting models provide maximum benefit for those with LTCs

5.4 Prescribing support and medicines optimisation

Medicines are the most frequent healthcare intervention. The NHS spends £13.8 billion per year. The number of prescribed items is growing by 5.3% annually, but:

- 30-50% of medicines prescribed for long term conditions are not taken as intended
- 4-5% of hospital admissions are due to preventable adverse effects of medicines
- In primary care it is estimated that £300 million per year of medicines are wasted, £3 million per year in Newcastle Gateshead CCG, of which half is avoidable.

Our aims are to ensure people with long-term conditions get the most out of medicines and the best outcomes; that they get the right medicine at the right time; that these medicines are taken correctly and safely; that unnecessary medicines aren't being taken; and medicines are not wasted.

We will do this by:

- Ensuring evidence based, cost effective prescribing by having robust local decision making processes for medicines in line with the NHS Constitution and effective systems for implementation of NICE guidance.
- Ensuring all medication is used safely. This includes reporting medicines errors and embedding learning into policies, training and practice; appropriate antibiotic prescribing.
- Understanding the patient's experience and supporting patients and clinicians to reach shared decisions on the use of medication
- Supporting patients to manage their condition and medicines and to make choices about prevention of illness and disease and healthy living
- Supporting medicines reviews for patients with long term conditions e.g. GP/nurse/pharmacist medicines reviews, and working with community pharmacy colleagues to maximise benefits from new medicines reviews and medicines use reviews
- Including medicines optimisation within all commissioning and service re-design, and support new models of delivery to embed safe, high quality and cost-effective use of medicines across providers and seamless care across care settings
- Delivering medicines optimisation QIPP initiatives each year promoting quality and innovation as well as productivity and prevention in pathways of care involving medicines
- Working with all stakeholders/ commissioned providers e.g. patients, primary care based contractors, community providers, secondary care, care homes, local authority to ensure medicines optimisation is part of routine practice
- Supporting the use of new technology e.g. telehealth and telemedicine where this will help to improve patient care.

5.5 Social Prescribing

An increasing body of evidence supports the greater use of a ‘more than medicine approach’ to health care. Working within 4 specific activation areas we will increase the current social prescriptions being offered, and build a sustainable approach via:

- Practice Activation: Supporting the currently workforce and development of the future workforce to offer social prescriptions to patients.
- Person Activation: Supporting patients to support themselves via self care or support their communities via asset based community development approaches.
- System Activation: Supporting NHS settings to work across system on the social prescribing agenda, engaging with all partners to develop robust models of health and wellbeing across communities.
- Community Activation: supporting communities to engage in health and wellbeing activities via the above.

5.6 Estates

The CCG estates strategy provides opportunities for practices and community services to work together in new ways to integrate services for those with long term conditions

6 Ensuring Delivery

6.1 Governance

Implementation of the LTC Strategy will be assured by the Newcastle and Gateshead Long Term Conditions Programme Board.

The Programme Board will be underpinned by clinical working groups delivering programmes of work in the following areas:

- Diabetes
- Respiratory care
- Cardiovascular disease
- Cancer
- End of life care
- Liver disease
- The Year of Care
- Frailty

It will be the responsibility of these working groups to ensure implementation of the LTC Strategy. The working groups are accountable to the LTC Programme Board and will provide quarterly updates on delivery of their work plans to the LTC Programme Board.

The LTC Programme Board is accountable to Newcastle and Gateshead CCG Executive Committee. This is illustrated in the following diagram:

6.2 Monitoring Implementation

An implementation plan will be developed for the strategy which will be underpinned by detailed work plans produced by all of the supporting clinical work streams.

An LTC Outcomes Framework will be developed in conjunction with our stakeholders to include the use of “I statements”, together with supporting metrics, will be used monitor ongoing implementation of the Strategy.

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HEALTH AND WELLBEING BOARD
3 March 2017

TITLE OF REPORT: Delivering Better Health & Social Care Outcomes for Newcastle and Gateshead 'Statement of Intent'

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1. Purpose of the Report

To update the Health and Wellbeing Board on a Statement of Intent that has been agreed by the Accountable Officers across Gateshead and Newcastle 'Delivering Better Health & Social Care Outcomes for Newcastle and Gateshead'.

2. Background

Accountable Officers (AOs) across the Gateshead and Newcastle Health and Social Care system have been collaborating on the development of an approach to system redesign. The AO Group includes the Chief Executives of both local authorities, the Foundation Trusts (acute healthcare and mental health) and the CCG.

The AOs have come together in acknowledgement of the need to work collaboratively, beyond the usual planning frameworks, to mitigate the impact of the severe cuts across both health and social care.

The group identified that investment in preventative social care and public health, and other areas where there is no statutory duty, are particularly under threat but are of critical importance to the longer term sustainability of the local health and social care system.

3. Development of a Statement of Intent

Accountable Officers identified the need for arrangements that:

- Ensures a clear and shared purpose across health and social care where decisions are made in the best interests of the whole system;
- Provides the basis for collective decision making;
- Enables a whole system approach to be developed for health and social care – planning; financing; decision making for commissioning and delivery;
- Helps in reducing budget pressures across health and social care.

One of the key outputs from this work last year was the development of a Statement of Intent (attached as an Appendix) which commits the partners to work together in developing a long-term approach to the health and social care economy of Gateshead and Newcastle beyond the timeframe of any individual planning cycle.

4. The Statement of Intent - a framework to progress local discussions

The Statement of Intent was signed by Accountable Officers at their meeting on 27th January 2017. Given the significant financial and other challenges facing the local health and care economy, the Statement of Intent provides a framework to progress discussions at a local level on such issues as:

- a long term approach to the health and care economy of Gateshead and Newcastle beyond the timeframe of existing planning cycles;
- the drivers of health and care spending and the impact of funding reductions on services and outcomes for local people;
- the robustness of different models of health and care delivery having regard to local needs, geography and circumstances;
- the initiation of work leading to proposals for new and innovative health and care interventions;
- governance arrangements across a complex health and care landscape.

This may lead partners to the Statement of Intent to revisit the planning assumptions of national bodies, making representations to national funding bodies for changes in funding, targets, regulation and reward to enable them to better serve the interests of the people of Gateshead and Newcastle.

It is also envisaged that the process of working together will lead to practical proposals in the short and longer term, including through the development of preventative health and social care. Clearly, the development of working relationships between local partners will be central to this.

5. Governance

In signing the Statement of Intent, it has been made clear that all substantive decisions relating to the future health and social care of Newcastle and Gateshead remain the responsibility of the Boards of Governance and Councils; and that any proposals for substantive change will need to be brought before these in the usual manner.

6. Recommendations

The Health and Wellbeing Board is asked to note the signing of the Statement of Intent.

Contact: John Costello (0191) 4332065

Appendix

Delivering Better Health and Social Care Outcomes for Newcastle and Gateshead

Statement of Intent

January 2017

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Newcastle City Council

The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

NHS
Newcastle Gateshead
Clinical Commissioning Group

Gateshead Council

Gateshead Health NHS
NHS Foundation Trust

1. Introduction and Background

Newcastle and Gateshead face persistent and high levels of health inequality and Council social care budgets are being cut as resources have fallen and are vulnerable to further cuts. Investment in preventative social care and public health, and other areas where there is no statutory duty, are under particularly acute threat.

The NHS in the area is facing a different but no less difficult set of challenges. With service demand rising and constrained budgets within the NHS itself and the impact of reduced social care impacting discharges and other areas, the system is under considerable strain, with falling performance outcomes in some areas and increasing incidences of budget deficits.

Joint working across health and local government including but extending beyond the integration of health and social care could play an important role in reducing budget pressures and improving outcomes. It could also play a role in sustaining and developing the economy of the region. Health and social care are a key part of the economy, in terms not only of employment, but also innovation and as a growing export industry. The issue is how best to enable a whole system approach to be developed which is more robust and fit-for-purpose yet realistic building on the excellent work already underway between a range of health and social care partners in the Newcastle and Gateshead area. The purpose of this Statement of Intent is to provide a framework to enable such changes to be made.

2. Parties

This statement of intent commits all the following parties to the actions set out in this document:

Gateshead Health NHS Foundation Trust
Gateshead Metropolitan Borough Council
Newcastle City Council
Newcastle and Gateshead Clinical Commissioning Group
Newcastle Upon Tyne Hospitals NHS Foundation Trust
Northumberland, Tyne & Wear NHS Foundation Trust

3. Vision

The vision of the partners is that Newcastle and Gateshead is a model for how every part of the health social care and third sectors can work together to enable the people they serve to live longer, healthier lives, supported by the very best services available.

4. Objectives

The objectives of the partners are as follows:

- A continuing and sustained improvement in the health and wellbeing of the people of Newcastle and Gateshead as evidenced by greater longevity and better outcomes from health and care interventions

- Greater equality of outcomes, enabling people from across Newcastle and Gateshead to share in the improvements to the health and care system

- The maintenance and development of the highest quality health and social care

- An appropriately integrated and well planned, effective delivery model for health and social care

- A robust health and social care economy that is efficient in its use of resources

- A delivery system that is responsive to the needs of users in the short term and additionally, in the longer term, supports communities to be more responsible for the achievement of these objectives.

5. Principles

In pursuing the objectives of this Statement of Intent the partners commit themselves to operating within a set of principles. These are as follows:

- A commitment to taking a strategic view of health and social care and the needs of communities, seeking long term improvement in outcomes for Newcastle and Gateshead residents.

- A commitment to protect and support existing high quality provision, managing change in a way that preserves excellent, efficient provision.

- An openness to change on the part of each organisation, with each being led by evidence and strategic ambition as well as budgetary requirement in the formulation and delivery of proposals.

- Subsidiarity will be central to the work of partners. – if something can done by an existing organisation and it is best placed, it should be.

- Until or unless agreed otherwise, the activity of each partner organisation remains the responsibility of its Board/Council whose decision will be needed to change this.

6. Activities

The partners have agreed to start the process of joint working through a series of work streams bringing together local government and NHS partners. These areas of work are as follows:

Finance, Planning and Infrastructure
The development of financial modelling of the system: mapping existing financial flows across the Newcastle and Gateshead health and social care system, and modelling the impact of individual changes on system performance in order to understand how the impact of funding reductions is likely to impact on services and outcomes.

Innovation in Practice
Leading the development of innovation in practice, and the capacity to change what organisations do, helping organisations plan better, fund and manage their activities, so as to ensure that the process of working together leads to practical and actionable proposals both in the short and longer term including through the development of preventative health and social care.

System Re-design
Developing an analysis of the institutional landscape of the Newcastle and Gateshead Health and Social Care system; understanding the inter-relationships; jointly developing and testing the robustness of different models of health & social care delivery), making a balanced assessment of each and recommendations for one or more models to be considered for further development.

Strategy and Communications
Building an understanding of the drivers of health and social care spending for Newcastle & Gateshead, a ready means of communicating these and leading the development of a plan to engage all parties in responding to these findings.

These areas of work will be led by chief executives with agreed lead roles. Other important supporting work, for example in relation to workforce issues, will be taken forward by the Joint Programme Board, reporting to the Chief Executives.

7. Relationship to Regional and National Planning Including the STP

This Statement of Intent commits the partners to work together in developing a long-term approach to the health and social care economy of Newcastle and Gateshead beyond the timeframe of any individual planning cycle. However, this work must be cognisant of the requirements of national funding bodies including NHS England and in particular at present the requirement for each area to have a Sustainability and Transformation Plan. The partners are committed to an outstanding STP The initial work undertaken in Newcastle and Gateshead under the terms of this Statement of Intent has informed the development of the regional STP and will assist in its implementation. The same is true in relation to the North East Health

and Social Care Commission whose work the partners support and the outcomes of which should be mutually beneficial.

In signing this Statement of Intent, the partners agree to undertake work which will lead to proposals for new and innovative health and social care interventions. This may lead them to wish to revisit the planning assumptions of any and all national and regional bodies, making representations to National Government bodies for changes in funding, targets, regulation and reward to enable them to better to serve the interests of the people of Newcastle and Gateshead.

8. Governance

In signing the statement of intent, the Chief Executives of all partners acknowledge and agree both that: all substantive decisions relating to the future health and social care of Newcastle and Gateshead remain the responsibility of the Boards of Governance and Councils; and, that proposals for substantive change will need to be brought before these in the usual manner. However, to facilitate this, and to engender a new level of cooperation between partners, the Chief Executives agree to undertake the work needed to formulate a new light touch governance mechanism at which representatives of the governance bodies of every partner can meet and agree the recommendations of each will take to its constituent body for recommended decision.

Name	Signature	
Louise Robson		The Newcastle upon Tyne Hospitals NHS NHS Foundation Trust

Name	Signature	
Pat Ritchie		Newcastle City Council

Name	Signature	
Ian Renwick		Gateshead Health NHS NHS Foundation Trust

Name	Signature	
Mike Barker		Gateshead Council

Name	Signature	
John Lawlor		Northumberland, Tyne and Wear NHS NHS Foundation Trust

Name	Signature	
Mark Adams		NHS Newcastle Gateshead Clinical Commissioning Group

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