Gateshead Council

Public Document Pack

# HEALTH AND WELLBEING BOARD AGENDA

**Friday, 28 April 2017 at 10.00 am in the Whickham Room - Civic Centre**

From the Chief Executive, Sheena Ramsey

| Item | Business |
|---|---|
| **1** | **Apologies for Absence** |
| **2** | **Minutes** (Pages 3 - 10)<br>The minutes of the meeting held on 3 March 2017 are attached for approval. |
| 2a | **Action List - 3 March 2017 (Pages 11 - 14)**<br>Action List from 3 March 2017 attached for note. |
| **3** | **Declarations of Interest**<br>Members of the Board to declare an interest in any particular agenda item. |
| **4** | **Updates from Board Members** |
| | **Items for Discussion** |
| **5** | **Neighbourhoods & Communities Model** (Pages 15 - 20)<br>Report attached to be presented by Julie Ross. |
| **6** | **'Fire as a Health Asset'**<br>Presentation by Steve Anderson, Tyne and Wear Fire and Rescue Service |
| **7** | **Childhood Obesity: Year 6 Data Update** (Pages 21 - 24)<br>Report attached to be presented by Alice Wiseman and Kirk Green |
| **8** | **Final Gateshead Substance Misuse Strategy & Action Plan** (Pages 25 - 64)<br>Report attached to be presented by Joy Evans |
| **9** | **Better Care Fund 2017 - 2019 Submission Arrangemnts** (Pages 65 - 68)<br>Report attached to be presented by John Costello |
| | **Items for Information** |
| **10** | **Deciding Together, Delivering Together: Update** (Pages 69 - 72)<br>Report attached for information. |

**11** **HealthWatch Gateshead Activity Report (September 2016 to March 2017)** (Pages 73 - 118)

Report attached for information.

**12** **Any Other Business**

Contact: Sonia Stewart; email; soniastewart@gateshead.gov.uk, Tel: 0191 433 3045,
Date: Thursday, 20 April 2017

**GATESHEAD METROPOLITAN BOROUGH COUNCIL**

**HEALTH AND WELLBEING BOARD MEETING**

**Friday, 3 March 2017**

| | | |
|---|---|---|
| **PRESENT** | Councillor Councillor Lynne Caffrey (Gateshead Council) (Chair) | |
| | Councillor Jill Green | Gateshead Council |
| | Councillor Mary Foy | Gateshead Council |
| | Councillor Martin Gannon | Gateshead Council |
| | Councillor Malcolm Graham | Gateshead Council |
| | Councillor Michael McNestry | Gateshead Council |
| | Douglas Ball | Healthwatch Gateshead |
| | Dr Mark Dornan | Newcastle Gateshead CCG |
| | James Duncan | Northumberland Tyne and Wear NHS Foundation Trust |
| | Ian Renwick | Gateshead Health NHS Foundation Trust |
| | Dr Bill Westwood | Federation of GP Practices |
| | Alice Wiseman | Gateshead Council |
| | Sally Young | Gateshead Voluntary Sector |
| | Steve Anderson | Tyne and Wear Fire & Rescue Service |
| **IN ATTENDANCE:** | John Costello | Gateshead Council |
| | Gerald Tompkins | Gateshead Council |
| | Peter Wright | Gateshead Council |
| | Sonia Stewart | Gateshead Council |
| | Iain Miller | Gateshead Council |
| | Elizabeth Saunders | Gateshead Council |
| | Jackie Cairns | |
| | Julie Ross | Newcastle Council |
| | Elizabeth Toberty | |
| **APOLOGIES:** | Councillor Ron Beadle<br>Mark Adams and Sheila Lock | |

**HW111 MINUTES**

RESOLVED - That the minutes of the meeting held on 20 January 2017 be agreed as a correct record.

**HW112 ACTION LIST - 20 JANUARY 2017**

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

**HW113 DECLARATIONS OF INTEREST**

**HW114 UPDATES FROM BOARD MEMBERS**

**Gateshead Council**

Gateshead Council has now agreed its budget at full Council. It was noted that despite the cuts the Council are still managing to provide a large range of services. The position is incredibly difficult. It was noted that our only option is to grow our income and we need to invest in order to do this.

**Newcastle Gateshead CCG**

The Board were advised that The Great North Care Record has been rolled out across the whole of the North East. Local Sharing Agreements are in place and Gateshead is one of the leading areas.

The CCG reported on financial issues for this financial year linked to the mandated requirement to produce a surplus.

Work will need to be undertaken with the public - in particular, highlighting "phone before you go" and "111" options before people use extra care facilities.

Joint Members seminars across Gateshead and Newcastle and being arranged on health and social care integration. Julie Ross will be in touch with John Costello to progress.

**NTW**

The trust have developed new services for people with challenging Autistic needs at the Northgate site; this provides a clear pathway for re-integratation into communities. NTW have also been commissioned to take the lead nationally on work to improve Mental Health.

**The Board were advised that John Lawlor and Ian Renwick were listed in the Top 50 Chief Executives in the HSJ Awards. Ian Renwick advised the Board that this was a reflection of the staff he has working for him across the Trust.**

**Community and Voluntary Sector**

It was noted that as part of the Budget Consultation, the Voluntary Sector submitted a detailed response to the proposals. It was queried whether it would be possible for a summary of the changes which had been made as a result of the consultation to be shared with the various voluntary sector organisations who had taken the time to respond.

The work on the survey "Doing Good in Gateshead" has been completed and it is anticipated that the report will be ready by the end of the month. It has highlighted some key issues and pressures experienced by the voluntary sector in Gateshead. It was noted that it would be helpful to have a discussion on the issues raised at a

future Board meeting and possibly also a members seminar.

There has been some discussion about communications and how the various messages can be communicated to the public. It was suggested that we progressa co-ordinated approach to communications.

**Healthwatch Gateshead**

The Board were advised that Tell Us North have been awarded the contract for Healthwatch provision in Gateshead.

**HW115 10 YEAR TOBACCO CONTROL ACTION PLAN**

The Board received a presentation from Alice Wiseman on the 10 Year Tobacco Control Plan. Alice advised the Board that the issue of engagement still hasn't been resolved however, it was agreed that the team would continue to provide updates to the Board.

In terms of a reminder of the Background to the plan the current position in Gateshead is that:

- 29,485 Gateshead Residents Smoke
- Smoking is the single most preventable cause of early death
- 462 Gateshead residents die every year from smoking related diseases
- More than half of smokers will die early from a smoking related illness
- For every death there are 20 people living with a life limiting illness
- Smoking accounts for over half of the differences in risk of premature death between the most and the least deprived

Alice advised the Board that we are making progress; however, this is not fast enough. It was reported that the need to develop a 10 Year Plan was driven by the following:

- the Gateshead Tobacco Control Strategy elapsed in March 2016;
- The National Tobacco Control Strategy elapsed in December 2015 with no replacement to date;
- Findings from California show the rapid decline in adolescent smoking will not continue if tobacco control expenditure and focus are reduced;
- The commitment by the Council as part of the Regional Tobacco Alliance, 'Making Smoking History', to reduce smoking to 5% by 2025.

The following recommendations were made by the Health and Wellbeing Board in June 2016:

- **Action 1**: Ensure a greater focus on tobacco control activity by all partners on Health and Wellbeing Board for Gateshead.
- **Action 2**: Undertake a CLeaR review of the Gateshead Smokefree Tobacco Alliance in July 2016 in partnership with HWB members.
- **Action 3**: Work with young people in Gateshead to establish their views and build local action.

- **Action 4**: Develop a local 10 year delivery plan based on both the output of the CLeaR assessment and national, regional and local intelligence.
- **Action 5**: Maintain public support for action, communicate a clear understanding of the harm caused by tobacco and the benefits of stopping smoking in partnership with FRESH NE.
- **Action 6**: Ensure the Sustainability and Transformation Plans (STPs) include challenging action and targets for reducing smoking locally.

The following 5 key objectives the plan aims to achieve are:

- Reduce smoking prevalence among adults 18 year+ by 1.5% per year to 5% by 2025
- Reduce smoking prevalence in routine and manual groups by 2.3% per year to 5% by 2025
- Reduce smoking prevalence among young people (15 year olds) by 0.8% per year to 5% by 2025
- Reduce smoking during pregnancy by 0/9% per year to 5% by 2025
- Show progress in tackling local inequalities in smoking rates on a year by year basis

It was suggested that the ambition of 5% smoking prevalence across the Board should be openly more ambitious when it comes to smoking during pregnancy and smoking amongst young people. The aim should be 0% for these particular groups.

There was a request that partners think about how they engage in the Tobacco Alliance.

It was noted that there will be a presentation at the next Board meeting on how the Tyne and Wear Fire Service can be a health asset and this could be an area in which they broaden their work around safety visits.

The Director of Public Health has been challenged to a Year of Action on Tobacco. Alice also advised the Board that Tobacco dependents need to be treated as though they have a long-term condition and in a non-judgemental way.

RESOLVED - (i) That the 10 Year Tobacco Control Action Plan be endorsed by the Board.
(ii) That it is noted that further engagement work will take place on the 10 Year Plan.

**HW116 STP UPDATE**

The Board were provided with an update on the current position with regards to the STP (Sustainability and Transformation Plan).

Feedback 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.

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

- 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.

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.

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.

It was agreed that it will be important to be upfront with the public on the true extent of the challenges facing the Gateshead area and to fully engage with them on how those challenges will be addressed.

RESOLVED - That the update on the current position regarding the STP process be noted.

**HW117 DEVELOPMENT OF OSC WORK PROGRAMMES FOR 2017/18: EMERGING THEMES**

The Board received a report which outlined proposals for the development of OSC Work Programmes and the emerging priority issues for all of its Overview and Scrutiny Work Programmes. Views have been sought from Board members, key stakeholders and the Gateshead Strategic Partnership. Emerging themes for OSCs have been put forward following consideration of a range of factors including:

- Vision 2030
- The Council Plan 2015-2020
- The Health and Wellbeing Strategy for Gateshead
- Relevant Legislation
- Performance Information
- Issues of concern to local people
- Issues highlighted by councillor on Overview and Scrutiny Committee
- Public Health Commissioning Priorities

- Clinical Commissioning Group Priorities
- Safer Gateshead Partnership Priorities
- Children Gateshead (the plan for children, young people and families)

RESOLVED - That the Board noted the emerging themes and had no additional comments to make.

**HW118 BETTER CARE FUND QUARTER 3 RETURN 2016/17**

The Board received the Quarter 3 Update Report on the Better Care Fund for 2016/17. The return sets out progress in relation to budget arrangements, meeting national conditions and performance against BCF metrics. In particular, it was noted that we are on track to meet our end of year targets for non-elective admissions and admissions to residential care.

RESOLVED - That the Better Care Fund Quarter 3 Return for 2016/17 be endorsed by the Board for submission to NHS England.

**HW119 PRIMARY CARE (MEDICAL SERVICES) GOVERNANCE ARRANGEMENTS**

Currently NHS England has joint responsibility with Newcastle Gateshead CCG, for the commissioning of primary care medical services. From April 2017, this responsibility will be delegated to Newcastle Gateshead CCG.

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 currently 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 CCG Standing Orders.

To reflect the increased responsibility for primary care commissioning, the CCG will establish a revised Primary Care Commissioning Committee, with effect from April 2017. Governance arrangements will be in accordance with national recommendations and the Primary Care Commissioning Committee will report to the CCG Governing Body. The Committee Terms of Reference are also based on the national template provided by NHS England.

It was noted that representatives of Healthwatch and the Health and Wellbeing Board will continue to be invited, in a non-voting capacity, to Primary Care Commissioning Committee meetings held both in public and private. This is something that both HealthWatch Gateshead and HealthWatch Newcastle had sought within a joint letter to the CCG.

A representative of NHS England will also be in attendance at all meetings.

RESOLVED - That the revised local arrangements for commissioning of primary care medical services as of April 2017 be noted.

## HW120 HEALTH PROTECTION ASSURANCE REPORT

The Board received the Annual Health Protection Assurance Report. This report is submitted to the Board to provide assurance on the delivery of the Council's statutory duties regarding health protection assurance.

The Board were advised that uptake in Gateshead (and nationally) of the flu vaccine had decreased for people aged 65+ and also for those aged under 65 and at risk. In regard to the latter, it was noted that there is significant variation across GP Practices in Gateshead with uptake ranging from 37.9% to 60%. Uptake amongst pregnant women and amongst children is also down for Gateshead.

It was reported that there are some specific data issues relating to thenewborn screening programme which are being addressed. The DPH has sought a report from Public Health England on progress made to-date and associated timescales.

The Board were advised that there is a Health Protection Assurance Group and issues are picked up and monitored at this group. The Board were advised that ,as a council, there has also been some successes e.g. a bid to secure £0.5m to look at measures to improve air quality.

The issues of Excess Winter Deaths was also raised and it was agreed that a report will be brought back to a future Board meeting.

RESOLVED - (i) that the information in the report be noted.
(ii) that the Board be assured that measures are in place to monitor screening and prevention programmes in order to protect the health of the local population.

## HW121 LONG TERM CONDITIONS STRATEGY

A report was presented to the Board (for information) to inform the Board of the publication and content of the Long Terms Conditions 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 also support the local implementation of priorities identified in the wider STP.

It was noted that there seems to be a lack of recognition of unpaid / non-professional input.

It was noted that Steve Kirk has offered to come to a future Board meeting to discuss implementation of the strategy.

RESOLVED - That the information in the report be noted.

## HW122 HEALTH AND SOCIAL CARE STATEMENT OF INTENT

An update was provided to the Board (for information), to advise that Accountable Officers across Newcastle and Gateshead have signed a Statement of Intent "Delivering Better Health and Social Care Outcomes for Newcastle and Gateshead."

The Accountable Officers across the Gateshead and Newcastle Health and Social Care system have been collaborating on the development of an approach to system redesign. This is an acknowledgement of the need to work collaboratively beyond the usual planning framework, to mitigate the impact of the severe cuts across both health and social care.

RESOLVED - That the information in the report be noted.

## HW123 ANY OTHER BUSINESS

No additional items of business were raised.

## HW124 DATE AND TIME OF NEXT MEETING

Friday 28 April 2017 at 10am.

**Item 2a**

**GATESHEAD HEALTH AND WELLBEING BOARD**
**ACTION LIST**

| AGENDA ITEM | ACTION | BY WHOM | COMPLETE or STATUS |
|---|---|---|---|
| **Matters Arising from HWB meeting on 3rd March 2017** | | | |
| **Updates from Board Members** | Consider findings of VCS study 'Doing Good in Gateshead' at a future Board meeting. | Sally Young & VCS colleagues | To feed into the Board's Forward Plan |
| **Health Protection Assurance report** | Bring back a report to the Board regarding Excess Winter Deaths. | Alice Wiseman | To feed into the Board's Forward Plan |
| **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 HWB meeting on 20th January 2017** | | | |
| **Updates from Board Members** | A discussion to take place on workforce issues and their implications for Gateshead at a future Board meeting. | All | Due to come to the **June** Board meeting. |
| **BME Needs Assessment** | An analysis of primary care data to be undertaken to investigate important risk profiles for this population.<br><br>An action plan to be developed to propose solutions to ensure | All | Ongoing<br><br>To feed into the Board's Forward Plan. |

| AGENDA ITEM | ACTION | BY WHOM | COMPLETE or STATUS |
|---|---|---|---|
| | BME communities receive important messages regarding access to appropriate services.<br><br>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. | | |
| **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 HWB meeting on 2nd December 2016** | | | |
| **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 |
| **Matters Arising from HWB meeting on 21st October 2016** | | | |
| **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 HWB meeting on 9th September 2016** | | | |
| **Gateshead JSNA 2016 Update** | An update report to be brought to the Board in September 2017. | Alice Wiseman/Iain Miller | To feed into the Board's Forward Plan |

| AGENDA ITEM | ACTION | BY WHOM | COMPLETE or STATUS |
|---|---|---|---|
| **HWB Forward Plan** | Partners to contact John Costello with any additional items to be included within the Forward Plan. | All | On-going |
| **National Joint Review of Partnerships and Investment in VCS in Health & Care Sector** | A further report to be brought back to the Board in three to six months' time. | Sally Young | To feed into the Board's Forward Plan |
| **Matters Arising from HWB meeting on 10th June 2016** | | | |
| **Drug Related Deaths in Gateshead** | An update report to be brought to a future Board meeting. | Alice Wiseman | To feed into the Board's Forward Plan |

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**Item 5**

**HEALTH AND WELLBEING BOARD**
**28 April 2017**

**TITLE OF REPORT:** **Communities and Neighbourhoods Model (Out of Hospital Care)**

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## Purpose of the Report

1. This report provides an overview of the Communities and Neighbourhoods model currently under development in Newcastle and in Gateshead designed to facilitate more care being provided in community and neighbourhood settings.

## Background

2. The Community and Neighbourhood model for Gateshead and Newcastle has been developed over the last 12 months through a range of stakeholder conversations. Describing a system architecture designed to shift care from hospital settings to community settings and ideally to people's own homes, the model captures work already underway in many parts of the Gateshead geography. The model will not duplicate existing work – but will bring into a coherent story, the collective efforts of statutory, voluntary, community and third sector agencies.

3. The Communities and Neighborhoods model is designed to deliver improved outcomes for the population in terms of their health and wellbeing and builds upon measures and metrics already in place. For example, its success will be measured through the number of patients remaining at home 91 days after discharge, permanent admissions to care homes, reduced readmissions and delayed transfers of care. Such measures of success are taken from existing frameworks, and importantly from the Better Care Fund.

## The Sustainability and Transformation Plan

4. In 2014 NHS England published the Five Year Forward View, setting out a vision for a better NHS and the steps needed in the Northumberland, Tyne and Wear and North Durham plan to deliver that vision by 2020-21. There are 44 footprints across England and ours covers the three local health and social care economies of:
    - Northumbria and North Tyneside
    - Newcastle and Gateshead
    - South Tyneside, Sunderland and North Durham area.

5. STPs will not replace existing plans to improve services in an area. Instead they will act as an 'umbrella' plan: holding underneath it a number of different specific

plans to address certain challenges, such as improving cancer diagnosis, mental health care, or transforming urgent and emergency care services.

6. Much of the STP describes transformation work and programmes already underway across the patch and is simply a continuation of that work over the next few years. The Health and Wellbeing Board and scrutiny arrangements have previously considered many of these; for example, the Deciding Together programme (mental health) was considered by a joint scrutiny meeting between Newcastle and Gateshead on 31 March 2016).

7. There are four 'Transformation Delivery Groups' which will operate at the STP footprint level and will oversee the development of the new care models in our STP. Each work stream is led by a nominated director – three of the four of which are from the Newcastle and Gateshead patch, giving us a really strong leadership role across the STP footprint.
   - Prevention, health and wellbeing – a north east wide programme (is covering two STP areas) and led by Amanda Healey, DPH at South Tyneside.
   - Neighbourhood and community services (out of hospital) – led by Dr Dan Cowie, Director of Transformation at Newcastle Gateshead CCG.
   - Optimum use of the acute sector – led by Susan Watson, Director of Strategy at Gateshead Health.
   - Mental Health – led by James Duncan, Deputy Chief Executive at NTW mental health trust.

8. There is a community and neighbourhood STP wide group (covering Northumberland, Tyne and Wear and North Durham) – its role is to provide expert clinical and non-clinical advice on the health and care outcomes all areas should be working to achieve. This work is led by Dr Dan Cowie (from Newcastle and Gateshead CCG) across the STP footprint. The design of the local model to achieve the outcomes is entirely within the gift of the local health economy.

**A Model for Communities and Neighbourhoods**

9. Right now, we have a high reliance upon hospitals beds in the north east compared with the rest of the country. In the next 20 years, we will see a 50% increase in the number of people over 70 years old and a 100% increase in the number who are over 80 years old. This increase will put more and more demand on the NHS and social care system unless we change the system. For example, in the next 20 years, if we continue as we are we will need twice as many hospital and social care beds than we currently have. We will not be able to provide the staffing nor the premises to meet this kind of demand – let alone be able to afford to do so. We therefore need a new care model.

10. So, we need to work together to help the population live healthy and happy lives, independently and at home and that means first and foremost focussing upon making the most of our personal health and wellbeing behaviours and our community resources and only when we need NHS or social care services, do we access them - quickly and easily.

11. Services will be designed to help people live their entire lives at home, reduce the number of people going into hospital; when people do go to hospital, they will stay there for as short a period as possible. Teams will include district nurses, social workers, matrons, GPs, physios, occupational therapists and a whole host of other professionals. Professionals will be asked to collaborate with colleagues

and help wrap their services around the person. We will see hospital specialists not only delivering services in hospital but also in communities, be that through providing advice, delivering training programmes or sitting within the communities teams and giving direct care to patients ***out of the hospital setting***.

12. To make a reality of the model, we need to change how some services will operate and ensure that they are set up to deliver the kind of services we will need for the future.

13. It is envisaged that an ***enhanced primary care*** model would operate across populations of 30 – 50,000. This doesn't mean practices having to merge with each other, but it does mean them working together and sharing their scarce workforce resources.

14. The model describes an approach where the population will receive its care from ***locality-based integrated care teams*** that bring together the NHS and Local Authority with voluntary and community sector services in each locality, wrapping the health and care service around the person, working in synchrony to help the person continue to live at home.

15. Equally the locality based integrated care teams would benefit from ***specialist interface services*** which will see specialist providers (acute and mental health trust, local authority specialist advice etc.) providing advice to the locality teams and direct services to the population in the community with the aim of reducing admissions to hospital and helping those who are in hospital get back home as quickly as possible.

    The attached Appendix provides a graphical representation of the model.

**Current Position**

16. The neighbourhoods and communities model is a large scale change programme and we have spent much of March and April in 'conversation sessions' with various stakeholder groups to share and shape the story further. To support the conversation programme, we have developed:
    - A standard slide deck
    - A single sheet handout describing the model and a series of statements about 'what this means to me/ my organisation' to help the public and stakeholders understand the model and shape it further with us.
    - Guidance notes for those presenting the model – which are of course, entirely sharable with the audience.

17. The first five conversation sessions held in March have also identified some points which **require further consideration**, including:
    - The slides and handout are written for professional audiences. We are working on the public facing documents.
    - The model encompasses health and care services – there is not yet sufficient emphasis on children, health inequalities or the workforce challenge. This will be addressed in the final version in May.
    - The work on 'prevention' and improving overall health and wellbeing is subject to a separate work stream. Again, this is not sufficiently described in the slides and will be addressed in the final version in May.

- The way in which we describe the voluntary sector in the 'what it means to me' part of the single sheet handout, needs to be reframed.

18. The following table lists the conversation sessions scheduled in March and April 2017. Members of the board are asked to provide direction about where the revised model should be discussed, following the conversation sessions below.

| **Organisation / Forum** | |
|---|---|
| Gateshead HWB | Joint Integrated Care Board |
| Newcastle well-being for life | Gateshead Transformation Board |
| Newcastle people directorate | Gateshead CWL directorate/ Strategy Group |
| Newcastle portfolio holders | NUTH Trust board |
| Gateshead portfolio holders | NUTH integration group |
| Accountable officers meeting | Gateshead Health Trust board |
| Sub AO meeting | NTW Trust board |
| Newcastle task force | NTW transformation team |
| CCG internal staff briefing | LMC/ CCG conversations |
| CCG corporate management | NG CCG governing body |
| Blue Stone consortium | Newcastle design lab |
| Estates group | Newcastle GP federation |
| GP forum | |

**Proposal**

19. It is proposed that the Gateshead Transformation Board, which exists as part of the Gateshead Care Partnership, leads the work to implement the communities and neighborhoods model.

**Recommendations**

20. The Health and Wellbeing Board is asked to:

(i) Note the title of the model will be changed from 'Communities and Neighbourhoods' following feedback already received;
(ii) Suggest alternative titles for the model;
(iii) Comment upon the content of the model and suggest alterations accordingly;
(iv) Provide direction on the meetings in which the revised model should be taken, following the 'conversation' sessions to shape the model.

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**Contact:** Julie Ross, Director of integration in Gateshead and Newcastle
Julie.ross@newcastle.gov.uk

ter Health
ter Care
tainability

People will live and age well as part of their community. If needed, care will be provided close to or at home. If hospital is necessary, people will stay as long as needed, but recover and recuperate in or around their homes.

# Community and Neighbourhood

*A New Care Model in Newcastle and Gateshead*

January 2017

**y?**

Unemployment + deprivation + unhealthy lifestyle choices → We are living longer with more long term illness → Our workforce is dwindling + needs new skills → We can't afford to carry on as we are

**t?** First and foremost we need:

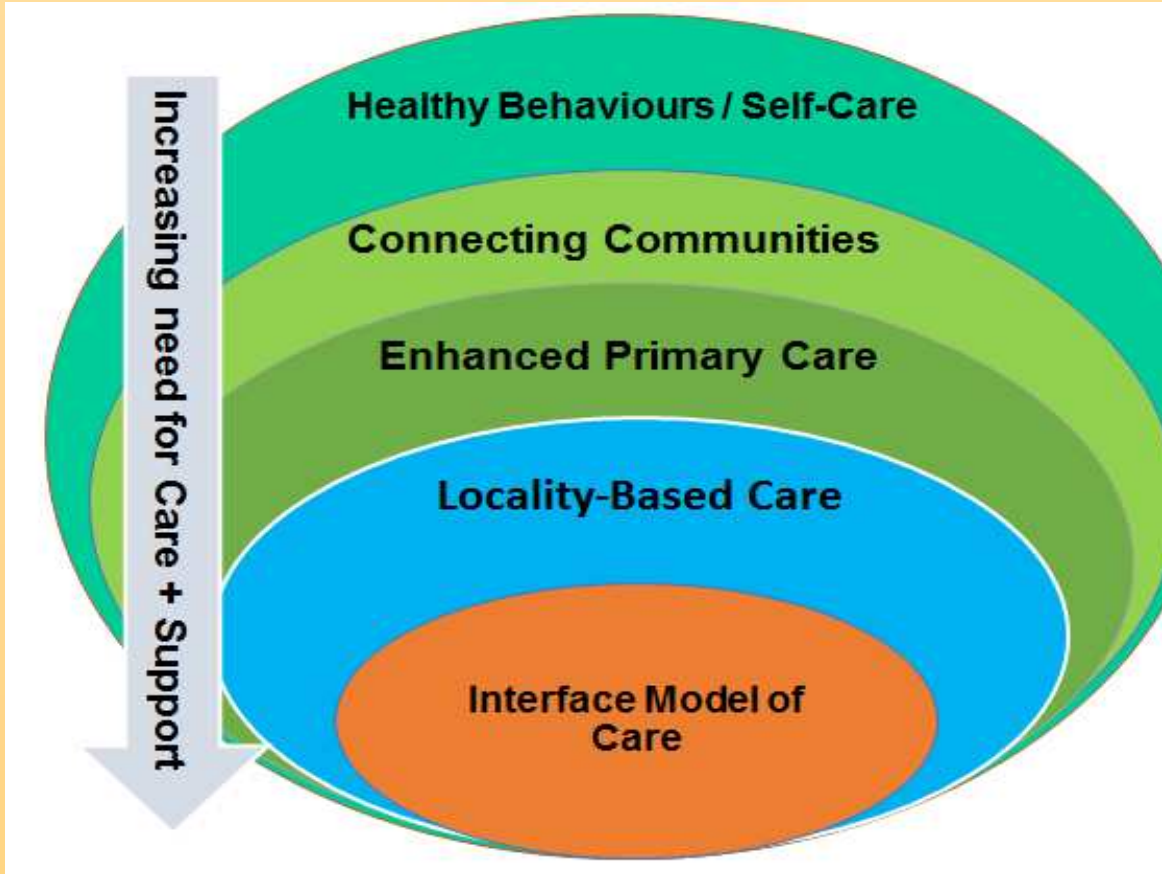
lthy lifestyle choices, behaviours, and self-care abilities; we need to rove wellbeing through

- Connecting communities to people and building assets. Then, only when needed we will provide
- Care and support in and around people's homes that is timely, easily accessible with continuity at its core.

**y?** We will see care delivery at 3 levels:

**anced Primary Care** with GP practices operating at scale, offering an nded range of services and access over 7 days as well as list-based care.

- **Locality-based Care** of population of 30,000-50,000 in 5 localities with Integrated community teams of health, social, and voluntary sector workers wrapped around GP practice groups in co-located settings (e.g. Community Hubs)
  - A joined up **Interface model of care** that links community and hospital professionals to prevent crisis and manage people with complex needs (e.g. specialist advice, pathways, access - including community beds and front door hospital care).




A ***workforce*** with the capability and capacity to deliver the model

An ***estate*** (buildings) equipped to deliver multi-functional health and care services

A ***shared IT*** and care record across the health and care system

A health and care ***payment system*** th improves system accountability & rewards outcome

## WHAT IT MEANS FOR:

### THE LOCAL POPULATION

- Receiving the right care at the right time and in the right place – and from a wider range of service providers in the local community, that are all joined up with the GP and social care system.
- Giving information just once – and knowing that it will be safely shared with the professionals who need to know it.
- Access to primary care services every day of the week and at a convenient time.
- Being cared for at home or as close to it as possible, with fewer trips to hospital, better access to digital care.
- Carers feeling supported and well linked into local communities support arrangements.
- A real focus on improving health and wellbeing.

### COMMUNITY BASED SERVICES (VOLUNTARY & STATUTORY SECTOR)

- Working across social care, general practice, health providers and the voluntary sector to provide a comprehensive package of support for our most vulnerable patients.
- Focussing our efforts in community settings and on promoting good mental health and wellbeing.
- Supporting care delivery and champion 'no health, without mental health' in all care pathway redesign work.
- Developing a flexible workforce that has a range of competencies.
- Working closely with acute health teams, to help keep people stay at home and facilitate transitional care from hospital (following an admission).
- Championing our services and help professionals and clients make the best use of our services.
- Helping people help themselves, their families, their communities and neighbourhoods.



### HOSPITAL SERVICES

- Giving advice and guidance to health and care professionals to support their efforts to manage people in their own homes.
- Providing a comprehensive hospital avoidance and discharge from hospital service to patients and professionals in the community.
- Delivering as many services as possible in community settings.
- Providing timely access to 'front-door' pathways (e.g. ambulatory care) reducing inappropriate admissions to hospital.

### GENERAL PRACTICE

- Having more time for patient care and less time spent on bureaucracy and paper work.
- A 'one team' ethos with cross working and skill development with a wider groups of colleagues, including digital capabilities.
- Providing high value-based care with seven day access to our services (where appropriate) by working with other practices where that's the right thing to do.
- Having greater accountability and responsibility of whole person and system outcomes.
- Coming together across the General Practice community to tackle the challenges collectively that we all face (e.g. workforce, estates, IT, etc.).

### COMMISSIONERS (NHS + LA)

- Setting outcomes based on the current and future needs of our population.
- Describing (with colleagues and our local population) what the health and care system needs to achieve, but not determining how it should be delivered.
- Building a collaborative provider model and trusting providers to deliver the high value-based services.
- Being open and honest about resource allocation (based on need).
- Using flexible and coherent payment and contractual models to allow providers to be innovative and flexible in redesign care delivery.

Gateshead Council

**HEALTH AND WELLBEING BOARD**
**28 April 2017**

# TITLE OF REPORT: Childhood Obesity / NCMP Update Report

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**Purpose of the Report**

1. To provide an update on the current picture of how Gateshead is performing in reducing childhood obesity. This will compare the previous year's data from the National Child Measurement Programme (NCMP) and consider future projections / trends.

**Background**

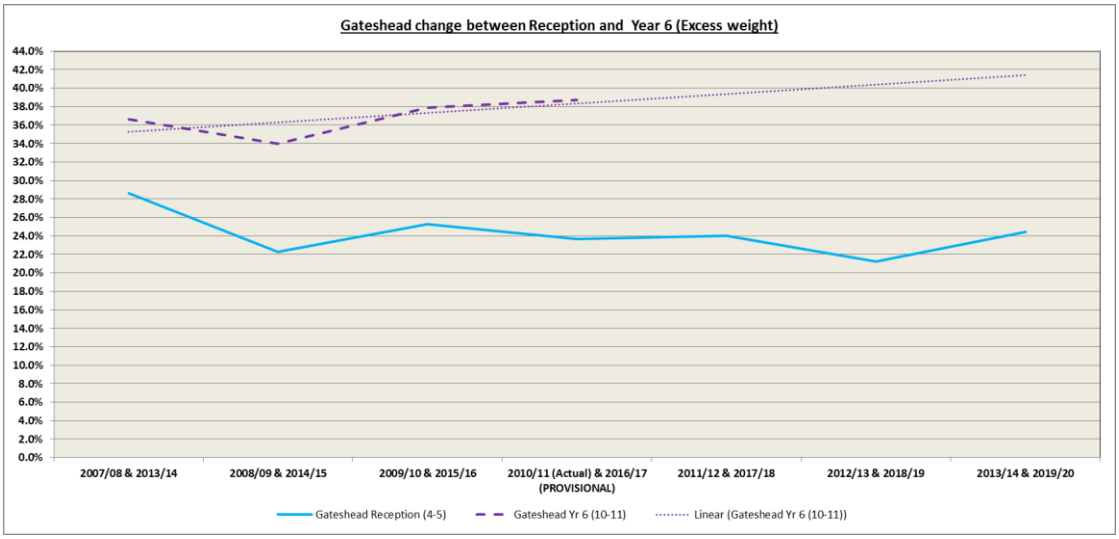
2. The National Child Measurement Programme (NCMP) is a scheme that measures the heights and weights of all pupils in Reception and Year 6 in primary schools.
3. Since the programme launched in 2006, the remit of the programme has changed from being a measurement programme that measures the rates of childhood obesity on a national and local level each year to something more similar to that of a screening programme that now informs parents of their child's results once they have been measured.
4. The responsibility of the implementation of the NCMP lies with Local Authorities following the transfer of Public Health responsibilities in April 2013 from Primary Care Trusts (PCT's).
5. The successful implementation of the NCMP on a local level requires a coordinated approach involving a number of key partners and organisations. This is a very good example of collaborative working as it requires specific input from each named partner to ensure a successful implementation and delivery.

   The key partners include:

   - Public Health
   - Schools
   - School nursing team
   - Child Health Records
   - Parents

**Child Obesity in Gateshead**

**6. Fig. 1.0**

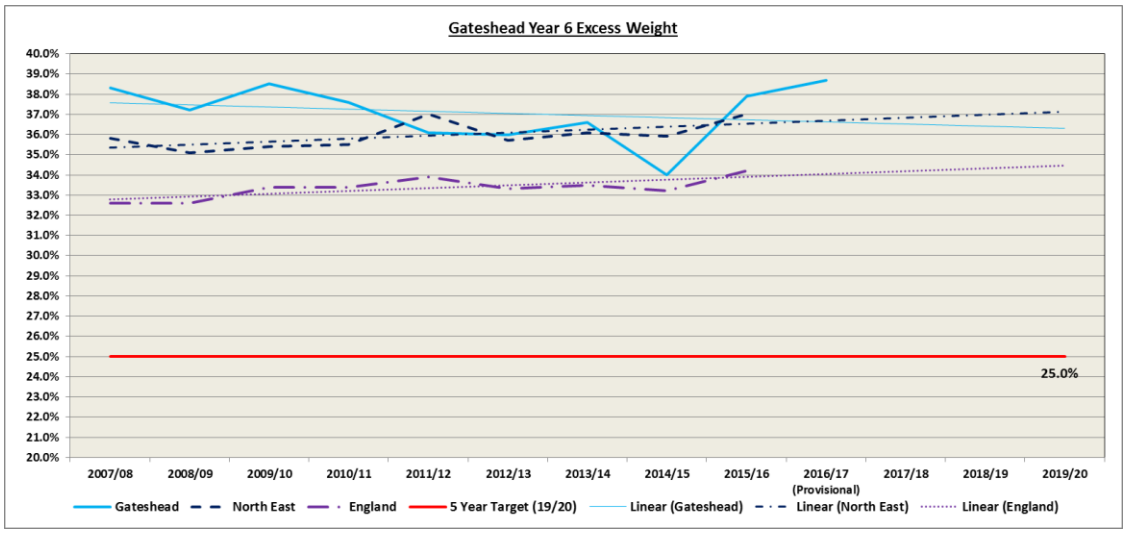



6.1 Since the launch of the NCMP programme in 2006, we have 11 years of data to help identify patterns and trends in our local obesity rates. In 2013/14 the Year 6 cohort that was measured was the same cohort which we measured in Reception during 2007/08. This has enabled us to track changes in obesity rates with the same cohort of pupils.

6.2 Figure1.0 above shows the change in rates of excess weight, between reception and year six, for this cohort. Trends, between matched cohorts for the first 3 years of the NCMP programme, followed the same pattern. Analysis showed when there was a drop in excess weight for the reception year this was mirrored with a drop in Year 6.

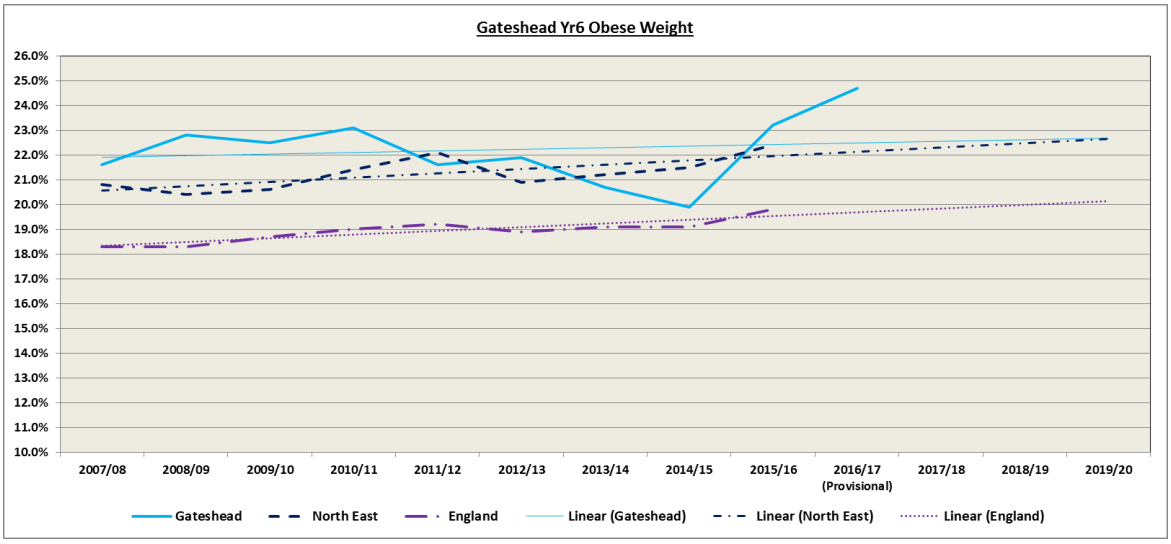
6.3 When the current Year 6 cohort (2016/17) was measured in reception there was a drop in excess weight. Based on previous trends we would have expected to see this drop reflected in the measures for 2016/17. However, what has actually been observed is an *increase* in the rate of excess weight from under 24% to over 38%.

**7. Fig. 2.0**



7.1 Excess weight patterns for Year 6 showed a downward trend until 2015/16 (Fig. 2.0 above). Over the last 2 years there has been an increasingly upward trend in rates of excess weight to its highest point since the beginning of the NCMP. As a result of this, a significant acceleration of action is required, by all partners, if we are to reach the target of reducing rates of excess weight in Year 6 to 25% by 2020.

## 8. Fig. 3.0




8.1 Considering obesity rates for Year 6 as opposed to excess weight the same upward trend, over the last 2 years, is observed. The current *provisional* data for 2016/17 shows the highest rate of Year 6 obesity in Gateshead since the launch of the NCMP.

## Future Plans

9. Since April 2013 local authorities have been responsible for commissioning public health services for school-aged children aged 5 to 19 (school nursing). In October 2015 the commissioning responsibility for the 0 to 5 public health nursing workforce (health visiting and family nurse partnership) also transferred to local authorities. This transfer of responsibilities has given local authorities the opportunity to ensure that commissioning for children age 0 to 5 and 5 to 19 is joined up so that the needs of everyone age 0 to 19 are comprehensively addressed.

10. Good health, wellbeing and resilience are vital for all our children now and for the future of society. There is firm evidence about what is important to achieve this through strong children and young people's public health. This is brought together in the national Healthy Child Programme 0 to 19. This programme provides a framework to support collaborative work and more integrated delivery. One of the key aims of the programme is to reduce childhood obesity by promoting healthy eating and physical activity

11. As part of the transfer of commissioning responsibility for the 0 to 5 public health nursing workforce it was agreed that a review of all public health 0 to 19 services should be carried out with a view to remodelling and re-procuring services during

2017/18. The remodeling of the 0 to 19 service will give us the opportunity to further consider, develop and enhance the role of the service in relation to how it can best support children, young people and their parents in tackling obesity in Gateshead.

12. Since September 2016, the Gateshead Healthy Schools Programme has operated a traded service for schools to buy into. Approximately half of Gateshead schools bought into the programme and, to date, 38 schools have signed up to the programme for 2017/18. Work is ongoing to continue the promotion of the Healthy Schools Programme to encourage all schools to become engaged. It is hoped the launch of the National Healthy Schools Rating Scheme in September 2017 will also encourage more schools to engage with the Programme.

13. The Public Health team has been restructured to enable an increased focus on opportunities to address obesity across the lifecourse. Work is planned to establish a strategy taking account of current action, emerging evidence (e.g. Millennium Baby Study) and local need.

14. The Public Health team is collaborating, with Edberts House, in a community development childhood obesity project, 'Fit 4 The Future', with families in the Old Fold and Nest Estates. The FUSE researcher, embedded in the Public Health Team, is undertaking participatory research to evaluate the impact of this approach. The Public Health Team in Gateshead is adopting a whole systems approach to tackling obesity, engaging local communities, VCS organisations, schools, teachers, parents, children and young people in activities defined by them, including diet and physical activities, sport, arts and cultural activities, and outdoor exercise. The project is progressing and a number of ideas are being generated by the community. An interim and final evaluation will be developed as part of the work.

**Recommendations**

15. The Health and Wellbeing Board is asked to:
    - Note and comment on the current position in relation to performance in reducing childhood obesity.
    - Agree to receive a report on the 0 to 19 service remodelling at the June meeting outlining a potential future model for delivery of 0 to 19 public health services.
    - Approve the development of a whole systems obesity strategy for Gateshead, in line with the work being developed nationally by Public Health England (PHE) and the Local Government Association (LGA) with Leeds Beckett University. The strategy will be developed across a life course approach and will involve key partners, with a number of sub group areas to emerge from this work.

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Gateshead Council

**HEALTH AND WELLBEING BOARD**
**28 APRIL 2017**

**TITLE OF REPORT: Substance Misuse Strategy and Plan for Gateshead**

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**Purpose of the Report**

1. The purpose of this report is to seek endorsement of the Substance Misuse Strategy 2017-2022 and Action Plan for Gateshead.

**Background**

**Substance Misuse Strategy 2017-2022**

2.1 The Substance Misuse Strategy has been finalised following a thorough consultation process and extensive partnership engagement. The strategy has joined the two issues of drug misuse and alcohol misuse due to the many similarities in the actions required to address this agenda. The joint approach is highlighted by the shared aims and objectives below.

- **REDUCE DEMAND / PREVENTION ACROSS THE LIFE COURSE**

Aim: To ensure that a coordinated 'whole family' approach is taken for initiatives working with children, young people, working age, older people, individuals, families and communities, protecting those most affected by substance misuse.

- **REDUCE SUPPLY PROTECTION AND RESPONSIBILITY**

Aim: To ensure all sections of the trade promote responsible retailing to support a reduction in substance misuse-related harm. To mitigate the role of substance misuse in fuelling crime, anti-social behaviour, violence and domestic abuse.

- **BUILD RECOVERY / HEALTH AND WELLBEING SERVICES**

Aim: To ensure an evidence based 'health and wellbeing' focused prevention, treatment and recovery approach is employed to address the needs of service users and their families experiencing alcohol related issues.

2.2 Although an integrated strategy has been developed, it is acknowledged that some distinctively different approaches are also required to address drug and alcohol harm. Alcohol requires a population approach to address availability, acceptability and safer use. Substance misuse relates to a more specific client group and has a greater crime and disorder focus. This strategy has two chapters; Alcohol and Drugs, to outline the specific work relating to each area.

2.3 The need for high level, strategic action was also identified which has been incorporated within the final strategy document. A multi-agency Implementation Plan is currently being developed which will sit underneath the Substance Misuse Strategy and provide a detailed breakdown of how partners will take forward key actions to deliver the objectives of the strategy.

2.4 A full copy of the final Substance Misuse Strategy for Gateshead is attached to this report. Key changes/additions made since the first draft strategy was considered by the Board in July 2016 include:

- The new Chief Medical Officers low-risk drinking guidelines and the need to raise public awareness of these revised levels;
- Increased recognition of the Carers' role and needs in supporting those who misuse substances;
- Further detail of the contribution of the Making Every Contact Count programme;
- A commitment to explore the possibility of pooled budgets and joint commissioning of services;
- The actions arising from the joint Health and Wellbeing and Community Safety Board meeting.

2.5 The Substance Misuse Strategy Group will prepare quarterly reports to track progress against the outcomes and indicators set out in this strategy, with remedial action being taken by partners in areas where there is under-performance or blockages.

**Recommendations**

2. The Health and Wellbeing Board is asked to:

- Endorse the Substance Misuse Strategy and Action Plan for Gateshead for the period 2017- 2022;
- Receive, challenge and scrutinise update reports as required;
- Take appropriate action to enable the Strategy Group to deliver the outcomes of the strategy, when issues arise.

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**Contact:** Joy Evans (0191) 4332421

# Preventing Harm Improving Outcomes

## Gateshead's Substance Misuse Strategy 2017-22

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# Foreword

Gateshead's Substance Misuse Strategy, Preventing Harm, Improving Outcomes, comes at an economically challenging time for all stakeholders. This strategy places its focus on the added value we can bring by working together to deliver on key priority areas.

National policy implementation and overarching strategic objectives are needed to address several determinants of substance misuse related harm, such as supply, availability, pricing, education, and employment. However, there is much that can be done locally to improve the health, safety and wellbeing of our population.

This strategy aims to galvanise partners to collectively reduce the harms of substance misuse. To do this we need a range of measures, which together provide a template for an integrated and comprehensive approach to tackling the harm associated with both drugs and alcohol, addressing short term and long term outcomes.

This strategy will build on and extend current work and outline ambitious strategic aims. The most important aspect of this strategy is to have dynamic and responsive action that reflect our local need and assets. Such an approach, which is built upon existing partnerships and local engagement, will enable local plans to evolve as new data, research and intelligence emerge.

We would like to acknowledge all those whose efforts have been successful in introducing effective programmes of work and policy implementation. We intend that this strategy will go above and beyond the excellent work that we have already progressed across Gateshead. Our focus is to reinforce the strong partnerships and collaborative working that we have here in Gateshead empowering our local population to make decisions and to take control of their own lives, therefore impacting on long term prevention.

## Vision

Our vision is to reduce the harms caused by substance misuse and make Gateshead a safer and healthier place, where less alcohol and fewer substances are consumed, and where:

- professionals are confident and well-equipped to challenge behaviour and support change
- recovery is visible bringing about enduring change to local communities
- substances are no longer a driver of crime and disorder
- reduction in the health inequalities between socio-economic groups are reduced
- we all work in partnership to identify gaps and work to resolve these
- an integrated and comprehensive approach to tackling harm is employed
- possibilities of pooled budgets and joint commissioning a re-explored

**Councillor John McElroy**
Chair of Community Safety Board

**Councillor Lynne Caffrey**
Chair of Health and Wellbeing Board

## Governance

Alcohol and drug misuse remain a cross-cutting theme that requires an on-going, joined-up partnership response. The delivery of the Substance Misuse Strategy is the responsibility of the Substance Misuse Strategy Group and will be supported, from an operational perspective, by the Substance Misuse Sub Group.

The Strategy Group is accountable to the Community Safety Board, but will also work closely with the other statutory partnerships within Gateshead.

A multi-agency Implementation Plan will sit underneath the Substance Misuse Strategy and provide a detailed breakdown of the actions that partners will undertake to deliver the strategy.

The Strategy Group will be required to present quarterly reports to the Community Safety Board in order to track progress against the outcomes and indicators set out in this strategy, with remedial action being taken by partners in areas where there is under-performance or blockages.

# ALCOHOL

## Introduction

The consumption of alcohol is an established part of life in the UK today. Perhaps contrary to common belief, nationally alcohol sales per head have actually declined since 2004. However, it still leaves them at roughly twice the level of the 1950s; the UK now having one of the highest levels of alcohol consumption in Europe.

It has been suggested that even if everybody stopped drinking above recommended levels tomorrow, demands on hospitals would remain relatively high for a further decade.

The harms caused by drinking are as complex as our relationship with alcohol. Alcohol may cause or exacerbate problems, its harms may be acute or chronic and issues may arise from individuals' binge drinking or addiction.

While many chronic health harms caused by drinking alcohol increase with the level of consumption and often over a period of many years, other harms – such as accidents, crime and the loss of productivity - are associated with other patterns of consumption including binge drinking.

The evidence base is growing:

- **For individuals**, regular drinking increases the risks of a future burdened by illnesses including cancer, liver cirrhosis and heart disease, and a taste for alcohol can turn all too easily into dependence.
- **For families**, alcohol misuse and dependence can lead to relationship breakdown, domestic violence and impoverishment.
- **For communities**, alcohol misuse can fuel crime and disorder and transform town centres into no-go areas.
- **For society** as a whole, the costs of alcohol consumption include both the direct costs to public services and the substantial impact of alcohol-related absenteeism on productivity and earnings. Indeed, it can be a barrier to achieving the outcomes we wish for our local community.

**Figure1: Passive Drinking - the harm arising from alcohol**

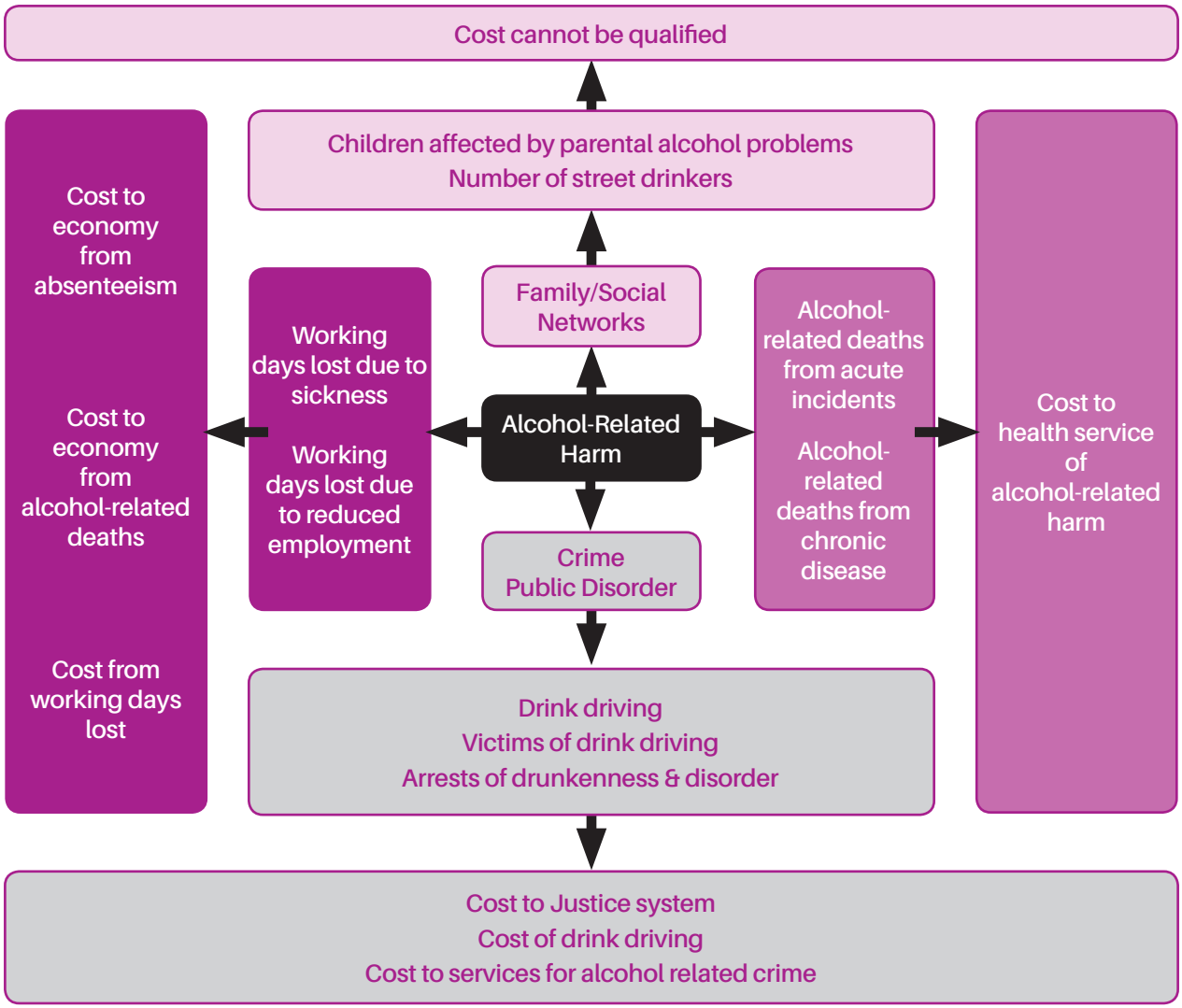
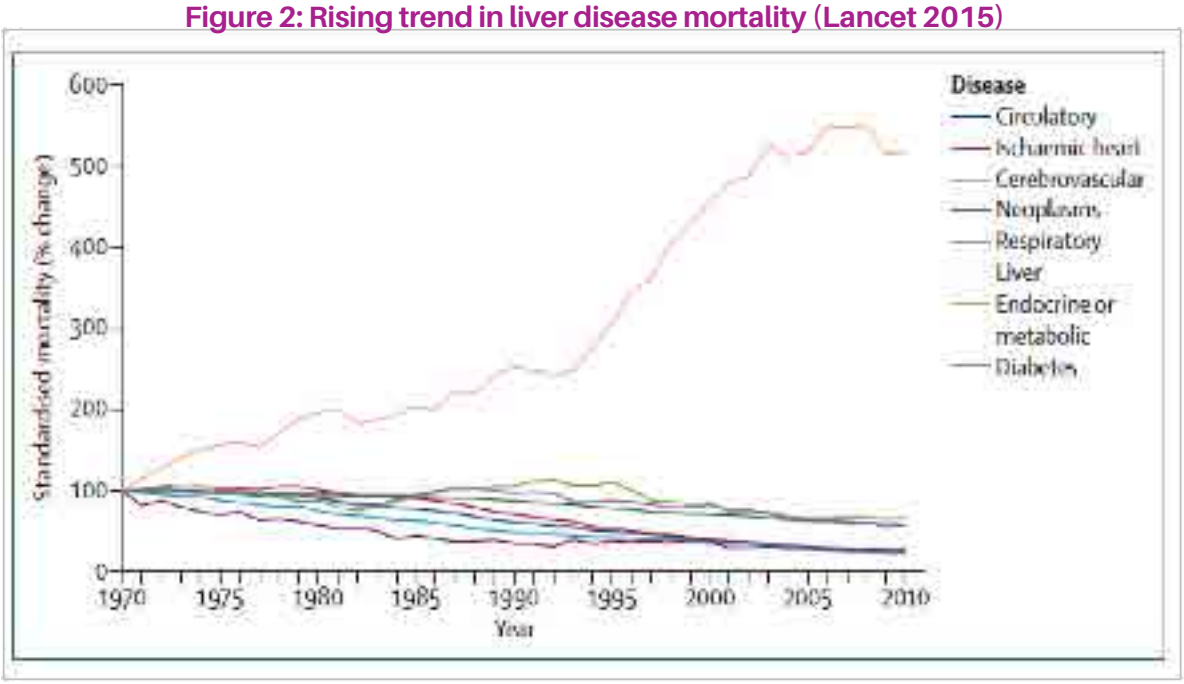



**Figure 2: Rising trend in liver disease mortality (Lancet 2015)**




Lancet Commission - Liver Disease The Lancet Vol. 384, No. 9958, p1953–1997

# National context

## Policy and evidence

The recent Chief Medical Officers' guidelines (2016) for both men and women are as follows:

- **14 units per week**, to keep health risks from drinking alcohol to a low level it is safest for men and women not to drink more than 14 units a week on a regular basis.
- **Alcohol free days**, it is best to spread this evenly over three days or more and have several alcohol-free days each week. One or two heavy drinking sessions increases the risks of death from long term illnesses and from accidents and injuries.
- **No alcohol during pregnancy**

**The National Institute for Health and Care Excellence (NICE)** has produced five key evidence guidelines that relate to alcohol:

- Alcohol Use Disorders: Preventing harmful drinking (PH Guidance 24, 2010)
- Alcohol Dependence and harmful alcohol use (G 115, 2011)
- Alcohol use disorders: diagnosis and clinical management of alcohol-related physical complications (CG 100, 2010)
- School-based interventions on alcohol (PH Guidance 7, 2007)
- Behaviour change: individual approaches (PH Guidance 49, 2014)

NICE describe two approaches to reducing alcohol related harm:

1. **Population-level approaches** are important because they the can help reduce the aggregate level of alcohol consumed. They can help those who are not in regular contact with the relevant services; and those who have been specifically advised to reduce their alcohol intake, by creating an environment that supports lower-risk drinking.
2. **Individual-level interventions** can help make people aware of the potential risks they are taking (or harm they are doing) at an early stage.

NICE evidence based activity focuses on:

- Prevention and education - availability, licensing and education
- Early identification and harm minimisation - whole system approach, community, primary and secondary care especially targeting vulnerable groups
- Treatment and rehabilitation - provision, promotion and referral pathways

The evidence shows that individuals drinking at increasing and higher risk level (but not dependent) benefit from brief intervention, while those drinking at dependent levels are best supported by specialist alcohol services.

The strategy resulting action plans will also incorporate recommendations from the following newly published papers:

- The public health burden of alcohol and the effectiveness and cost-effectiveness of alcohol control policies (PHE 2017)
- An independent review into the impact on employment outcomes of drug or alcohol addiction, and obesity (Dame Carol Black 2016)

# Local context

## Current position

Current methods for estimating levels of alcohol consumption rely on self-reported surveys. Recent research suggests these underestimate the amount we drink, and therefore underestimates the size of the population at risk of alcohol-related harms, which often cannot be further segmented by different population groups, such as ethnicity.

We know that nationally:

- 83% of those who regularly drink above the guidelines do not think their drinking is putting their long term health at risk.
- Only 18% of people who drink above the lower-risk guidelines say they actually wish to change their behaviour.
- External and environmental factors can hugely influence both positively and negatively, the amounts that individuals or groups of the population drink and the ways they drink.

Health related harms in Gateshead are worse than the England and regional average, though there are some positive trends developing including a decline in young people's drinking and resulting hospital admissions.

## Under 18s

For young people the rate of admissions has decreased by 54% to 58.8 per 100,000 since 2006/07. However, the rate of admissions is still significantly higher than the England value 36.6 per 100,000.

Alcohol consumption by under 18's continues to fall, however, evidence suggests that though fewer young people are drinking, those who do drink, drink at excessive and harmful levels.

## Alcohol related hospital admissions (persons)

Gateshead currently has the 3rd highest rate of alcohol related admissions (2015/16 persons, narrow definition) to hospital in England

Gateshead has the highest rate for alcohol related hospital admissions for males in the North East (2015/16)The rate of admissions to hospital for alcohol related conditions has increased by 23.63% Since 2008/09For women the rate of admissions to hospital for alcohol related conditions has increased by 34.33% Since 2008/09.

For older people (65 and over), the number of alcohol related hospital admissions has more than doubled in the recent years - 197,000 to 461,000 between 2002-2010. (NHS Information Centre, 2011).

## Emerging trends

A number of clear national trends have emerged in recent years, which require a response from local agencies and are addressed in this strategy:

- An increase in the number of women and mid- and older age people drinking to excess
- A rise in consumption of alcohol within the home
- An increase in the mortality rate from liver disease

# Cross cutting priority groups

## Health inequalities

***"There is a social gradient in the harms from alcohol consumption but not in alcohol consumption itself."***

Evidence suggests that while drinking is most common among many of our more affluent communities, those who drink at the greatest levels (and suffer the greatest health harms) live in some of the borough's most deprived neighbourhoods.

## Alcohol and its impact on Children and Young People

***"The drinking behaviours of our children are some of the worst in Europe, the health consequences are alarming and this is a situation that must change."***

National guidance recommends that no alcohol at all should be consumed before the age of 15. Drinking at age 15-17 should be confined to no more than one day a week and strictly supervised, as binge drinking at this age may lead to violent behaviour, risky sexual activity, low educational attainment and a drift into crime and drugs.

40% of 13 year olds and 58% of 15 year olds who have drunk alcohol have had a negative experience including taking drugs/having unprotected sex.

It is imperative that we continue to support children and young people to reduce their levels of alcohol consumption, delay the age at which they may choose to start drinking alcohol and support venues to be alcohol free for those young people who choose not to consume alcohol and, provide a family approach to understanding the risks from alcohol consumption.

The issue of parental responsibility also needs to be addressed, with evidence suggesting that most young people do not buy alcohol illegally; they get it from their parents and/or older siblings, often within the home and sometimes without their parents realising.

Further, there is a considerable body of evidence which indicates that parental alcohol issues can lead to risky attitudes among young people and, in turn, risky behaviours can lead to problematic consumption in later adult life.

Children and young people's perceptions of their parents' attitudes to their drinking is strongly related to whether or not they have drunk alcohol; if their parents would disapprove, they were less likely to consume alcohol.

## Alcohol and families

Alcohol is a teratogen (an agent which causes malformation of an embryo) that freely crosses the placenta. Drinking during pregnancy can cause premature birth, low birth weight, damage to the central nervous system, physical abnormalities and the difficult to diagnose condition Foetal Alcohol Spectrum Disorder (FASD). In turn, this condition may not be identified in future diagnosis including Attention Deficit Hyperactivity Disorder (ADHD) and dyspraxia.

Nationally, it is estimated that only 7% of babies with FASD are diagnosed at birth, the average age of diagnosis being 3.3 years. Earlier diagnosis would help prevent this condition in future siblings. Diagnosis is improving and Gateshead has been a regional leader in this area, but there is much to be done to address the knowledge and skills regarding this disorder and the health and social care system and the stigma associated with this neuro developmental disorder.

Children of parents who drink excessive amounts, i.e. above the recommended limit, may suffer a lack of supportive and consistent parenting, and even be thrust into the role of carer themselves, often without anyone knowing, the so-called 'silent carers', for parents and younger siblings.

Growing up amid the conflict and disharmony associated with alcohol misuse can result in children and young people having increased:

- Anti-social behaviour such as aggression, hyperactivity
- Emotional problems such as bed-wetting, depression
- Problems at school such as learning difficulties, truancy

## Alcohol and older people

***"Between 2001 and 2031, there is projected to be a 50% increase in the number of older people in the UK. The percentage of men and women drinking more than the weekly recommended limits has also risen, by 60% in men and 100% in women between 1990 and 2006"*** (NHS Information Centre, 2009a).

Given the likely impact of these two factors on health and social care services, there is now a pressing need to address substance misuse in older people and to understand the picture locally.

As we get older, the negative impact of alcohol on our physical and mental health increases. Ageing slows down the body's ability to break down alcohol and so alcohol remains in the system for longer. This in turn results in the older person reacting more slowly and they tend to lose balance more easily and lead to an increased risk of falls and other accidents, leading to long term injury and can be a cause for residential care.

It may also cause serious complications with any medication(s) the individuals may be taking. Data on numbers of falls and their association with alcohol is limited and further research is needed regarding this.

About a third of older people with alcohol problems develop them for the first time in later life. Bereavement, physical ill-health, becoming a carer, loneliness, difficulty in getting around, unhappiness and depression can all lead to increased alcohol consumption. Social isolation can result from a loss of contact with family members, loss of partners, loss of mobility, less contact with friends and less involvement with, and action in, the community.

The Community Mental Health Survey (2011) found that older adults are one group that is least likely to be asked about their alcohol use, especially older women. Increased alcohol intake is often hidden in the older population and not always identified because:

- Older people do not talk about it, possibly because of the perception of shame, stigma or embarrassment
- Alcohol problem can be mistaken for physical or mental health problem
- Assumed not to be a problem for this population group
- Older people have a poor awareness of lower risk drinking limits

## Alcohol across the life course

The life-course approach must be adopted to stop the negative impact of alcohol on children and link with other strategies and developments in addition to alcohol alone.

Due to the complexity of this issue it is important that interventions take a multi-agency and whole-family approach. The relationships between universal and specialist services, adult/child and family services, and drug/alcohol treatment services is crucial as well as the relationship with other activity areas, including health and wellbeing, crime and disorder, and planning and licensing.

## Early intervention and prevention

There are real opportunities, often under-exploited, for health services to identify those at risk and provide advice and support to those who need it, whether via regular contact with NHS staff, or in particular settings such as A&E and Gastroenterology departments, through well evidenced brief interventions. Identification and Brief Advice (IBA) is a simple, evidence based intervention aimed at individuals who are at risk through drinking above the guidelines, but not typically seeking help for an alcohol problem.

## Have a word and making every contact count

Making every contact count, is a train the trainer approach which enables health improving conversations to be delivered at scale, as part of existing job roles across many organisations, facilitating the reach of very brief alcohol interventions. Have a Word is one tool that can be used to support workforce development enabling intervention in a teachable moment.

## NHS health checks

Since April 2013, the Department of Health has included alcohol identification and any subsequent brief advice needed within the NHS Health Checks for any adults aged 35-75 years.

## A&E departments

A&E departments can be a particular flashpoint for those who have drunk to excess, causing fear and distress to others awaiting and administering treatment. The NHS does not tolerate any violence or disorder in hospitals to its staff and to those waiting for medical attention, which is often fuelled by alcohol consumption. Locally, there is an agreed referral pathway with the commissioned service's outreach worker who works out of the Acute Trust (A and E and Gastroenterology) three times a week.

## Alcohol-related assault data

Cardiff Model data is an excellent opportunity to understand the local picture more, and to identify hotspots for violence and excessive alcohol consumption, whether it is a personal home address or, a licensed premise. Work is underway to improve the collection and sharing of this data.

## Recovery Orientated Treatment Service

The continued development and promotion of a Recovery Orientated Treatment Service is a positive approach within Gateshead. This puts the person who requests help at the centre, surrounding them with options and choices so that they can design their own support and recovery journey.

People who have experienced alcohol problems and service users themselves have made it clear that recovery is best supported by peers and allies who are trained, competent, and supervised: mutual support and mutual aid groups including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Those in recovery are 'assets' who contribute to community developments.

## Dual diagnosis

Gateshead is currently developing a strategy and action plan in response to the NICE Guidance 58 co existing severe mental illness and substance abuse; community health and social care services, this guidance proposes ways to address the need of co-existing mental health and substance misuse.

## Carers

Gateshead has a strong history of understanding and seeking to support the carers of those with an addiction to substances, by commissioning services reflecting this priority. Carers are defined as *'a person who provides, or intends to provide, care for another adult'*.

Like someone with a drug or alcohol problem, those affected also find themselves on a journey which may require different types of support at each stage. Typically, carers first access services at a time of crisis or after stress and strain has been building for some time. Allowing them time to simply talk, express their feelings and be heard in a supportive, non-judgemental environment is important.

Specific information, programmes or interventions, signposting and referring to additional support services (eg debt advice, counselling and support groups) may be offered alongside but it is important to recognise that individuals experiencing high levels of stress may struggle to engage immediately. Feeling heard, learning they are 'not the only one', receiving basic information and perhaps meeting others in similar circumstances all help to provide a level of support and reduce stress so that family members can benefit from other programmes or types of support.

## Protected characteristics

It is well recognised that there is often a lack of information available concerning specific groups, e.g. older people, the Jewish Community, those suffering from mental ill health; unfortunately this is sometimes most pronounced in the protected groups, although not exclusive.

Through the development and refinement of the local action plans, we aim to gain intelligence around such barriers and challenges, identifying gaps and opportunities. We must build upon local intelligence and contribute to the refresh of the Joint Strategic Needs Assessment when relevant.

## Crime and Disorder

Alcohol misuse places a profound burden on the social fabric of the UK. In addition to the extensive healthcare costs, lost productivity and premature deaths, there are a range of crime and disorder problems associated with excessive consumption of alcohol. This includes alcohol-specific crime, such as being drunk and disorderly in public, criminal damage and, drink-driving.

Many other offences can take place under the influence of alcohol, such as alcohol related violence, anti-social behaviour, domestic violence, property damage and arson. It is well evidenced that alcohol consumption is a risk factor for many types of violence, including child abuse, youth violence, intimate partner violence and elder abuse.

Individuals who start drinking at an earlier age, who drink frequently and who drink in greater quantities, are at increased risk of involvement in violence as both victims and perpetrators (World Health Organization, 2012).

In its report "Alcohol misuse: tackling the UK epidemic" the British Medical Association outlined the extent and impact of alcohol-related crimes and behaviours in the UK:

- Among victims of violent crimes in England and Wales 44% perceived the offender as under the influence of alcohol at the time of the crime.
- Alcohol consumption is strongly associated with anti-social behaviour such as nuisance and rowdy behaviour, noise disturbance, littering, and harassment.
- Nearly half of domestic violence offenders were under the influence of alcohol at the time of their offence, and alcohol-fuelled domestic violence is more likely to result in victim injury and the need for medical care.

Domestic abuse is a priority for the borough; the number of reported incidents of domestic violence has increased to 4,476. A total of 1,558 crimes were generated from these incidents. 677 crimes involved alcohol (43% of domestic abuse crimes).

Nationally, domestic abuse was linked to almost 70% of all child protection cases and victims of domestic abuse are 15 times more likely to abuse alcohol.

## Licensing

Nationally, in April 2012, Health was added to the list of 'responsible authorities' invited to comment upon licensing applications. Public Health departments have retained this responsibility since transferring to local government control in April 2013. Listed below are recommendations for licensing, devised by Public Health England:

- Ensure sufficient resources are available to prevent under-age sales, sales to people who are intoxicated, proxy sales (that is, illegal purchases for someone who is under-age or intoxicated), non-compliance with any other alcohol license condition and illegal imports of alcohol.
- Work in partnership with the appropriate authorities to identify and take action against premises that regularly sell alcohol to persons who are under-age, intoxicated or making illegal purchases for others.
- Undertake test purchases (using 'mystery' shoppers) to ensure compliance with the law on under-age sales. Test purchases should also be used to identify and take action against premises where sales are made to people who are intoxicated or to those illegally purchasing alcohol for others.
- Ensure sanctions are fully applied to businesses that break the law on under-age sales, sales to those who are intoxicated and proxy purchases. This includes fixed penalty and closure notices (the latter should be applied to establishments that persistently sell alcohol to children and young people).

Locally, we have recently revised Gateshead's Statement of Licensing Policy to increase the emphasis on the licensee to promote the licensing objectives and public health.

Gateshead has recently participated in the Public Health England, Health as a licensing objective pilot, building an analytical data tool and exploring the impact a public health objective might have in licensing representations and decisions.

# Our response

## Reduce demand/prevention across the life course

Aim: To ensure that a coordinated 'whole family' approach is taken for initiatives working with children, young people, working age, older people, individuals, families and communities, protecting those most affected by alcohol.

## Restrict supply / protection and responsibility

Aim: To ensure all sections of the trade promote responsible retailing that supports a reduction in substance misuse related harm, to mitigate the role of alcohol in fuelling crime, anti-social behaviour, violence and domestic abuse.

## Build recovery/health and wellbeing services

Aim: To ensure an evidence based 'health and wellbeing' focussed prevention, treatment and recovery approach is employed to address the needs of service users and their families experiencing substance misuse related issues.

# THEME 1

## Reducing Demand: Prevention across the life-course

**To ensure that a coordinated 'whole family' and population approach is taken for initiatives that work with children, young people, working age and older people, families and communities, to lower the population's risk of alcohol-related harm.**

## What is known to be effective?

NICE Guidance (2013) and PHE Evidence Review (2017) state that population-level approaches are important because they can help reduce the aggregate level of alcohol consumed and therefore lower the whole population's risk of alcohol-related harm. They can help:

- Those who are not in regular contact with the relevant services.
- Those who have been specifically advised to reduce their alcohol intake, by creating an environment that supports lower-risk drinking.

A life course approach, from pre and early pregnancy through to older age, should be taken to address health and social consequences of alcohol use/misuse.

IBA has been proven to reduce drinking, leading to improved health and reduced calls on hospital services. At least one in eight 'at risk drinkers' reduce their drinking as a result of IBA.

The National Institute for Health and Clinical Excellence (NICE) recommends that NHS health professionals routinely carry out alcohol screening as an integral part of their practice, focusing on groups at increased risk.

Action needs to be taken to address this increasingly significant issue, such as developing the skills of frontline workers to be aware of the needs of the ageing population and to 'Make Every Contact Count' with this and every group. It must also be ensured that services are accessible for older people especially those with disabilities.

At the service delivery level, access to prevention and treatment should be enhanced by removing barriers, training of healthcare staff, use of valid screening instruments and developing closer working models – including innovative paradigms – between services at all levels.

## In Gateshead we will:

**Employ a population approach to address the needs and issues of all population groups by:**

- Challenging drinking culture by increasing awareness of the harms of alcohol
- Communication/engagement activities, eg Dry January, FASD Day, Balance campaigns
- Further develop the Council's work supporting the Alcohol Declaration
- Ensure partner agencies are aware of their safeguarding responsibilities relating to alcohol
- Improve quality and increase access to low level interventions (further development of IBA, increased training and clear referral pathways to support)
- Routine enquiry (including NHS Health Checks)

**Use a targeted approach to address the needs and issues of specific groups/ communities by:**

- Supporting local people to understand the true long term health impact of alcohol

- Explore needs of various groups (Jewish Community, dual diagnosis, isolated older people)
- Empowering local people to understand the impact of alcohol misuse on their mental health and wellbeing, in particular those living in more disadvantaged areas
- Workforce development - raising awareness of the harms and the opportunities for alcohol brief interventions e.g. 'Have a Word'
- Address issues of intergenerational drinking and proxy purchasing by parents and siblings
- Introducing interventions to reduce the cycle of harm

# THEME 2

## Reducing Supply: Protection and Responsibility

**To ensure all sections of the alcohol trade promote responsible retailing that supports a reduction in alcohol-related harm and to mitigate the role of alcohol in fuelling Crime, Anti-Social Behaviour, Violence and Domestic Abuse.**

One of the biggest challenges that we face is the availability of the 'off trade' sales, i.e. the low cost sales within local supermarkets/local shops, which can be open 24 hours a day, as opposed to more controlled purchases through 'on-trade' sales, i.e. pubs/clubs.

Because alcohol is so cheaply available off-trade, and the strength of alcoholic drink products has increased over time, people are frequently drinking more units of alcohol at home, often without realising it.

The numbers of people drinking at home are increasing, which includes those who are pre-loading (where a person drinks large amounts of alcohol before going out for the evening).

Alcohol misuse is a risk factor for many types of violence including child abuse, violence in public settings, youth violence, sexual violence, intimate partner violence and elder abuse.

In England and Wales, alcohol is thought to play a part in approximately 1.2 million violent incidents per year - almost half of all violent crimes, with devastating health consequences for victims, their family, friends and the wider community.

While health, police and other public services deal with the consequences of alcohol-related violence, the same workers are also victims; for example, 116,000 NHS staff are assaulted each year, primarily by patients and relatives.

## What is known to be effective?

Controls on price and availability have been identified by the World Health Organization (World Health Organization Europe, 2011) as the most effective measures that governments can implement to reduce the harm caused by alcohol. Minimum Unit Price for Alcohol (MUP) is considered the most effective approach to reduce the levels of consumption of very low cost alcohol.

Other initiatives have been found to have a positive impact on reducing the harm caused by low cost, high alcohol content drinks, i.e. reducing the strength.

There is evidence that initiatives which: prevent under-age sales and Challenge 25; sales to people who are intoxicated; proxy sales (i.e. illegal purchases for some-one who is under-age or intoxicated); non-compliance with any other alcohol license condition and preventing illegal imports of alcohol, are effective (NICE PH 24, 2010).

## In Gateshead we will:

**Ensure that there is commitment to address the problems associated with very cheap and high alcohol content drink; encouraging availability to be restricted in areas of most need by:**

- Supporting and lobbying (locally, regionally and nationally) for a minimum unit price for alcohol (MUP).

- Exploring the opportunities to reduce the availability of super-strength alcohol that is on sale in Gateshead, focusing on the off-trade licensees, and learning from other areas.
- Reinforcing 'Challenge 25' as a whole system wide approach and, proxy sales messages.

**Ensure that we continue to develop and implement robust systems and have procedures in place to support a positive and responsible alcohol trade by:**

- Supporting the use of 'Challenge 25' policies.
- Working with Trading Standards to address the sale of illicit and below duty alcohol.
- Ensure robust proactive licensing procedures, utilising HALO data to reduce the impact of alcohol related harm for the public.
- Provide training to the Licensing Committee
- Explore the possibilities of implementing a Gateshead levy in partnership with the Community Safety and Health and Wellbeing Boards.
- Use tools and powers within the Criminal Justice System to take appropriate and robust action on those who cause harm.

# THEME 3

## Building Recovery: Health and Wellbeing Services

**To ensure an evidence based 'health and wellbeing' focussed treatment and recovery approach is employed to address the needs of people and their families experiencing alcohol related misuse.**

The complex and problematic behaviour associated with alcohol misuse impacts negatively on the lives of others, placing significant pressures to bear on their own family life, reducing their ability to function positively within society, and our public service provision. They also affect a range of provisions and increase demands faced by our accident and emergency departments, hospitals and other emergency services, families and wider communities.

Local Authorities, Clinical Commissioning Groups, the wider NHS, the Police and other statutory bodies and the voluntary, faith and community sector must work together to address local needs.

Treatment services which take a recovery orientated approach are already being commissioned in Gateshead and excellent services are provided.

Furthermore, interventions aimed at individuals can help make people aware of the potential risks they are taking (or harm they may be doing) at an early stage. This is important, as they are most likely to change their behaviour if tackled early. In addition, an early intervention could prevent extensive damage.

Involvement in service planning and delivery by people who are able to contribute to the growth of innovative recovery focussed projects that are developed and underpinned by volunteer advocates is crucial. This ensures positive influence and role model opportunities to contribute to the on-going support needs of others, many of whom place high demands on their families, communities, hospitals, the criminal justice system and other universal services.

Recovery orientated community support which goes beyond addressing the medical or mental health complexities associated with alcohol related behaviours also needs to be promoted.

By reinforcing responsibility and resilience among recovery focussed networks we should promote awareness, information and advice within communities to ensure improved outcomes for all.

The extension of alcohol screening involves identifying people who are not seeking treatment for alcohol problems but who may have an alcohol-use disorder; the scope for delivering these brief (and often low level ) interventions is vast, for example, community pharmacists, wellbeing services, community assets.

## What is known to be effective?

Promoting and enabling the delivery of effective specialised treatment and recovery services is important to improve public health and social outcomes.

## In Gateshead we will:

- Ensure that we have high quality services for individuals and families, developed in partnership, with service user representation and volunteer advocates, which enhance the wider developing recovery system of support that is asset based.
- Continue to develop and increase the effectiveness of the drug and alcohol treatment and recovery services including on-going opportunities to enhance outcomes, including working collaboratively with community treatment services.
- Address the needs of complex, hazardous and harmful drinkers to improve outcomes.
- Support and champion the development of knowledgeable Health and Wellbeing services that promote and deliver prevention, sensible drinking and abstinence programmes as their core business, as appropriate.
- Ensure the involvement and support of carers in the treatment and recovery process.
- Work with emergency services to encourage alcohol screening and brief interventions and referrals to reduce the risk within alcohol abusing client's homes.
- Continue to the development of the Dual Diagnosis strategy and Action Plan

# Outcome and Indicators

The overall success of this strategy will be measured through the achievement of a number of high-level performance indicators including:

- Reduction in young people's alcohol consumption/Increase the age young people start to drink (Balance surveys)
- Increased awareness of alcohol-related harm across the whole population (Balance surveys)
- Reduction in alcohol related hospital admissions
- Minimum Unit Prices in place
- Test purchasing scheme continued
- Reduction in under-age sales
- HALO data used to inform licensing
- Reduction in number of alcohol related complaints from residents.
- Reduction in alcohol related crime
- Increased numbers accessing the treatment, successful discharge
- Increase referrals from secondary care to Specialist Recovery and Treatment Service
- Increase in number of interventions 'protected groups'

## Public Health Outcome Framework

- Hospital admissions for alcohol-related conditions (narrow definition), all ages, directly age standardised rate per 100,000 population European standard population.
- Number of alcohol only clients that left substance misuse treatment successfully who do not then re-present to treatment within 6 months as a proportion of the total number of alcohol only clients in treatment.
- Age-standardised rate of mortality from liver disease in persons less than 75 years of age per 100,000 population.
- Age-standardised rate of mortality that is considered preventable from liver disease in persons less than 75 years of age per 100,000 population.

The Multi-Agency Substance Misuse Strategy Group will monitor performance against outcomes and take remedial action where improvement is needed.

# Effects of **ALCOHOL** abuse in the UK

Alcohol causes **60** medical conditions and contributes to over **22,000** deaths a year

**4,182**
Alcoholic liver disease

**7,634**
Cancers

**2,195**
Cardiovascular disease

**3,335**
Injuries

**£67.2m**
Overall cost of alcohol harm

- Social care **£7.5m**
- NHS **£18.4m**
- Crime and licensing **£15.3m**
- Workplace **£26.2m**

Equivalent to **£763** cost to each taxpayer per year

## How **drinking** affects Gateshead

Over **1 in 2** people have been harmed by someone else's drinking in the last 12 months

**55%**
residents drink at increasing and high risk levels

**304**
11-15 year olds become regular drinkers every year

**5,106**
alcohol related hospital admissions - over 20 are children with alcohol specific conditions

**11,735**
estimated number of alcohol related crimes

Figs courtesy of BALANCE

| Challenges | Priority Actions | Key Outcomes |
|---|---|---|
| Cultural acceptance include high level of lifestyle risk<br><br>Low aspirations for good health behaviour<br><br>Historic high drinking levels | **Reduce demand**<br>• Ensure all agencies are aware of their safeguarding role re: children, young people and alcohol<br>• Raise awareness of the harms of alcohol with all population groups<br>• Increase awareness of the needs of most vulnerable groups and alcohol<br>• Increase understanding of the alcohol consumption in these groups<br>• Support national and develop local communications, campaigns, and engagement work<br>• Increase the quality/effectiveness/uptake of brief interventions in all settings<br>• Lobby locally, regionally and nationally for minimum unit price (MUP) and increased health information on labels eg units, calories, no drinking in pregnancy<br>• Increased dissatisfaction amongst residents regarding price and availability of alcohol | Reduction in young people's alcohol consumption<br><br>Increase the age young people start to drink<br><br>Increased awareness of alcohol related harm across population<br><br>Reduction in alcohol related morbidity and mortality |
| Increase opportunities for early interventions in the wider community<br><br>The industry: eg advertising and cheap sales<br><br>Reduce availability of cheap and high alcohol drinks | **Restrict Supply**<br>• Support Balance as a regional and national leader to build appetite and understanding for MUP and increased taxasion on alcohol<br>• Membership of proactive Responsible Authorities Group to influence licensing reviews<br>• Training to Licensing Committee to increase use of alcohol related harm data in licensing hearings<br>• Use local health, crime and social care data to inform licensing policy and decisions<br>• Undertake and extend alcohol test purchasing operations<br>• Reinforce 'Challenge 25'<br>• Target and prosecute sellers of Illicit alcohol and less than duty sales<br>• Explore the possibilities of implementing a Gateshead levy<br>• Use tools/powers within the Criminal Justice System to take appropriate and robust action on those who cause harm<br>• Encourage and challenge the council to model behaviour eg alcohol endorsed events/advertising via alcohol declaration<br>• (Facilitate, support and commission recovery services/support groups including mutual aid) | Minimum Unit Price in place regionally and/or nationally<br><br>Test purchasing scheme continued<br><br>Reduction in under-age sales<br><br>Increase in use of HALO data to inform licensing<br><br>Reduction in number of alcohol related complaints from residents.<br><br>Reduction in alcohol related crime and disorder |
| Alcohol declaration commitment<br><br>Address the needs of the most vulnerable groups e.g. older people<br><br>Historic high drinking levels<br><br>Complexities of addiction | **Build Recovery**<br>• Challenge developing drinking culture within Gateshead<br>• Further more develop the recovery oriented treatment service for all population groups, provide training and monitor the effects on practice.<br>• Increase reach and monitor effectiveness of drug and alcohol treatment and recovery services in secondary care and ensure referral pathways are effective<br>• Alcohol advocates active in communities, raising awareness and delivering brief interventions Identify and increase support and training to those who need it most, including 'protected groups' i.e. offenders, Jewish community and children and young people etc.<br>• Ensure support and involvement of carers in recovery process<br>• Work with emergency services to encourage alcohol screening and brief interventions and referrals to reduce the risk within alcohol abusing clients homes<br>• Promote activities and events to ensure recovery is visible in Gateshead | Increased numbers accessing and successfully completing treatment<br><br>Increase referrals from secondary care to Specialist Treatment & Recovery Service<br><br>Reduction in alcohol related alcohol admissions.<br><br>Increase in number of interventions 'protected groups' |

# DRUGS

## Introduction

Drug misuse is a significant issue for individuals, families and communities alike. The estimated annual cost of drug-related harm in England is estimated to be around £15.4 billion.

While most people do not use drugs, drug misuse can be found across all communities in society. From heroin and crack use among adults, to cannabis use amongst young people, to the use of novel psychoactive substances ('legal highs') used by the most vulnerable, drugs are available and misused by a wide range of people.

The harms caused by drugs are wide-ranging. Drug misuse may cause or exacerbate existing problems, its harms may be acute or chronic, and issues may arise from recreational use as well as dependency or problematic use.

Drug misuse is strongly related to crime, but harms are not just related to crime. Substance misuse can be found amongst homeless populations and those with mental health problems.

Problematic drug use is associated with unemployment, domestic abuse, poor living conditions, ill-health and safeguarding concerns.

Whilst drug dependence can affect anyone, we know that those in our society with a background of childhood abuse, neglect, trauma or poverty are disproportionately likely to be affected. In turn, the children of those dependent on drugs have to cope with the impact on their own lives and some may end up in care.

Some drug concerns are familiar and long-standing - for example inter-generational substance misuse and the negative impact of parental drug use on children. However, there are new concerns as well, especially around young adults and the purchasing of drugs over the internet.

Finally, a number of trends have emerged in recent years, which require a response from local agencies:

- An ageing opiate population with chronic health and social care needs
- A secret/undisclosed addiction
- A slowly growing market of novel psychoactive substances (NPS) sometimes known as 'legal highs'
- An increase in the number of people misusing medicines such as Gabapentin and Pregabalin
- An increase in drug related deaths
- Dual diagnosis – patients who have both substance misuse and mental health problems

# National context

## Policy and evidence

Public Health England took responsibility of drug and alcohol treatment in 2012 and their work builds on the work of the National Treatment Agency, which spent ten years building the evidence base for treatment in the UK.

With data collected via the National Drug Treatment Monitoring System (NDTMS), the UK now has a robust evidence base for treatment and interventions.

Treatment in the UK is underpinned by clinical advice and quality standards provided by **NICE (National Institute for Health and Care Excellence)** in a number of key documents:

- Drug misuse: psychosocial interventions (CG51) 2007
- Drug misuse: opioid detoxification (CG52) 2014
- Interventions to reduce substance misuse among vulnerable young people (PH4) 2007
- Needle and syringe programmes (PH52) 2009
- Drug misuse – naltrexone (TA115) 2007
- Drug misuse – methadone and buprenorphine (TA114) 2007
- Drug use disorders (QS23) 2012
- Coexisting server mental illness and substance misuse : Community health & social care services (NG58)

Drug misuse and dependency can lead to a range of harms for the user including:

- Poor physical and mental health
- Unemployment
- Homelessness
- Family breakdown
- Criminal activity

But drug misuse also impacts on all those around the user and the wider society.

The National Drug Strategy, published in 2010, outlined the ambition to provide recovery-focused treatment in the UK rather than a maintenance programme focused on harm minimisation as previously advocated. It also strengthened the focus on families, carers and communities.

## The cost to society

The Home Office estimated in 2010-11 that the cost of illicit drug use in the UK is £10.7bn per year, this figure includes:

- 8% health service use
- 10% enforcement
- 28% deaths linked to eight illicit substances
- 54% drug related crime

The annual cost to family members and carers of heroin and/or crack cocaine users is estimated to be £2bn.

The economic costs to society from drug misuse are high and there is a strong invest-to-save argument for providing drug treatment. Research has shown that for every £1 invested in drug treatment results in a £2.50 benefit to society.

## The changing treatment population and its impact on outcomes

Around 75% of people in drug treatment in England are receiving help for problems related to the use of opiates, mainly heroin. Public Health England estimates that the proportion of people in treatment with entrenched dependence and complex needs will increase, and the proportion who successfully complete treatment, will therefore continue to fall.

The proportion of older heroin users, aged 40 and over, in treatment with poor health has been increasing in recent years and is likely to

continue to rise. An ageing cohort of heroin users (many of whom started to use heroin in the 1980s and 1990s) is now experiencing cumulative physical and mental health conditions. Older heroin users are also more susceptible to overdose.

## Drug misuse harms families and communities

Risk factors are all negatively associated with health status and there is a complex and reciprocal association between social factors and illicit substance misuse. Homelessness, for example, is a complex problem that occurs for many different reasons. Some individuals may later turn to addiction as a means of coping with their lack of a fixed home.

There have also been recent increases in the number of people rough sleeping, the number of statutory homeless applications accepted and the number of households in temporary accommodation.

Drug misuse can cause social disadvantage and socioeconomic disadvantage may lead to drug use and dependence. In addition, risk factors associations with dug misuse often lead to other adverse outcomes such as poor physical or mental health, often offending or risky behaviour.

- Parental drug use is a risk factor in 29% of all serious case reviews.
- Heroin and crack addiction causes crime and disrupts community safety.
- A typical heroin user spends around £1,400/ month on drugs (2.5 times the average mortgage).

## Drug related deaths

The drug related death rate in England is substantially higher than elsewhere in Europe. The number of drug misuse deaths has increased over the past 20 years, with a significant rise in the last three years, to the highest number on record. In the next four years, PHE estimates that there will be an increase in the proportion of people in treatment for opiate dependence who die from long-term health conditions and overdose.

Drug use and drug dependence are known causes of premature mortality. There were 3,674 drug poisoning deaths involving both legal and illegal drugs registered in England and Wales in 2015, the highest since comparable records began in 1993. Of these, 2,479 (or 67%) were drug misuse deaths involving illegal drugs only. The mortality rate from drug misuse was the highest ever recorded, at 43.8 deaths per million population.

Males were almost three times more likely to die from drug misuse than females (65.5 and 22.4 deaths per million population, for males and females respectively). Deaths involving heroin and/or morphine doubled in the last 3 years to 1,201 in 2015, and are now the highest on record. Deaths involving cocaine reached an all-time high in 2015 when there were 320 deaths - up from 247 in 2014.

People aged 30 to 39 had the highest mortality rate from drug misuse (98.4 deaths per million population), followed by people aged 40 to 49 (95.1 deaths per million).

Within England, the North East had the highest mortality rate from drug misuse in 2015 for the third year running (68.2 deaths per million population), while the East Midlands had the lowest (29.8 deaths per million).

The overall increase in drug-related deaths is largely made up of the increase in deaths among older drug users, with significant rises seen in those aged 30-70. It is likely that many of these deaths occurred in people who were long-term users of heroin and are more susceptible to the risk of a drug overdose because of their poor health.

Public Health England recently published the findings of an inquiry into the recent increases in drug-related death and concluded that the factors responsible are multiple and complex. The most notable factor was the ageing cohort of heroin users experiencing cumulative physical and mental health conditions that make them more susceptible to overdose.

Other factors included increasing suicides, increasing deaths among women, improved reporting, an increase in poly-drug and alcohol use, and an increase in the prescribing of some medicines.

## Novel Psychoactive Substances

The number of individuals presenting with problematic use of NPS or a so-called 'club drug' has dramatically increased in recent years (below 500 presentations in 2013/14 to more than 2000 in 15/16). Robust data on the prevalence of NPS use in England is limited, as is evidence on long-term harms.

There is increasing evidence that NPS are being used by increasingly diverse groups, many of who are from vulnerable groups, including the homeless and people with coexisting mental health problems. NPS have also been identified as a significant issue in some prisons and attributed to significant mental health and behavioural reactions among users.

Synthetic cannabinoids (which mimic the effects of cannabis) are increasingly prevalent in England, with widespread reports of severe mental and physical health problems associated with its use. There is evidence that they are increasingly used by vulnerable groups, particularly the homeless and prison populations. Prison staff consistently express concern about high rates of synthetic cannabinoid use, including by prisoners without a prior history of drug misuse. Controlling the availability of NPS in prisons is a significant challenge.

The number of people recorded by NDTMS who have reported problems with NPS increased significantly in 2015-2016. Mephedrone is the mostly widely used NPS among those presenting for drug treatment. The number of presentations for treatment for ecstasy-related problems has been falling since 2009-2010. Though this partly reflects an increase in use of these substances, it is also because new reporting codes for NPS were introduced in the previous year.

There are also concerns that some NPS are injected. This appears to be linked to members of three distinct populations: those who only use NPS but do so frequently; older drug users who appear to be supplementing or switching from established drugs that are prepared for injection; and those engaging in 'chemsex'.

A frequent pattern of NPS injecting among all these groups represents a significant concern for BBV transmission and health damage.

## Prescription and over-the-counter medicines

Problems of misuse and dependency of some prescribed medicines (principally benzodiazepines), have been reported in England since at least the 1980s. Drug treatment services and primary healthcare have developed interventions to meet local need but self-help and patient-led groups have also provided specialist support. Drug related deaths from prescription and over the counter medicines have increased in the past few years.

## Statistics from the National Drug Treatment Monitoring System (NDTMS) 15/16

In all, 288,843 individuals were in contact with drug and alcohol services in 2015-16; this is a 2% reduction on last year. Of these, 138,081 commenced their treatment during the year, with the vast majority (97%) waiting three weeks or less to do so.

Individuals that had presented with a dependency on opiates made up the largest proportion of the total numbers in treatment in 2015-16 (149,807, 52%). This is a fall of 2% in the number since last year and substantial reduction (12%) since a peak in 2009-10, when there were 170,032 opiate clients in treatment.

The decrease in opiate clients in treatment is most pronounced in the younger age groups with the number of individuals aged 18-24 starting treatment for opiates having reduced substantially from 11,351 in 2005-06 to 2,367 now, a decrease of 79%.

Alcohol presentations make up the second largest group in treatment, with a total of 144,908 individuals exhibiting problematic or dependent drinking. Of these, 85,035 were treated for alcohol treatment only and 59,873 for alcohol problems alongside other substances.

Specialist substance misuse services saw fewer young people in 2015-16 than in the previous year (17,077, a drop of 1,272 or 7% compared to 2014-15). This continues a downward trend, year-on-year, since a peak of 24,053 in 2008-09.

Just under two-thirds of the young people accessing specialist substance misuse services were male (65%), and just over half (52%) of all persons were aged 16 or over. Females in treatment had a lower median age (15) than males (16), with 26% of females under the age of 15 compared to 20% of males.

The most common drug that young people presented to treatment with continued to be cannabis. More than four-fifths (87%) of young people in specialist services said they have a problem with this drug compared to 86% in 2014-15. The numbers in treatment for cannabis as a primary substance have been on an upward trend since 2005-06, although numbers have dipped slightly in the last two years. Alcohol is the next most commonly cited problematic substance with just under half the young people in treatment (48%) seeking help for its misuse during 2015-16.

Alongside cannabis and alcohol, young people in specialist substance misuse services used a range of substances. Of those who were in contact with services, 1,605 cited problematic ecstasy use (9%), 1,477 cocaine use (9%), 1,152 amphetamine use (7%), and 1,056 (6%) with concerns around the use of new psychoactive substances (NPS).

Although the proportion of young people reported by specialist services as having problems with NPS rose for the second year (from 5% in 2014-15 to 6% in 2015-16), it is still relatively small. Specialist services will want to remain alert to the possibility that young people may develop problematic use of NPS in the future and ensure that services continue to be accessible and relevant to their needs.

# Local context

## Young people

There were 145 young people in treatment in 15/16, 117 of these were new presentations.

- The majority were male (66%).
- 75% of young people in treatment were classed as living with parents or other relatives.

Alcohol and cannabis were joint highest substances with 71% of young people listing these as the primary substance they need help with.

In terms of vulnerabilities disclosed at first assessment:

- 12% were Looked after Children
- 29% disclosed domestic abuse
- 31% disclosed self-harm
- 20% disclose NEET
- 35% disclose anti-social behaviour or criminal acts

NPS use continues to be low. While wider services cite the increase in the use of NPS in young people there were only eight referrals into the service in 15/16 where NPS were disclosed as one of the misused drugs.

The 2015 Health Related Behaviour Survey was completed by 11 primary schools. It had the following key drug related indicators:

- 42% of pupils said their parents have talked with them about drugs; 29% said their teacher has talked with them in school lessons.
- 11% of pupils responded that they are 'fairly sure' or 'certain' that they know someone who uses drugs (not as medicines).
- 1% of pupils responded that they have been offered cannabis. 8% said they 'don't know' if they have been.
- 3% of pupils responded that they have been offered other drugs (not cannabis). 4% said they 'don't know' if they have been.

## Adults

The number of people in treatment in Gateshead is increasing, there were 1989 clients in treatment in 15/16 compared to 1826 in 2014/15. The majority are male (69.6%), aged between 30-34 (19.8%).

The primary referral source in 15/16 was self, family and friends with 55.2% of all new presentations to treatment coming from this referral source compared to 2014/15 where it was 50.4% of all new presentations from self, family and friends.

There has been a notable shift in the main substances that people seek help for. In 15/16 alcohol was the main reason for treatment (54.1%) compared to 53.2% in 14/15. In 15/16 47.1% of clients cited opiates compared to 51.6% in 14/15. 16.8% of people sought help for Cannabis in 15/16.

In 15/16 New Psychoactive Substances accounted for only 1.2% of the substances cited for treatment; however since Q4 14/15 this rate has gone up from 0.7% to 1.2% (12 clients to 22 clients). This rate has increased by 84% in the percentage of clients citing this type of substance as one of the reasons for being in treatment over the last 3 quarters.

In contrast to the national picture where only 0.8% of all users cited these as their reason for treatment. This is the highest overall percentage increase of any of the substances cited as a reason for treatment.

## Drug related deaths

The local picture is reflective of the national picture. Deaths in Gateshead have more than tripled since 2012.

The characteristics of the deceased remain similar – with the majority of deaths continuing to be male, white, aged 25-34yrs and male. A number of other trends have also been identified:

- Living alone
- Single
- Unemployed
- In substance misuse treatment
- Using a cocktail of drugs
- Involvement with mental health services
- Previous overdoses
- Complex/chaotic lifestyle

Gateshead's Drug Related Death annual report 2016 gives additional information.

# Cross cutting priority groups

While efforts to reduce the harms caused by drug use must be delivered across the whole population, interventions must be targeted on those who need it most.

Intervening early, with at-risk groups and when people are in greatest need of support is critical. 'At risk' groups include a diverse range of individuals who are particularly susceptible to drug use and are more likely than others to experience adverse outcomes and would include:

- Children from households where there is drug use;
- Looked After Children;
- Offenders;
- People with mental health problems; and
- People from deprived neighborhoods.

It is well-known that while drug use can affect anyone, problematic heroin and opiate use is concentrated in areas of deprivation, where residents tend to have lower levels of recovery capital (supportive friends, family, educational qualifications, mental strength, money, employment, and so on).

In light of this, the following main groups will be prioritised across all three of the strategy's priority themes:

- Children and young people
- Opiate and crack users
- Residents of priority (most deprived) neighbourhoods
- Families involved in the 'Troubled Families' programme

In addition to the above, Gateshead will also look to focus efforts and resources to the following:

- Adults with complex health and social problems
- Dual diagnosis patients (mental health problems and substance misuse problems)
- Offenders
- Vulnerable individuals, including rough sleepers and the homeless
- Young adults (16-24)

# Our response

## Reduce Demand

Aim: To create an environment where people who have never taken drugs continue to resist any pressures to do so and fewer people are using drugs at levels or patterns that are damaging to themselves or others

## Restrict Supply

Aim: To ensure  a joined up approach to disrupt the drugs trade by targeting activity along the entire supply chain, from organised crime groups that import drugs from source to the dealers that sell drugs in our communities.

## Build Recovery

Aim: To support people who wish to tackle their dependency on drugs and/or alcohol and achieve lives free from substance dependence.

# THEME 1

## Reduce Demand

**To create an environment where people who have never taken drugs continue to resist any pressures to do so and fewer people are using drugs at levels or patterns that are damaging to themselves or others.**

## In Gateshead we will:

- Provide specific education and information for targeted groups e.g. Troubled Families, Looked After Children, in an effort to divert or stop potential drug use.
- Take a whole system approach and support individuals in treatment on a range of issues including training, employment, housing, family relationships.
- Support schools and other youth settings in their efforts to challenge young people's attitudes to drugs.
- Recognise the importance of early intervention and intensive support for young people, those at risk of becoming involved with crime and families where there is drug misuse, and provide appropriate support and help to those who need it, in times and places which suit individuals.
- Establish and promote clear pathways into services to ensure those using substances receive the most appropriate support.
- Raise awareness about the harms of drugs and encourage agencies to put measures in place to support those individuals at risk.
- Implement approaches to modify risky behaviours amongst high prevalence or high risk groups.
- Gain a better understanding of prescription and non-prescription medication.
- Provide effective substance misuse treatment in the criminal justice system including prisons, and ensure that support is in place to reduce the chances of re-offending and encourage a successful reintegration into society.

# THEME 2

## Restrict Supply

**To ensure a joined up approach to disrupt the drugs trade by targeting activity along the entire supply chain, from organised crime groups that import drugs from source to the dealers that sell drugs in our communities.**

## In Gateshead we will:

- Improve the quality of data collection to understand the full impact of drugs on crime, health, offending, re-offending and the community.
- Improve our ability to develop and share data/ intelligence to support evidence informed approaches to drug misuse and better target services or schemes, focussing on those in greatest need.
- Work with primary care to ensure that prescription drugs and over the counter medication are not misused or causing patient's problems.
- Protect vulnerable residents by providing local housing which is safe and drug free.
- Lobby for change and work in partnership to tackle supply and drug dealing in Gateshead, ensuring a tough local stance.
- Tackle organised crime groups and drug dealing and undertake robust offender management to those who have committed drug related crime, making best use of positive disposals/requirements.
- Encourage housing providers to take appropriate action when drugs are sold/ cultivated in their properties.
- Undertake clinical audit of prescribing arrangements in Gateshead.

# THEME 3

## Build Recovery

**To support people who wish to tackle their dependency on drugs and/or alcohol and achieve lives free from substance dependence.**

Research literature suggests that investment in drug treatment is likely to substantially reduce social costs associated with drug misuse and dependence.

Social factors are important influences on treatment effectiveness. Drug use and misuse tend to be clustered; for example, areas of relatively high social deprivation have a higher prevalence of illicit opiate and crack cocaine use and larger numbers of people in treatment.

Unemployment and housing problems have a marked negative impact on treatment outcomes and exacerbate the risk that someone will relapse after treatment. Alongside other benefits, employment support and achieving good employment may lead to improvements in treatment outcomes and reduced relapse.

Today, drug misuse and dependency is associated with a range of harms including poor physical and mental health, unemployment, homelessness, family breakdown and criminal activity. The health and wellbeing of family members and carers can also be affected. Heroin and cocaine are associated with the majority of social costs associated with drug misuse and heroin dependence continues to be the most common problem treated in England. People with heroin dependence usually develop a tolerance through daily use, which can result in an expensive addiction and a motivation to commit crime.

## In Gateshead we will:

- Commission effective, accessible treatment and support services for drug users, carers and families.
- Further develop recovery orientated treatment services and workforce that is focussed on all aspects of recovery - housing, employment, mental health, family life - and not just medical treatment.
- Make a commitment to the roll out of substance misuse awareness and overdose awareness training for frontline staff, partner agencies, carers and family members.
- Tackle dual-diagnosis to ensure those who mental health and substance misuse issues receive the most appropriate and effective treatment.
- Increase the visibility of, and access to, a wide range of recovery communities across the borough.
- Facilitate peer support and mutual aid networks so communities become empowered and individuals who have exited services can continue to receive support that enables them to sustain their recovery.
- Establish a recording, monitoring and referral pathway to reduce the number of overdoses.

# Outcomes and indicators

The overall success of this strategy will be measured through the achievement of a number of high-level performance indicators, including:

- Increases in number of young people leaving treatment with reduced drug use or drug free
- Increase in number of young people leaving treatment with reduced risky behaviours
- Increase in the number of people leaving treatment and not representing
- Reduction in number of young people presenting with complex issues
- Increase in proportion of adult opiate & crack users exiting treatment successfully
- Increase in the number of new referrals into treatment services
- Decrease in the number of those offending/re-offending linked with drugs
- Increase in number of people in treatment
- Decrease the number of people who think drug dealing is an issue

## Public Health Outcome Framework

- Number of users of opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within six months as a proportion of the total number of opiate users in treatment.
- Number of users of non-opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within six months as a proportion of the total number of non-opiate users in treatment.
- The rate of drug misuse deaths per million population over a three year period.
- Adults with a substance misuse treatment need who successfully engage in community-based structured treatment following release from prison'.

The multi-agency Substance Misuse Strategy Group will monitor performance against outcomes and take remedial action where improvement is needed.

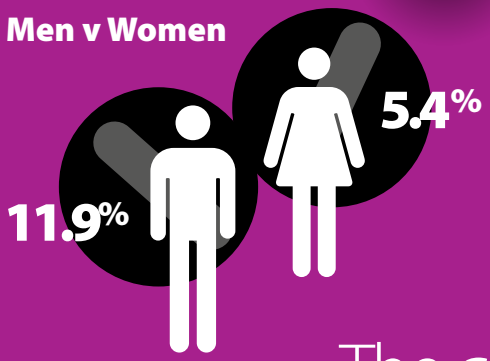
# Effects of **DRUG** harm in the UK

In one year **2.8m** people aged 16-59 used illicit drugs:

**6.7%** cannabis
**2.3%** powder cocaine
**1.7%** ecstasy

**279,000** adults used a NPS **('Legal highs')**

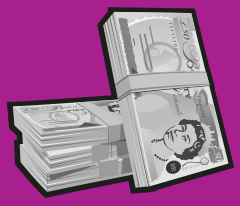
**Men v Women**




**Young people** are more likely to take drugs

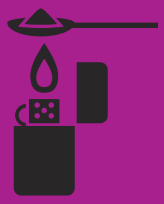

## The **cost** of drug harm in UK

Overall cost of drug harm **£15.4bn**



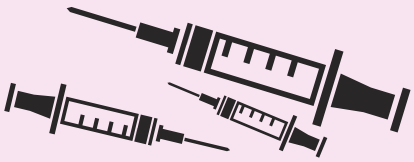
NHS **£488m**
Crime **£13.9bn**
Annual cost of deaths **£2.4bn**

A typical heroin user spends around **£1,400** per month on drugs (2.5 times the average mortgage)




of crime was drug related

## How **drug harm** affects Gateshead



Average of **300** visits each month to needle exchange

**80%** of drug offences were possession

**18** drug related deaths
**145** young people in treatment
**1,989** adults in treatment

| Challenges | Priority Actions | Key Outcomes |
|---|---|---|
| Inequality and deprivation<br>Low aspirations for good health behaviour<br>Unemployment and rise in homelessness | **Reduce demand**<br>• Target specific education/information in an effort to divert/stop potential drug use<br>• Take a whole system approach and support individuals in treatment on a range of issues<br>• Support schools/youth settings to challenge young people's attitudes to drugs<br>• Recognise importance of early intervention/intensive support for young people, those at risk of becoming involved with crime and families where there is drug misuse, providing appropriate support<br>• Establish and promote clear pathways into services so users receive support<br>• Raise awareness about drugs and encourage agencies to put measures in place<br>• Implement approaches to modify risky behaviours in high prevalence/high risk groups<br>• Gain a better understanding of prescription and non-prescription medication<br>• Provide effective substance misuse treatment in the criminal justice system including prisons with support in place to reduce chances of re-offending and encourage successful reintegration into society | Reduction in Drug Related Deaths<br>Reduction in overdoses<br>Reduction in number of young people presenting with complex issues<br>Increase in the number of people presenting for treatment |
| Recent spike in drug related deaths<br>Ageing population of drug users<br>Availability of drugs and diversion of prescription | **Restrict Supply**<br>• Improve the quality of data collection to understand the full impact of drugs on crime, health, offending, re-offending and the community<br>• Improve development/sharing of data/intelligence to support evidence informed approaches to drug misuse and better target services/schemes, focussing on those in greatest need<br>• Work with primary care to ensure that prescription drugs and over the counter medication are not misused or causing patients problems<br>• Protect vulnerable residents by providing local housing which is safe and drug free<br>• Lobby for change working in partnership to tackle supply/drug dealing, ensuring a tough local stance<br>• Tackle organised crime groups and drug dealing and undertake robust offender management making best use of positive disposals/ requirements<br>• Encourage housing providers to take action when drugs are sold/ cultivated in their properties<br>• Undertake clinical audit of prescribing arrangements in Gateshead | Decrease in the number of those offending/re-offending linked with drugs<br>Increase in drug seizures<br>Decrease the number of people who think drug dealing is an issue |
| Dual diagnosis and healthcare system issues<br>Complex and chaotic lifestyles<br>Under developed recovery community<br>Secret / undisclosed addiction | **Build Recovery**<br>• Commission effective, accessible treatment and support services for drug users, carers and families<br>• Further develop recovery orientated treatment services/workforce focussed on all aspects of recovery<br>• Commit to roll out of awareness training for frontline staff, partners/ carers/family members<br>• Tackle dual-diagnosis to ensure those with mental health and substance misuse issues receive the most appropriate and effective treatment<br>• Increase visibility of and access to a wide range of recovery communities across Gateshead<br>• Facilitate peer support and mutual aid networks to empower communities/individuals who have exited services so they can continue to receive support that enables them to sustain their recovery<br>• Establish a recording, monitoring and referral pathway to reduce the number of overdoses | Increase in number of people in treatment<br>Increase in the number of people leaving treatment<br>Increase in number of young |

# Contact information

**If you require further information of Gateshead's Substance Misuse Strategy, please contact Gateshead Council on the contact details below.**

Public Health
Gateshead Council
Telephone: 0191 433 2421

Community Safety
Telephone: 0191 433 3910

Website: www.gateshead.gov.uk

Gateshead Council

**HEALTH AND WELLBEING BOARD**
**28 April 2017**

**TITLE OF REPORT: Better Care Fund 2017-19 Submission Arrangements**

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## Purpose of the Report

1. To provide an update to the Health & Wellbeing Board on the Better Care Fund Plan submission requirements for 2017-19.

## Background

2. The Better Care Fund (BCF) was originally announced by the Government in the June 2013 spending round, with the goal to secure a transformation in integrated health and social care. The BCF created a local single pooled budget to incentivise the NHS and local government to work more closely together around the needs of people, placing their wellbeing as the focus of health and care services, and shifting resources into community and social care services for the benefit of local people, communities and health and care systems.

3. The HWB approved the Gateshead Better Care Fund (BCF) 2016/17 submission for Gateshead at its meeting on 22 April 2016, which in turn was approved by NHS England in July 2016.

4. NHS England published a Policy Framework on 31st March 2017 for the implementation of the BCF for the period 2017-19 which confirmed the statutory and financial basis of the BCF, the main conditions of access to the Fund, and arrangements for the assurance and approval of plans. The Policy Framework covers two financial years to align with NHS planning timetables.

5. At the time of writing this report, detailed Planning Guidance on the BCF is awaited from NHS England and latest indications suggest that the Guidance will be published in the week commencing the 24th April.

## National Conditions and Metrics

6. For 2017-19, there are four national conditions relating to the BCF, rather than the previous eight:

   (i) Plans to be jointly agreed.

   (ii) NHS contribution to adult social care is maintained in line with inflation.

   (iii) Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care.

   (iv) Managing Transfers of Care (this is a new condition to ensure people's care transfers smoothly between services and settings).

All areas are required to implement a 'High Impact Change Model for Managing Transfers of Care'. Eight high impact changes have been identified, including those relating to early discharge planning, monitoring of patient flows, multi-disciplinary working, and using Trusted Assessors to carry out a holistic assessment of need. Narrative BCF plans will need to set out how local partners will work together to fund and implement this.

7. As in previous years, NHS England have also set the following requirements which local areas will need to meet:
    - A requirement that the BCF is transferred into one or more pooled funds; and
    - A requirement that Health and Wellbeing Boards agree plans for how the money will be spent, with plans signed-off by the relevant local authority and Clinical Commissioning Group.

8. Areas will need to agree targets for the following four metrics:
    - Delayed transfers of care;
    - Non-elective admissions (General and Acute);
    - Admissions to residential and care homes; and
    - Effectiveness of reablement.

**BCF Resources**

9. The BCF Policy Framework covers the two financial years 2017-19. Details of the BCF financial breakdown for Gateshead is set out below:

| BCF Contribution | 2017-18 (£m) | 2018-19 (£m) |
|---|---|---|
| Minimum NHS (CCG) Contribution | £15.277 ^ | £15.567 ^^ |
| Disabled Facilities Grant (capital funding for adaptations to houses) | £1.480 | £1.480 |
| New Grant Allocation for Adult Social Care (referred to as the 'Improved Better Care Fund') * | £5.922 | £7.320 |
| **Total** | **£22.679** | **£24.367** |

^ i.e. an uplift of 1.79% on the CCG's Minimum Contribution for 2016/17
^^ i.e. an uplift of 1.90% on the CCG's Minimum Contribution for 2017/18
* i.e. the combined amounts announced at the Spending Review 2015 and Spring Budget 2017

10. The main change to the BCF Framework from last year is the inclusion of some local authority social care grant funding. This was initially announced at the 2015 Spending Review, with an additional provision over three years announced as part of the Spring Budget 2017.

11. The Government will require that this additional 'Improved Better Care Fund' (iBCF) funding for adult social care in 2017-19 is pooled into the local BCF. This funding does not replace, and can't be offset against, the NHS minimum contribution to adult social care.

12. The new iBCF grant will be paid directly to local authorities via a grant from the Department for Communities and Local Government. The Government will attach a set of conditions to the grant, to ensure it is included in the BCF at a local level and that it is spent on adult social care. Whilst the final conditions are expected to be issued shortly, it is understood that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities will be able to spend the grant, including to commission care, as soon as plans have been locally agreed.

13. The Policy Framework goes on to say that the iBCF funding is also intended to support councils to continue to focus on core services, including to help cover the costs of the National Living Wage. This includes maintaining adult social care services, which could not otherwise be maintained, as well as investing in new services.

**Agreeing a Local Vision for Integration**

14. As part of BCF planning, NHS England is asking areas to set out how they are going to achieve further integration by 2020. Areas are encouraged to align their approach to health and care integration with Sustainability and Transformation Plan geographies, where appropriate. This also links to a requirement that local areas ensure the overall direction of travel within their BCF plans and local STPs are fully aligned. However, the Policy Framework goes on to say that what matters is that there is locally agreed clarity on the approach and the geographical footprint which will be the focus for integration.

15. The Policy Framework states that a number of initiatives within an area can also contribute towards overall system integration. These may not be sufficient in themselves to secure full integration of health and social care, but can offer important contributions to key cohorts of patients and service users. In this connection, the Gateshead Care Partnership, already in place, is progressing work around the transformation of community health services.

16. NHS England is seeking to rapidly develop integration metrics for assessing progress, particularly at the interface where health and social care interact. It is understood that they will combine outcome metrics, user experience and process measures.

**Other Points to Note**

17. Other points to note from the Policy Framework include a reference to:
    - the contribution that housing can make to good health and wellbeing - helping people to remain healthier and independent for longer and supporting them to perform the activities of daily living that are important to them.
    - the importance of supporting informal carers to improve outcomes for both carers themselves and those they care for.

**Graduation from the BCF**

18. The BCF is intended to encourage further integration. For the most integrated areas, there will be benefits in graduating from the Fund to reduce the reporting and oversight to which they are subjected. Areas will be able to graduate from existing BCF programme management arrangements once they can demonstrate that they have moved beyond its requirements.

19. It is envisaged that all areas will be able to work towards graduation from the BCF to be more fully integrated by 2020, with areas approved in waves. NHS England will test the graduation process with a small number of areas in a 'first wave', in order to develop the criteria for graduation. Once the criteria have been confirmed, subsequent graduation waves will not be restricted in numbers in the same way.

**Assurance Arrangements**

20. Recommendations for approval of overall BCF plans will be made following moderation of regional assurance outcomes by NHS England and local government. Plans will be approved and permission to spend the CCG minimum contribution to the BCF will be given once the conditions attached to that funding have been met.

**Proposed Arrangements for Developing Gateshead's BCF Submission for 2017-19**

21. Subject to confirmation within BCF Planning Guidance to be published, it is understood that there will be a two stage submission process for the BCF:
    - A six week period to prepare an initial first submission (i.e. from the publication date of the guidance). This will be followed by feedback on the first submission.
    - A three to four week period to prepare a second submission as required.

22. As in previous years, it is proposed to utilise existing working arrangements in place to develop our BCF submission. Progress updates will also be brought to the Health and Wellbeing Board and approval sought to the BCF submission. Plans will also need to be signed-off by the Council and Newcastle Gateshead Clinical Commissioning Group.

**Recommendations**

23. The Health and Wellbeing Board is asked to note the key requirements of the BCF Policy Framework and to agree the arrangements for developing the Gateshead BCF Plan for 2017-19.

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**Contact:** John Costello (0191) 4332065

Gateshead Council

**HEALTH AND WELLBEING BOARD**
**28 April 2017**

**TITLE OF REPORT:** **Deciding Together, Delivering Together: Update on Designing Inpatient and Community Mental Health Services**

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## Purpose of the Report

1. To provide an update on arrangements being put in place to design inpatient and community mental health services across Gateshead and Newcastle.

## Introduction

2. The Deciding Together process involved asking people who use mental health services, their families, carers, mental health professionals and service providers for their views on improving the way specialist adult mental health services are arranged in Gateshead and Newcastle. It culminated in a listening exercise held during winter 2014/15 and was published in April 2015.

3. In June 2016, the CCG governing body considered the findings of the Deciding Together process and made its decision about the future of the services. The following statement was released:

   *"Mental health services in Newcastle and Gateshead are set to be transformed – reducing the amount of time people will spend in hospital and creating better, more integrated care outside of hospital in the community, and helping people to recover sooner – and bringing them onto an equal footing with physical health care…. The changes will mean the creation of new in-patient facilities at Newcastle's St Nicholas' Hospital, and the opportunity to innovate a wider range of improved and new community services, some that will be specifically provided by community and voluntary sector organisations under future new contracts, that will link with statutory NHS services.*

   *While the decision will mean the closure of Gateshead's standalone Tranwell Unit, as well as the Hadrian Clinic in Newcastle, it provides the opportunity to make significant changes that will create new interlinking community and hospital mental health services that will reduce the reliance on hospital stays, shorten the time people spend in hospital and overall improve their experience of services, helping them to recover sooner, stay well and have fulfilling lives.*

   *Older people's services in Newcastle would also change and be consolidated at St Nicholas' Hospital, closing wards based on the former Newcastle General Hospital site.*

*The money released from these changes will be invested into new and enhanced services that will create a better way for people to be supported and cared for in their own communities, minimising the need for in-patient care because new innovative services will support them, when they need it."*

4. Following the CCG decision, work began to understand how to best to take forward its implementation. On 1 February 2017, a stakeholder workshop was held to identify the next steps. There was representation from Gateshead Council at the workshop.

5. The 'Deciding Together, Delivering Together' work will implement the decision of Deciding Together – it is not intended to start again.

6. The workshop group in February 2017 proposed to work in a collaborative way to redesign the pathways for adults and older people in Newcastle and Gateshead who have urgent (in its broader sense) and more complicated / intense mental health needs, by December 2017.

7. The redesign work will cover all adult and older peoples mental health services in Gateshead and Newcastle; this recognises that the Deciding Together scope was limited to NTW provided services and that it was not sufficiently broad to redesign services to meet the mental health needs of the population. The increased scope, therefore, means covering the Gateshead and Newcastle provision of:

   - All NTW NHS Trust provided adult and older people's services
   - Gateshead Health NHS Trust provided older peoples mental health services (new to scope)
   - Third sector services, community and voluntary service services
   - Social care services

**Creating the Implementation Plan**

8. The Accountable Officer Partnership for Gateshead and Newcastle has identified Ian Renwick, Chief Executive of Gateshead Health NHS Foundation Trust, as the accountable officer sponsoring this work. Three work streams will be established and will complete their work between March and August 2017. These are:

**Resource review**

- Briefly revisiting the validity of the Deciding Together resource assumptions (finances, activity, capital).
- Appraising the available capital to accommodate the decision.

**Stakeholder views**

- Appraising the outcomes of Deciding Together and providing feedback on them.
- Proposing solutions to any concerns raised.

**Design programme**

- Developing a community services specification
- Developing an inpatient services specification

9. In addition to the work to implement the Deciding Together decision as it stands, consideration will need to be given to the way in which older people's services operate across Gateshead and Newcastle. The original Deciding Together work excluded older people's services in Gateshead.

## Three Work Streams – Tasks and Outputs

10. Tasks and outputs have been identified for each of the three work streams as follows:

***Resources Review Group***

***Tasks:***

1. Restate the case for change activity and for finances (brief exercise) considering specifically:
   a) The financial envelope projected to 2022 – drawing conclusions about the revenue and capital affordability of the Deciding Together decision.
   b) The demand for services in light of demographic analysis, projected to 2022.

2. Review the Gateshead resources and services delivered (this reflects the increased scope of the work).

3. Assess existing capital and what needs to change to accommodate Delivering Together outcomes and specifically:
   a) Identify the specific site for the Newcastle based in-patient provision.
   b) Identify existing alternative capital (e.g. Intermediate Care) and its scope to complement/ provide in patient capacity.

***Outputs:***

A single document that provides all necessary resource information (financial, activity and capital) to inform the workshops in June. *Target date: 1 June 2017*

***Stakeholder Views Group***

***Tasks:***

1. Review the outcomes of Deciding Together and identify strengths, concerns and potential solutions where possible.

2. Describe key components of a community service – including specific references to voluntary and community sector.
3. Support the planning of the workshop design events in the summer, feeding in the outputs of the group and shaping the community services specification.

***Outputs:***
A single summary document, including a series of ideas/ solutions to feed into the design workshops. *Target date: 1 June 2017*

***Design Group***

***Tasks***

1. **Design community services** across adult and older people services using both the Delivering Together work to-date and available national evidence of effectiveness and efficiency. The scope of the design must include maximising the use of the voluntary and community sector, as a key delivery partner in mental health services.

   This work will need to be taken forward through a series of **workshop events**, to be held just before the summer months. The workshops will draw upon the existing transformation methodology of the NTW Transformation programme.

   Consideration will need to be given as to whether there should be a single specification for Gateshead and Newcastle – or one for each area.

2. **Design inpatient delivery** parameters including:
   a) Acute mental health inpatient needs for adults and for older people.
   b) Shared care (physical and mental health inpatient needs) if appropriate.

   This work will be critical to ensuring we develop a new in patient facility that will work easily with community services, focus on recovery, and support patients over a longer term such that readmission to hospital is prevented as far as possible.

***Outputs:***
A community services specification and an inpatient services specification (operating parameters). *Target date: 31 October 2017*

**Recommendations**

11. The Health and Wellbeing Board is asked to note the arrangements being put in place to progress this work. Further updates will be provided as this work progresses.

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**Contact:** Alice Wiseman (0191) 4332777 and John Costello (0191) 4332065

# Healthwatch Gateshead Activity Report
# September 2016 to March 2017

**1. Introduction.** This report outlines the key activities undertaken by Healthwatch Gateshead to support, promote and encourage residents to have a stronger voice in their health and social care by either being the representative of diverse communities or by providing intelligence – including evidence from people's views and experiences – to influence the policy, planning, commissioning and delivery of health and social care.

**2. Healthwatch Gateshead.** The Health and Social Care Act 2012 set out that Healthwatch would be established in April 2013 in order to provide local citizens and communities with a stronger voice to influence and challenge how health and social care services are delivered within their locality.

**3. Governance.** The Board currently has a core of four Directors, previous Directors having left due to illness or work promotion out of the area. The Board had been actively recruiting individuals who committed to the ethos and goals of Healthwatch Gateshead. They had intended to take up their roles if Healthwatch Gateshead C.I.C. had won the contract from April 2017 to deliver Healthwatch services on behalf of Gateshead residents.

**4.** The shadow board have been expanding the involvement and impact of Healthwatch Gateshead C.I.C. while the staff were concentrating on delivering the Healthwatch services contractual commitments.

**5. Research Projects.** Healthwatch Gateshead engages with national and local policy makers, residents, commissioners, service providers and stakeholders to inform the type of research and engagement activities that Healthwatch Gateshead may undertake based on residents' experiences of health and social care.

**6. Customer Relationship Management (CRM) system.** We have installed the latest version of Healthwatch England (HWE) CRM system which enables us to capture information more efficiently from meetings, activities, residents' issues etc in a single place. This enables us to track issues, identify local problems and enable Healthwatch England to identify potentially national issues and enables us to satisfy requests from the Care Quality Commission in a more efficient and effective manner.

**7. Volunteer Programme.** To supplement the resources provided under the Healthwatch services contract we have been developing our volunteer programme to undertake a range of activities which provide feedback on services received by Gateshead residents. We have a core team of trained volunteers who undertake the following roles:

- Enter and View Authorised Representatives
- Mystery Shoppers

### 7.1 Enter and View:

The latest Enter and View visit was to Springvale Court Residential Care Home in October. A team of four trained volunteers and a staff member conducted the visit. This is a residential care home recently judged to as Requires Improvement by the CQC. The purpose of the visit was linked to their most recent CQC inspection and NICE guidelines regarding engagement of residents in meaningful and individualised activity.

The subsequent report made several key recommendations to the provider. The home was given the chance to comment on the report but no comments were forthcoming. This report was also shared via the normal channels to the CQC, Healthwatch England, NHS England, Local Authority, CCG, Health and Wellbeing Board. The CQC have advised that they will be using the information and recommendations as part of their next inspection of the service.

The next Enter and View visit is planned for 8 March 2017.

### 7.2 Mystery Shopping:

Mystery Shopping is a new project which was developed in September. The first Mystery Shopping Project was to explore mechanisms to support meaningful patient engagement in GP surgeries. A team of volunteers contacted all GP practices in Gateshead acting as a potential new patient to explore patient engagement based on a specific scenario.

A report was produced and circulated to all Practices and the CCG. Practices were offered specific feedback about their Practices performance should they wish to receive it. One Practice asked us for this.

The report was received favourably by the CCG who have advised that they thought the report was very clear and made some useful recommendations.

Furthermore, they advised us that they discussed the report at the CCG delivery group which includes practice managers from Newcastle and Gateshead. It was agreed that the highlighted an area where improvements could be made and that the practice managers will take the report to the Newcastle and Gateshead practice managers meetings to share the recommendations and agree actions for practices.

We are currently undertaking a mystery shop of NHS providers regarding the NHS Accessible Information Standard. The resulting report will be circulated via the normal channels. All reports are published on our web site.

The “Mystery Shopping” role has proved very successful.

The purpose of this role was:

- To test the service user experience of the health and care services for Gateshead residents using different scenarios and situations.
- To find out about the consumer experience of people with disabilities or other specific groups such as young people.
- To see if contacts and services advertised are up to date and still available.

The expected outcomes achieved include:

- Recognise good practice and highlight areas of excellence.
- Identify areas of concern to assist with service improvements.
- Gain a good understanding of what it feels like to be a service user.
- Make recommendations to the service provider about how to improve the service user experience.
- Improved training programmes instituted by CCG.

**7.3 Partnership working with the QE Hospital**

Collaborative working with the Queen Elizabeth Hospital is being developed in two ways. Firstly, we are working with them to carry out Patient Led Assessments of the Care Environment (PLACE visits). One of our volunteers will be participating in these alongside QE staff and volunteers.

Secondly, we are working with the Day Surgery Matron and the Quality Improvement Team to recruit patients using Day Surgery as mystery shoppers. Patient Experience Mystery Shoppers will provide us with real time feedback about their patient experience and how it could have been improved. We will collate all responses and produce a final report and recommendations. This project will start week commencing 13 February 2017 and will run for three months.

We are helping with the recruitment and training of volunteers.

**7.4 Volunteer Involvement in Social Care QA Visits**

Discussion have been held with representatives from Social Care Commissioning Team. They were very open to involving our volunteers in their QA process. We have discussed the possibility of our volunteers being included in their inspection timetable. It is likely that

our volunteers would focus on conducting observations and conversations with residents prior to the LA visit. This would provide the opportunity for HWG to identify any issues, areas of concern and other key emerging themes which we can flag up to the LA team so they can be explored further during their visit.

We are awaiting contact from LA representatives to determine next steps and to progress this further.

**8. Annual General Meeting.** At our AGM we invited organisations the opportunity to take part in round table discussion with residents. Only the Council Commissioning group did not accept the invitation. Topics chosen by the different organisations were: -

- **Queen Elizabeth Hospital** – the balancing of patients' priorities'
- **North East Ambulance Service** – what can be expected
- **Health Champions** (Newcastle and Gateshead Clinical Commissioning Group) – how to get involved
- **Newcastle and Gateshead Clinical Commissioning group** – Continuing Healthcare criteria and funding
- **Adult Social Care** - service delivery and social care pathway
- **Northumberland Tyne and Wear NHS Trust** – mental health service provision
- **Public Health** - in Gateshead and what it does.
- **Healthwatch Gateshead Volunteer Proposition** – what we do and why?

It was a very successful event for all participants. The full report is provided at **Appendix 1**.

**9. Oversight and Scrutiny Committee.** At the September meeting Healthwatch reported discussions with NEAS regarding shortfalls in paramedics

**10. North East Ambulance Service**. We attend the regular meetings of the Ambulance Service Health Watch meetings, to raise issues for Gateshead residents.

**11. Care Home Vanguard.** Significant involvement with the various Vanguard groups to understand the new models being proposed and to influence their development. Healthwatch Gateshead delivered training courses for volunteers. HWG has taken part in the programme evaluations undertaken by both Newcastle and Sunderland Universities. To ensure effective and efficient use of resources we have challenged the value of so many meetings, some of which have now been discontinued.

**12. Adult Safeguarding Board.** HWG has raised concerns that CQC had identified that several care homes where marked as unsafe and that there could be safeguarding issues for vulnerable adults. The Adult Safeguarding Board has now agreed to monitor the situation and has requested regular reports to identify whether the situation is improving or deteriorating.

**13. Empowering and Informing Gateshead Residents.** Healthwatch Gateshead has a statutory duty to empower residents to enable them have a voice in both national and local consultations which could impact on their health and social care and to represent their views to those who commission and provide health and social care services. We have continued our role of reaching out to different groups to inform and collect views. Initial contact has been made with religious groups. We attended 51 outreach events to reach a cross section of residents.

**14. Deciding Together Consultation on the Future of Specialist Mental Health Services in Newcastle & Gateshead.** We continue to actively promote the residents' views on the proposed changes to Adult Mental Health Services in Gateshead and Newcastle and had planned to monitor the actual impact against proposed impact for residents.

**15.Health and Wealth - Closing the Gap in the North East, Report of the North East Commission for Health and Social Care Integration.** We represented the local Healthwatch organisations on the North East Commission evidence review panel and submitted our comments on their final report to both the Health and Wellbeing Board and directly to NECA. We were the only North East Healthwatch to comment directly to the commission.

**16 Gateshead Council Consultations on Social Care budget for 2017.** We presented residents views from previous consultations on this subject.

**17. Other Consultations publicised**. We have actively publicised 18 consultations covering a range of health and social care topics, far too many for any one individual to have the time to read, digest and then respond. Those we have publicised are shown at **Appendix 2.**

**18.** Healthwatch Gateshead informs residents about national and local consultations which could affect the health and social care. This is undertaken by either holding special events, participating in local events across the borough, through our social media, website, our electronic newsletter, council newsletter or through partners, our contacts database and Survey Monkey. Our electronic newsletter goes to over 500 organisations and individuals, see **Appendix 3.**

**19. Strategic Partnerships Representing Gateshead Residents**

Healthwatch Gateshead Chair, Board members and the Staff team represent Healthwatch Gateshead at a variety of forums, networks and strategic boards. Our role is to ensure that the voice and opinions of local people are taken into account when decisions are being made about health and social care services. We have had regular representation and input to the following: -

- **Primary Care Joint Commissioning -** the body responsible for the planning and commissioning of healthcare services to meet the needs of the local community.

- **Gateshead Safeguarding Adults Board**- whose overarching purpose is to help and safeguard adults with care and support. Healthwatch Gateshead has provided an Interim Chair for this committee until a new chair is appointed.

- **Local Engagement Board** - Members of the public are invited to these quarterly Local Engagement Boards (LEBs) to discuss important health issues and services and to help shape, improve and develop local NHS services.

- **Health and Wellbeing Board** - established and hosted by local authorities, health and wellbeing boards bring together the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch, to plan how best to meet the needs of their local population and tackle local inequalities in health.

- **Care, Health and Wellbeing Overview and Scrutiny Committee -** Council overview of provision of health services to the local population.

- **Gateshead Patient User Carer Public Involvement *Group (PUCPI)* -** aims to ensure that the needs and issues identified by members are brought to discussion with commissioners.

- **Gateshead Smoke Free Tobacco Alliance (Ten Year Tobacco Plan) -** reducing the number of residents who smoke in Gateshead. Healthwatch Gateshead is providing the Vice-Chair for this committee.

- **Gateshead Care Home Vanguard -** a joint approach by NHS Newcastle Gateshead CCG and Gateshead Council to deliver improved health and social care into homes for residents and their families.

- **North East Commission for Health & Social Care Integration -** The purpose is to establish the scope and basis for integration, deeper collaboration and devolution across NECA's area to improve outcomes and reduce inequalities. (The area covered by NECA and the Commission is County Durham, Gateshead, Newcastle, North Tyneside, Northumberland, South Tyneside and Sunderland.).

- **Joint Integrated Care Programme Board/STP -** response to NHS England regarding the future structure of healthcare in the North East.

- **Achieving More together -** Gateshead Strategic partnership to enable residents make the most of their capabilities.

- **Gateshead Voluntary Sector Advisory Group -** provide input to Health and Wellbeing Board.

- **Gateshead and Newcastle Joint Overview and Scrutiny Committee -** has a statutory role in considering whether it has been appropriately consulted and whether any proposed developments are in the best interests of the health service in their area.

- **North East Ambulance Service NHS FT –** provides ambulance services which cover the counties of County Durham, Northumberland, and Tyne and Wear, along with the boroughs of Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-on-Tees.

- **A&E Local Delivery Board –** Concentrating on managing the winter demand for services

**Appendix 4** list the meetings generally attended by the Chair, board member or Senior Manager.

**20. Website.** The HWG website has been refreshed and offers more information on local services and our marketing and promotional activities are increasing, including closer working with Citizens Advice. We provide an A to Z list of services for all kinds of health and social care information, advice, complaints, care pathways, patient and support groups. There is also a section on frequently asked questions which is reviewed on a regular basis to save individual's time if we have already responded to a similar question. We do however encourage new questions.

**21. Partnership Working.** Healthwatch Gateshead works in partnership with both voluntary organisations and statutory bodies to reduce duplication of effort and provides greater value for money in an era of austerity. We have started discussion with religious organisations to gather feedback from their communities and outreach. Our partners inform Healthwatch of issues raised by their members or who may be affected by the various consultations.

**22.** In accordance with our business plan we have continued to offer our assistance by informing key stakeholders of the views HWG has gathered. This included: -

- participating whenever possible in consultation events run by Health and Social Care commissioners and providers.
- continuing to work closely with the Care Quality Commission to help inform and shape their forward plans. We will assist CQC in their inspections, provide detailed information received from Gateshead residents.
- working with the North East Commission for health and social care integration to try and ensure that any future design is resident orientated, rather than institution based.
- working with the joint integrated care programme board to develop a sustainable transformation plan with is more patient based then institution based.
- delivering the agreed contract requirements.
- promoting and supporting the Council's 10 Year Tobacco reduction programme.
- promoting well being events.

**23. Summary.** This OSC is asked to note the contents of the report and the significant contribution that Healthwatch Gateshead has made in enabling residents of Gateshead to have a voice in the health and social care they receive. The contract for the delivery of Healthwatch services in Gateshead from April 2017 has been award by Gateshead Council to 'Tell Us North' who currently hold the contract for the delivery Newcastle Healthwatch Services. This is the final report from the current contract holder.

**D.G.Ball** **Chair of Healthwatch Gateshead**

**Appendix 1 - Healthwatch Gateshead Annual Event Report**

See separate report

**Appendix 2 - Consultations on website and e-bulletins from September 2016**

- Dementia Care and Support
- Sustainability and Transformation Plans
- Unpaid Carers Survey
- Dementia Care and Support for Carers
- Supported Housing Fund
- Care Quality Commission Regulations Fees
- Work Health and Disability
- Dementia Friendly Swimming

**Surveys** on website and e-bulletins from September 2016 – present

- Under 25's Health Survey
- Gateshead College Health Survey
- Learning Disability and Mental Health Services
- Work Health and Disability Green Paper
- Accessible Information Standard
- Urgent Care – What does Urgent mean to you
- Gateshead Councils Health and Lifestyle survey
- Eating Disorders
- North East Ambulance BAME survey
- National Dementia Citizens Programme

**Appendix 3 - Recipients of Healthwatch Gateshead Electronic Newsletter**

- All Care Homes in Gateshead
- All Residential Homes
- All Nursing Homes
- Individuals
- All Schools
- Various Council departments i.e. Communities, Neighbourhoods and Volunteering, Community Safety, Wellness Hub, Looked After Children, Safeguarding Team etc.
- Public Health department
- Various healthcare personnel – Sexual Health Lead, Dementia Leads, Volunteering Lead, Patient Experience Teams, Hospital Communication Department, PALS, NTW, CCG staff, Health Champions Lead etc.
- Ambulance Service
- All GP surgeries and Practice Managers
- Many voluntary sector organisations – i.e. Age UK, Carers Association, Hearing Loss Support, Your Voice Counts, Rape Crisis Centre, Changing Lives etc.
- All Community Centres
- All Leisure Centres
- Readers At Home Service
- All Councillors
- Local MP's
- All Dentists
- All Opticians
- Local Media - including radio and newspaper
- Hospital Radio
- ICA – Independent Complaints Advocacy
- All Pharmacies
- All Children's Centres
- Specific Black and Minority Ethnic Community Groups
- All Advocacy Projects in the Borough
- HWG staff, volunteers and Board members
- Other local Healthwatch organisations
- Health and Wellbeing Board

- All Libraries
- Clinical Professional Networks – pharmacy, dentistry, ophthalmology
- Northumbria Police
- Tyne and Wear Fire Service
- Care Quality Commission

**Appendix 4 - Meetings generally attended by the Chair, board member or Senior Manager**

September

- Health and Wellbeing Board
- HWG Board

October

- PUCPI
- World Mental Health Day
- Learning Disability Partnership
- Vanguard
- NE Ambulance Service
- Accident and Emergency Delivery Board
- Transforming Participation Board
- Health and Wellbeing Board
- Local Engagement Board (LEB)
- HWG Board
- HWG Annual Event and AGM

November

- Care Health and Wellbeing OSC
- Vanguard
- Learning Disability Partnership
- Adult Safeguarding Board
- Accident and Emergency Delivery Board
- CCG engagement Event
- HWG Board

December

- Tobacco Alliance
- Health and Wellbeing Board
- HWG Board
- PUCPI
- Care Health and Wellbeing OSC
- Accident and Emergency Delivery Board
- Learning Disability Partnership

January 2017

- Vanguard
- STP Public event

- Learning Disability Partnership
- QE strategy Meeting
- Accident and Emergency Delivery Board
- NE Ambulance Service
- Children's Safeguarding Board
- Health and Well Being Board
- Adult Safeguarding Board

February 2017

- Learning Disability Partnership

healthwatch Gateshead

# Annual Event
# October 2016

"Have your say and we will make sure your voice is heard by those who make decisions on your behalf"

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healthwatch Gateshead

# 1. About Us - What is Healthwatch?

Healthwatch organisations were established across England to create a strong, independent consumer champion whose role is to:

- Strengthen the collective voice of citizens and communities in influencing local health and social care services in order to better meet their needs.

- Enable residents to find the right health and social care service for them by providing appropriate information, advice and signposting.

Healthwatch works with local residents, patients, service users, carers, community groups, organisations, service providers and commissioners to get the best out of all local health and social care services.

## 1.1 Healthwatch Nationally and Locally

Healthwatch Gateshead was established under the Health and Social Care Act 2012 and is the independent local consumer champion across Gateshead.

Healthwatch Gateshead provides an opportunity for local residents to have a stronger voice to influence and challenge how health and social care services are provided locally.

The organisation brings together residents views and experiences' of local health and social care services and uses this feedback to build a picture of where services are doing well and where they can be improved.

Healthwatch Gateshead can provide residents with health and social care information about the choices they have and what they can do if things go wrong.

Nationally the Healthwatch Network is made up of 148 local Healthwatch's with Healthwatch England in place to offer leadership, guidance and support to the network.

# 2. Executive Summary – Key Findings

This report has been written following Healthwatch Gateshead facilitating an open event after identifying 8 key areas to stimulate conversation between the residents of Gateshead and some key decision makers / influencers of health and social care services in Gateshead.

This approach was to ensure there was a wide choice to attract the biggest participation. The areas for discussion included:-

- **Healthwatch Gateshead Volunteer Proposition** – what we do and why?
- **Public Health** - in Gateshead and what it does
- **Queen Elizabeth Hospital** – the balancing of patients priorities'
- **North East Ambulance Service** – what can be expected
- **Health Champions** (Newcastle and Gateshead Clinical Commissioning Group) – how to get involved
- **Newcastle and Gateshead Clinical Commissioning group** – Continuing Healthcare criteria and funding
- **Adult Social Care** - service delivery and social care pathway
- **Northumberland Tyne and Wear NHS Trust** – mental health service provision

The aim of the event was to facilitate a safe, comfortable environment where users of health and social care services were able to directly discuss their experiences with some of the key stakeholders and service providers in Gateshead and gain some mutual understanding of why decisions were being made and how they were able to influence service delivery.

This report accurately reflects what the audience felt where their priorities and this can be seen from the very wide ranging discussions. The clarification process for this report included making an approach to the key representatives for each topic to ensure they were given the opportunity to reflect and give any further added value to the comments and commitments made – there has been no editing of the comments to remove any individual's observations.

In terms of key findings:-

- The format and structure of an open forum to enable dialogue between users and provider of services was unanimously endorsed
- What was established clearly from the event was the obvious public interest in health and social care services and the need to have an established way of engaging with providers
- There are topics which need an event in their own right – Adult Social Care, for example
- There are engagement opportunities for the public which need more publicity – Health Champions
- Have more senior people around the tables to hear "stories" and experiences
- Continuing Healthcare criteria and funding – there is not enough information on how to qualify and what the process is for both adults and children.

# 2.1 Recommendations

Recommendations after the analysis of comments received from attendees by Healthwatch Gateshead are as follows: -

**Recommendation 1** – Healthwatch Gateshead build in a programme of quarterly meetings to facilitate the ongoing dialogue between residents and service providers.

**Recommendation 2** – Gateshead Council Adult Social Care to improve the process of accessing social care reviews and assessments

**Recommendation 3** - Newcastle and Gateshead Clinical Commissioning Group to develop clear simple to understand guides for Adults and Children's Continuing Healthcare Pathway

**Recommendation 4**- Newcastle and Gateshead Clinical Commissioning Group to publicise the role of Health Champions alongside the social prescribing agenda

**Recommendation 5 -** Public Health to inform the public how to access information to support their health needs.

**Recommendation 6 -** Ambulance Service to consider needs of accessible transport for wheelchair users when going to hospital

**Recommendation 7 -** Queen Elizabeth hospital to review standard of British Sign Language standards to patients

**Recommendation 8 -** Northumberland and Tyne and Wear NHS Foundation Trust to develop a single point of contact for Gateshead residents

Excellent event should be held more often. Once a year is too long.

# 3. Understanding the Issues

## 3.1 Aim of the Report

To demonstrate the value of holding listening events with the public who in turn can inform the providers of health and social care services in Gateshead of their experiences and concerns and build a common understanding on how this can be taken forward.

Secondly to demonstrate that Healthwatch Gateshead met one of its stated objectives:-

"***Making sure residents voices are heard by those who make decisions on their behalf".***

Overall the event was extremely well received with wide ranging discussions and dialogue. The key stakeholders took away some rich information to address some of the health and social care challenges of the future.

## 3.2 Methodology

There were 8 round table topics. The day was split into two discussion forums with the ability of the public to move between tables during the break for Afternoon Tea. In reality some discussions continued over the designated break time due to the interest generated. Each table was facilitated either by a staff member from Healthwatch Gateshead or a Board member. This report is generated from their notes.

## 3.3 Overview

Overall the event was extremely well received with wide ranging discussions and dialogue. The key stakeholders took away some rich information to address some of the health and social care delivery challenges. In turn has informed Healthwatch Gateshead's work plans for the foreseeable future

# 4. What We Did

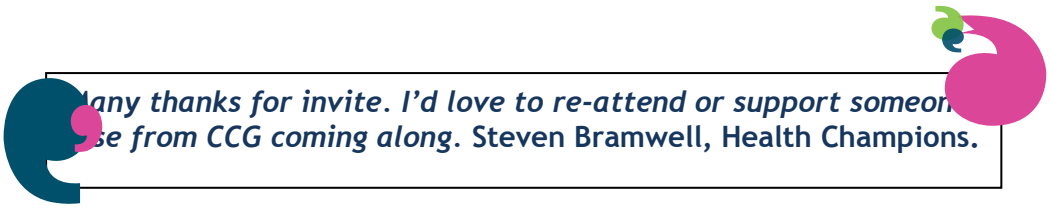
We made the decision to have a listening event for local residents prior to our formal Annual General Meeting (AGM). We advertised the event widely and obtained an appropriate, accessible venue. We canvassed all the main stakeholders we had been working with and they committed to attend.

We wanted the public to hold us to account for one of our objectives:-

Making sure residents voices are heard by those who make decisions on their behalf

# 5. What People Told Us

There were some very lively and positive discussions around 8 topics of Health and Social care services in Gateshead with key decision makers present. Continue reading to find out more about what people told us.



## Table 1 - Gateshead Foundation Trust (Queen Elizabeth Hospital)

**Carole Gourdie, Healthwatch, Joanne Stout, QE Clinical Lead Safecare and Judith Portlock, QE PALS Manager.**

The North Regional Association for Sensory Support (NRASS) highlighted that their users had reported that the hospital was failing them as deaf patients. Some of the issues are highlighted below:-

**Issue:- Interpreters** are not available when deaf patients arrive in A & E.

When interpreters are booked often a request is not made for a gender specific interpreter, for example, if the patient is there for gynaecological issues then a female interpreter is required.

Ambulance personnel have no British Sign Language training.

Hospital staff, from reception to medical personnel with no BSL training and/or no identified staff members with this skill that can be called upon to offer support when a deaf patient requires assistance/support.

Carers/friends who arrive to support a deaf person not being able to be present during a consultation with the doctor due to not being 'family' to provide background to the patients circumstances.

No interpreter present at patient assessment. Do staff know how to access BSL interpreters?

**Response:- Interpreters -** A process is in place for booking BSL Interpreters who are available 24 hours a day. The QE will raise this in the Ward Managers meetings and propose that all ward staff are briefed regarding accessing BSL Interpreters.

The booking process for BSL interpreters will be highlighted to all support /reception staff in A & E, Outpatients and Clinics. Training will be provided to staff that are identified as unsure regarding the process.

Healthwatch Gateshead will follow these actions up also with the QE and will also have an additional meeting with NRASS to clearly identify all of the issues facing patients who are deaf and the difficulties this presents when accessing/using health and social care services.

**Issue:- 'Carers Passport'** available to non-family members through PALS – people are not aware of this.

PALS close at 5pm therefore outside of normal office hour's non-family would be unable to obtain a Carers Passport therefore would still be unable to support patient and/or be given any patient information.

**Response:-** The QE have the Carer's Passport across all wards. Signage is displayed to prompt Carers to ask staff for a Carer's Passport to enable them to visit outside visiting hours and be present during medical examinations and be given information on a patient's condition if the patient gives their permission.

The QE will raise this in the Ward Managers meetings and propose that all ward staff are briefed again to promote the Carer's Passport.

Healthwatch will promote the QE Carers Passport through their website, e-news and social media.

**Issue:- Communication** across the board for deaf patients is challenging as they are unable to use the telephone to access services/book appointments without support.

As the hospital is a new building 'why are hearing loops not part of the infrastructure'?

The Data Protection Act can be a barrier for non-family (Carers/friends) – regarding medical information about the patient.

**Response:-** The QE are looking at other methods of communication for example text messaging for patients to book appointments at clinics etc.

**Issue:- Hospital Discharge-** A general comment was made about patients being discharged without follow-up when they return home no direct instance was given by a patient.

A general comment was made about patients being discharged late at night on their own without communication with family/carers or community support arrangements being in place. No direct instance was given of this by a patient.

Discharge delayed due to waiting for medication.

Outpatients discharge delayed due to waiting for medication.

The Freeman Hospital has specialist nurses in place and contact details are given to a patient on their discharge so they have support when back home. This means when a patient has concerns they have a designated person to contact who is familiar with them and their condition and can provide advice/support. All communication is recorded so when a patient returns to see their consultant or GP they do not have to go over any previous discussions they have had, the history is logged. Could this system be adopted by the QE in appropriate cases?

**Response:-** The QE stated that they have received no concerns or complaints to support the statement regarding patients are being discharged at night, work is ongoing to improve the discharge process. The QE will continue to improve hospital discharge and care pathway back into the community.

The QE have advised that additional pharmacists have been recruited to address the level of work the department experiences in an attempt to reduce waiting times during peak periods.

Healthwatch Gateshead will follow these issues up as part of the review of Hospital Discharge at the QE project work.

**Issue:- Communication -** Patient waited 3 hours in A&E to be seen by a doctor. This consisted of being seen at triage then taken through and put into a cubicle and left. Nobody came to update me on what was happening and how long it would be before a doctor came to see me, I felt very isolated. When I eventually saw a doctor the treatment and care was excellent.

**Response:-** Work is underway to have specific staff assigned to cubicles to keep patients up to date at regular intervals about the timescale to see a doctor if there are delays or long waiting times due to service demand.

**Issue:- GP Referral Appointments -** A patient told the table that he had experienced a delay in receiving an appointment at a clinic at the QE. When he rang up to enquire, he was asked for a 'password' to access any appointment information, he did not have this, so had to return to his doctor for the process to begin again.

Patient also advised that the telephone system does not answer your call straight away and puts you in a queue, it just continues to ring out until someone can take your call, therefore you don't know how long you will have to wait/let the call ring before it is going to be answered.

**Response:**- All appointments are booked through a central point - Bensham Hospital – the comment regarding the telephone system will be fed back.

The table was advised that there is a process in place for making a hospital appointment but it is clear that different GP surgeries are working in different ways. At the time a referral is made, patients need to be clear about their hospital appointment and ensure they receive their password so they can make enquiries if necessary with the hospital.

Healthwatch Gateshead will publicise this through their website, e-news and social media.

**Issue:- Stroke Services.** A patient advised that the QE A & E were not told by the ambulance crew that a stroke patient was on their way to them. The patient was not initially put on the stroke ward and was concerned that this could cause a delay of specialist treatment being given. The patient was moved onto the stroke ward after assessment.

The patient advised that the care received during assessment was excellent and when they were transferred to ward 22 they received excellent care.

The patient is however concerned about the plans to transfer all acute stroke cases to the Royal Victoria Infirmary (RVI), Newcastle from November. The rehabilitation ward will remain open at the QE and patients will return here when stable.

**Response:** Healthwatch Gateshead advised that there is a new model of care being implemented from the end of November 2016. The Clinical Commissioning Group is confident that this change in service will result in improved care for patients in Gateshead.

Healthwatch will highlight this change through their website, e-news and social media. They will put a link to the CCG Stoke Services in Gateshead briefing that provides a background to the changes and information about the changes.

**Issue:- Feeding.** A patient told the table that he had been in intensive care for 9 days and was then transferred onto the ward where he stayed for a further 3 days before being discharged. During this time he was still weak and when food was brought at meal times it was placed on the trolley but he couldn't reach it and felt too weak to eat. No assistance was given and the food was taken away which meant he had very little to eat during these 3 days.

**Response:-** The QE are very concerned about the issue around meals and will follow this up, however to prevent this happening there are volunteers on the ward at mealtimes along with staff to ensure patients are provided with assistance should they require it.

**Issue:- Patient Isolation.** A patient was on the Jubilee ward, the facilities are excellent with on-suite etc. but he felt very isolated.

**Response:-** The QE are aware of the issue around patient isolation that the new ward facilities present and they have put in place an initiative that is called 'Intentional rounding' where staff will visit each room regularly to interact with patients and check they are OK. All patients should have a general idea when a member of staff will be back to see them. Volunteers are also on wards to provide social interaction/company with patients who would like it.

These issues will be raised at Ward Manager's meetings.

**Issue:- End of Life.** A member of the public told the table about his father being admitted to hospital as an emergency and eventually passing away. The family were with the deceased but felt unhappy that a doctor was unable to attend to confirm 'that there was no sign of life'. The deceased died at 12.30 am and the family waited until 3.30 am. The doctors confirming the death would have given them closure so they felt very upset with this not happening within what they felt was a reasonable period of time.

**Response:-** The QE acknowledge how this must have felt and apologised for this and confirmed that the doctor would have arrived as soon as they possibly could to confirm that their father showed no sign of life.

**Issue: Moving patients.** A patient told the table about the staff trying to move them to another ward during the night with no explanation or discussion. The patient firmly refused to be moved and said it was upsetting and distressing to be woken up to be informed she was being moved and it would have been terrible to have woken up in a strange ward.

**Response** - The QE apologised to the patient and advised that they would raise this issue at the Ward Managers meeting but advised that sometimes it has to be done due to hospital bed pressures.

**Issue:- Car Parking.** Patients and visitors unable to get a parking space.
Why is the ambulance entrance shared with the public entrance and there is a bus stop at the junction and pedestrians walk across the entrance?

**Response:** - QE will feed these comments back

**Issue:- Signage.** A patient commented that it is very difficult to find your way around the hospital from the Windy Nook entrance due to lack of signage.

**Response: –** QE will feed this back and to have the issue resolved by signage being put up.
Members of the public highlighted that they found the Healthwatch Gateshead stand with information in the PALS area very useful.

It was also highlighted that members of the public also mentioned that they saw this Annual Event posters on the wards when visiting.

**Issue:- Ambulance Service –** a patient told the table after an accident at Gateshead Interchange when a person fell backward on the escalator onto her she had to wait 2 ¼ hours for an ambulance to arrive.

**Response:-** Healthwatch will feed this back to the Ambulance service for comment.

**Issue:- GP Services** - A patient told the table about having blood tests undertaken by their GP and the hospital contacting the GP to advise that the patient required urgent medical treatment and was to attend the hospital immediately. There was a delay in the GP contacting the patient but eventually this contact was made and the patient went straight to A & E. On arrival no note regarding the patient's situation was highlighted on their hospital record when their name was put into the system.

GP did not follow up with patient to ensure that they had attended for treatment.

**Response:-** Communication between GP and hospital departments and with patients, family, carers and friends (where there is no family). The hospital will always have difficulties when friends or voluntary carers want information about a patient because they do not have a right to the information and hospital staff do not know if the patient would like them to have information about their condition. It would be a breach of confidentiality for the hospital to give out personal information to anyone who states they are a carer or friend of the patient.

Healthwatch will follow this up by looking into the process that should be followed in these circumstances.

**Response:-** Healthwatch could introduce a **'Do you know'** section on the website:
For example, "Do you know" - if you are registered with a GP practice in England, you will have a Summary Care Record (SCR) unless you have chosen not to have one. Your SCR contains the following basic information:

- the medicines you are taking
- your allergies
- bad reactions you may have to certain medicines

It also includes your name, address, date of birth and unique NHS Number which helps to identify you correctly. An SCR is used in a number of healthcare settings and will provide healthcare professionals with any information they wouldn't otherwise have. For example, when you're visiting an urgent care centre or being admitted to a hospital, staff could view your SCR and discover you are on a particular medication or have allergies.

## Table 2 - North East Ambulance Service

**Mark Johns, NEAS Engagement Manager and Nicola Winship, Healthwatch Gateshead**

Areas of North East Ambulance Service work discussed:

- Emergency and Urgent Care
- Patient Transport Service - PTS and
- 111 (non emergency)

**Issue:** I can no longer book an ambulance to take me for my hearing test at hospital.

**Response:** Eligibility criteria has been introduced to try and eliminate abuse of the system. Member of public was encouraged to try and book again and at each appointment as may now meet criteria. Telephone number to ring to book Patient Transport Service is 0191 3017687. Criteria is based on age/mobility/disability.

**Issue:** If I'm going to hospital in an emergency ambulance I am unable to take my wheelchair along with me and therefore I have no independence during my hospital stay.

**Response:** NEAS is aware of this issue however emergency vehicles are not equipped for this and NEAS are currently not commissioned to do this however they are holding an event on 15 November at John Buddle House to discuss this issue, ideas include using accessible taxis to take wheelchairs to and from hospital.

**Issue: (Historic):-** I had an accident on the metro escalator and was in a great deal of pain. I waited 2 ½ hours for an ambulance despite numerous phone calls being made. My shoulder was dislocated. On arrival at Accident and Emergency there were further delays which combined with the delays from NEAS had an impact on my treatment and subsequent recovery.

**Response:** Discussed historic issues due to staff shortages. NEAS has undergone a big recruitment campaign and has recruited more paramedics to fill these gaps. Also discussed triage and that paramedics must attend life or death situations (red calls) first and this is why the triage call is so important. Delays in ambulance wait times can sometimes be out of NEAS control due to lengthy delays with handovers at hospitals.

**Issue: (Historic) Staff Attitudes:**

1. Don't pre-judge. Had a bad experience with the Patient Transport Service (PTS). Recently recovering from a stroke and so was unable to drive. Ambulance driver was judgemental when collecting the patient as there was a car on the drive and asked her if she really required the ambulance. Although she looked healthy she was not and was unable to drive – don't pre-judge.

2. Having a serious asthma attack. GP visited and called an ambulance. After a long wait an ambulance arrived however it wasn't an emergency ambulance as the call had been incorrectly triaged. In praise of the NEAS driver however, he assessed the seriousness of

the situation and decided not to wait for another ambulance as he had oxygen on his vehicle already and took her straight to hospital.

**Response:** Agreed that staff shouldn't pre-judge and confirmed that NEAS staff do receive regular and appropriate training. With regards to the second issue, again, this was an historic issue regarding delays but once again reinforced the issue of getting the triage right so that the correct ambulance is sent in each situation.

**Issue:** Residents living close to the Queen Elizabeth hospital advised that staff parking is affecting access for ambulances.

**Response:** This matter should be directed to the Queen Elizabeth hospital and addressed with staff.

**General comments:**

- Used emergency ambulance service recently. Very quick response and excellent service.
- Paramedics – excellent and calming manner, they fully take control of the situation.
- NEAS has recently introduced a text service for Patient Transport Service (PTS), however this has not yet been rolled out to include dialysis transport.
- NEAS staff are fully trained to be dementia friendly and will explore working with Alzheimer's society too.
- Problems with access to Metro Centre as sometimes paramedics are directed to the wrong access door.

*Successful event and well organised. Thanks for the invitation, we were really happy to be part of it. I'm happy to explore how we can work together better in the future.* **Mark Johns, North East Ambulance Service.**

## Table 3 - Healthwatch Gateshead Volunteer Proposition

**Karen Bunston, Healthwatch. Christina Massey and Freda Bevan, Healthwatch Volunteers**
Key themes for discussion and information sharing on Healthwatch Gateshead table included:

- The Enter and View process, the role of Authorised Representatives and how people can get involved.
- Mystery Shopping projects and opportunities for people to volunteer as Mystery Shoppers
- The role of Community Ambassadors and how we ensure this is as inclusive as possible and covers the whole of the Borough.
- Healthwatch volunteers shared their experiences with participants.
- Opportunities for collaboration with local voluntary and community groups and organisations.
- How to broaden Healthwatch's appeal to all members of the local community.

Participant's feedback:

- People generally agreed that the volunteer role descriptions were comprehensive and clearly defined the role, expectations and benefits to the volunteer.
- The "critical friend" approach to Enter and View adopted by Healthwatch Gateshead was considered to be the most appropriate way of achieving service improvement.
- The volunteering opportunities were of good quality and likely to have broad appeal although it was acknowledged that involving men in volunteering was still a challenge.
- Recognition that Healthwatch Gateshead is committed to inclusivity of opportunities by meeting additional support needs wherever possible and through training, support and re-imbursement of expenses.
- The Enter and View reports were positively received.


- Participants heard from our volunteers about their positive experiences of Enter and View visits and Mystery Shopping.
- There is an opportunity to develop a mystery shop in collaboration with Action on Hearing Loss specifically around NHS England Accessible Information Standard.
- Arthritis Care are also keen to link up with Healthwatch and have extended an invitation to attend one of their sessions which are held at the Civic Centre (first Monday of each month, 60-80 people attend), include information in their newsletter and potentially put a Healthwatch widget on their website.

## Table 4 - Adult Social Care

Clare Ault, Service Manager / Care, Wellbeing and Learning/ Adult Social Care Assessment and Planning/ Gateshead Council

Kim Newton, Healthwatch

The following issues and questions about Adult Social Care were raised and responded to at the Adult Social Care table:

**Issue: -** What is the current structure within Gateshead Council?
Discussion took place around the recent changes in Adult Social Care staffing in Gateshead and Clare Ault gave a brief explanation of the new structure.

**Response: -** Sheila Lock is the Interim Strategic Director Care, Wellbeing and Learning
Stephanie Downey is the Service Director Adult Social Care and Independent Living
Clare Ault is the Service Manager and Principal Social Worker for Care, Wellbeing and Learning, responsible for Adult Social Care Assessment and Planning, Safeguarding Adults Team and the MASH (Multi-Agency Safeguarding Hub).

**Issue: -** What is the future for Blaydon Lodge and Marquis Way Bungalow? This was identified for closure in the Social Care review last year?

**Response: -** This is a service for complex and severe needs. No decision has been made yet. Clare Ault will speak with the appropriate Service Manager to provide carers with a more comprehensive update.

**Issue: -** How can I get help to put on compression stockings? I have been told by my GP that the district nurse can't do this for me.

**Response: -** This is a health need and it really ought to be health professionals who help you to do this task. If you also have social care needs then you will need to receive a care act assessment. Clare explained the Care Act eligibility criteria.
In the future health and social care will integrate and this brings opportunities for pooled money to make accessing services easier.

Clare spoke with person asking the question in private and agreed to follow up actions to help solve the problem.

**Issue: -** Is there a budget to help with extra costs for someone living in their own home with complex behaviour needs?

**Response: -** There is a Transforming Health Care budget available to meet extra costs that may occur, where people have left or are leaving long stay hospital placements relates to complex behaviours/mental health needs. Social Care or health colleagues apply for this budget if a person

is eligible to access it.  For other people with complex behaviour needs that are eligible for health and or social care services these needs will be met from those budgets.

**Other Comments**

Social Care Services
Of those people who currently use social care services it was noted that these were generally good or very good and current care packages are meeting the needs of people and their carers.

Social Care Pathway
The Social Care Pathway was discussed at length.
The following points were raised regarding the process of accessing social care reviews and assessments:

- There is no continuity of social workers
- My social worker went on long term sick and my case was not picked up
- There needs to be a clear pathway for people trying to access social care services
- There is delay in getting back to people
- I have had to chase up my carers assessment
- I feel let down as a Carer
- You have to fight to have your loved ones needs met
- No one returned my call

**Response and Actions**

It was acknowledged that there should be consistency at the “front door” for people accessing services.

Adult Social Care phone-lines are often the first point of contact for people requiring social care support and therefore need to be triaged correctly to ensure they are navigated correctly.

Phone calls and follow-ups should always be actioned as agreed with people accessing the service.

Clare and her colleague Jean Kielty are currently looking at standards and processes within and across the service and will implement any changes required.

Healthwatch Gateshead could offer support in a volunteer led mystery shopping exercise on the quality of the front door triage phone system.

## Table 5 - Newcastle/Gateshead Clinical Commissioning Group

**Victoria Clark, Healthwatch and Norah Stevens, CCG Gateshead Engagement Lead**

Continuing Healthcare (CHC) process and criteria was brought up several times for both adults and children. The process and criteria for CHC is very complicated for family members and lay members to understand. Members of the public don't know what is available or where to get the information from.


**Issue: -** CHC process for children is awful. We got eligibility of care criteria given and nothing else. The forms must be completed on the child or persons worse day – its heart breaking.
Why don't social workers and clinicians tell you about everything that is available when you are in that position i.e. CHC etc?

**Response: -** The Local Authority is responsible for carrying out assessments for Continuing Healthcare. If this isn't done by the Local Authority then Continuing Health Care cannot be awarded or considered.

**Issue:** Why can't the CHC forms be simplified and social workers use "our language" not jargon. Why do people use scary words like court of protection, deprivation of liberties, best interest's assessor etc. The forms are not appropriate. They are designed for older or almost dead people.

**Response: -** It is very difficult to have 1 form that fits all and it is not always appropriate. Efforts have been made previously to simply form as much as possible.

**Issue:** Members of the public don't know where to go to get information from re: carers, DOLS, Continuing Healthcare etc.

**Response: -** Social workers should give you information. There is also a wealth of information from Healthwatch, your GP or health practitioner, PALS, Local Authority, Advocacy services and various voluntary organisations, for example Carers Association and Crossroads.

**Issue: -** Our care plan now is not relevant to our needs and when we do get a care plan, we only get 2/3rds of actual care. Care plans are great on paper – if you get one. However, care plans actions are not actually happening.

**Response: -** You should receive all the care detailed in your plan. If you are not getting this it needs to be addressed with your social worker.

**Issue: -** What about when your social worker says there is nothing available? That there is no provider for the care needed? If the social worker says there is no provider available, we then get nothing. If the social worker can't find a provider then how can I? We have to struggle on, or leave family members in hospital when there's nothing medically wrong with them.
**Response:-** This is a local authority issue and should be taken up with Adult Social Care.

**Other comments and suggestions**

We are tired - we also have jobs to go to. When I was younger and caring for my disabled child(ren) it wasn't so much of a problem. Now I am older, I am tired, I have my own health problems, I have less energy, and I also have my elderly parents to look after. When I was younger my parents helped me care for my disabled child(ren), now they can't because they are old so I care for those as well. Yet my child(ren) son(s) needs have increased because of his age / condition / lack of social care.

Why is there not 1 person overseeing someone's care? – This includes children hence the confusion and difficulty around appointments, care and the family as a whole.

Social workers always cancel and re-arrange meetings at short notice, this is not always convenient for us but what can we do? We have to do what social worker says and when the social worker is available because if we don't, we get even less than we have now.

I worry if I have to go into hospital or have an accident that will look after my child (ren) then? Who will look after my elderly parents?

Continuing Health Care for children is allowed in their own home, yet it's not for adults. For adults it's got to be in a care home. Why is this? There's no consistency.

My kids have had no assessment from health. There is no defined process for children continuing healthcare needs.

I had the courage to complain about a particular service, then it was withdrawn with zero notice yet I know service provider is still providing this service to other families.

You've got to be practically dead or nearly dying in order to get CHC.

Gateshead Access Panel helped me get my CHC. It took me 5 years and had to try 3 times. It's a very complex system.

I didn't even know you could get CHC for children.

Services for those with severe learning disabilities and complex needs i.e. The Grove, are excellent and have had a budget reprieve but we have had to fight for everything.
Once Chris Pearcy came to Marquis Way and saw how the service actually worked he understood more.

Advocates do a fantastic job.

Finding out all of this information, the forms, the stress, the appointments, the inconsistencies are all just too much when you are a carer.

My advocate came to my home and explained the form and it was great.

The changes in continuing healthcare over the last 6 or 7 years are unrecognisable.
Continuing healthcare is moving (if not already moved) to palliative and end of life care – it's not continuing healthcare.
Continuing Healthcare is basically 24-7 nursing care.
Understanding the system is just too stressful.

Carers are at breaking point. It is a real fear that carers have – re: managing when you are older and are tired and have your own health problems.
If things are bad now – what is it going to be like in 10 or 20 years time?

As carers we have a real fear about the future.

## Table 6 - Health Champions


Discussions began with a positioning statement around the origin of Health Champions and also what social prescribing is. Health Champions are volunteers who have an interest in health and social work within their GP practice to support patients with, information or access, to other activities which may support recovery in their health and well being.

The role of a Health Champion is all about the skills and abilities. It is part of the NHS 5 year Forward View which focuses on social prescribing. The role bridges the gap between the individual and actual setting up of social, community and activity groups. For example - a walking group established at a GP practice which runs regularly and gives patients some regular exercise – it also assists with social isolation and improves the well being of attendees.

Social prescribing is now going to have some funding released nationally as it is recognised that 20% or more of GP appointments are social care issues for which a medical prescription will not help. The ability of GP's to refer to a Health Champion frees up their time and supports the patient to access something which may be of more intrinsic value.

While resources are stretched, now is time where more creative responses to health and social care needs are required.

In Gateshead, 12 Practices are involved with Health Champions and Social Prescribing. 3 have been so for more than 3 years. 8 practices involved of up to 3 years and 1 practice is just starting. The benefits to the GP practices are measured in less repeat appointments.

The main questions were as follows:-

**What can a Health Champion do for me?**

The idea is that they will be able to help a patient access information and link in with local organisations to help address some of the patients needs without necessarily needing a GP referral. This may also mean working with Wellness Coaches too.
Health Champions would provide some guidance around lifestyle and accessing meaningful engagement in the community which can result in reduced loneliness, depression etc. This may be art based or something practical like gardening and walking groups or maybe a knit/natter group.

**Does this mean I would never see my GP?**
No, you can obviously see your GP when you have a medical need.
You may see other health professionals within your GP practice, like a Nurse, who can assist you without needing a GP appointment. It is more likely to be part of a holistic package treating you as a whole person rather than one bit of your body.
You may see your GP first as part of your diagnosis and then be passed to a Health Champion for further input with a review later. It is all about patient choice and what works for you.

**You mentioned a number of GP Practices in Gateshead have Health Champions – why not all?**
The Clinical Commissioning Group are working hard to get all Practices on board though it is a voluntary option at the moment. It has national support from NHS England and once benefits are demonstrated more support will follow. It is a new way of looking at solutions creatively and takes time to embed.

Other comments:-

This is open to everyone and it is about how we make residents of Gateshead's health better in more innovative ways. It is recognised that there are many areas of life that affect us – for example where the loss of a social security benefit can be detrimental to mental health. The loss of a job may result in both physical activity dropping and low self esteem and general well being – whilst a Health Champion will not be the total solution, they will be part of it in getting people back on the track to wellness.

There are also the benefits of volunteering your time as a Health Champion though it is acknowledged that the general public do not have much knowledge yet of this role. How do we get the message to people who don't go to the doctors?

## Table 7 - Public Health


**Catherine Wood and Janet Gauld, Healthwatch Board Member.**

The Public Health agenda is very broad, how and what we eat, drink and live our lives impacts on all of our health. Public Health is therefore focussed on prevention and supporting the public to understand how they need to consider these health issues.

The Gateshead plan is about 'Living Well in Gateshead', investment is in prevention and trying to prevent ill health. We need to balance treatment and prevention and work closely with others. Public Health looks at the evidence base of health factors and inequalities.

Public Health's challenge is the treatment and care of people and how to prioritise prevention.

**Issue - Smoking cessation** is the biggest thing to save lives and save money in health. Cigarette and tobacco packaging needed changing. Public Health England worked on packaging. Government interested in tax from funding. Show less smoking on TV.

**Response: -** 7 steps campaign launched to help prevent passive smoking health conditions. Stoptober is a national smoking cessation campaign with celebrity endorsements. No TV advertising for smoking products anymore. Legislation is now in place re: smoking in cars with children and smoking in public places. There has been an impact of this on cafe culture. Smoke free hospitals were only introduced last March. Contracts now in place with GP's on smoking cessation.

**Issue – Alcohol**. Young people turn up at hospital with severe liver disease due to the price of strong, cheap alcohol. Retired people drink at home now. People who are working drink more due to stress. Are people drinking more because they are not in jobs, poor mental and physical health? Is this a vicious circle? It's cheap or cheaper to drink at home and easier for people to drink to cheer themselves up and block out stress. The units of alcohol in a bottle of wine for example clearly indicate what the recommended intake is. If you drink everyday you would be alcohol dependent it has no link to DNA.

Lots of things impact on alcoholism and drinking too much. People need educating rather than attacking the price - it's both - to enable people to make choices.

Alcohol is calorie laden and therefore impacts on obesity as well. Biggest issue in the North East is the viability of pubs and the social issue of alcohol acceptance.

A large number of pubs are closing down. Focus nowadays is on young people getting drunk. New demographics shows people are drinking more due to having a disposable income and drinking on a Sunday afternoon. Recent study also found some people only had one drink a week.

**Response: -** Public Health try to prevent underage drinking by working with shops and providing support and education to reduce alcohol intake. There is a heavy drinking reputation / culture in the North East. It has been found to be a big problem by the Befriending Service. Public Health's job is to recognise it has become a way of life and to address it. There is a clear public health link in with liver damage.

**Issue - Access to Services** is very tech heavy nowadays. The onus is on the service user to get it right rather than staff who work there, what if you are not confident with technology? Make a mistake? How do deaf people access services? Elderly will not use technology generally, so don't know what support exists. Everything suggests telephoning e.g. booking an appointment. If you have no communication support then you cannot access telephone. Deaf and hearing impaired community have to use websites, this is not always clear.

**Response: -** Public Health has to take into account the diverse needs of the population and support accessibility in whatever format it takes.

**Issue - Obesity** and being overweight is a big problem for public health. 66,000 residents in Gateshead are overweight – that's a significant part of the population. This is based on the Body Mass Index (BMI) calculation. It is different for some ethnic citizens though – Asian ethnicity is different, so waist size is used as a measure.
NHS Health Check – people between 40 yrs and 74 yrs, height, weight, blood sugar and cholesterol checked and asked questions about their alcohol levels.

**Response:-** Whilst Public Health is there to support people with prevention there is a joint partnership because people need to take responsibility for their own lives too. They also need awareness of what is in the food they buy and consume so they are able to make informed choices.

**Other comments and suggestions**

- How do we educate adults as well as children?
- How can we positively promote how to look after yourself and have fun instead of going to the gym?
- People become more dependent on the state and can't stand up for themselves.
- Cooking on a budget needs to be addressed as it's easy to make the wrong choices.
- Children don't know how to use a knife and fork these days.
- A test was carried out of a takeaway with a university and one meal equals to one week of saturated fat.
- People don't know what they are eating.
- Fast food is cheap and has big portions so we need to help people learn cooking skills and how to cook on a budget.
- Gateshead High Street dinner club for the homeless feed 9 people on a budget of £7.00, for example spaghetti bolognaise.
- It is difficult for people to buy the right things when they are on low incomes.
- Promote food courses to help people access and develop cooking skills.
- How do we get cooking back into life skills?
- Initiatives have worked for example, OAP swimming was free
- Gateshead Active card is only £1.80
- Should people get things for free?
- People need to take more control over their lives
- Live Well Gateshead
- Public Health funds fluoride in water. Why put fluoride in as it doesn't do anything for teeth and causes cancer? Does the local authority feed into research or is it national research. We have no say in what you drink and people should know what they are drinking. Why do dentists say not to swallow it? It is the other chemicals it contains.
- I'm glad Public Health has moved away from the NHS as the NHS is all medicine and pills
- How do we get information to people in a simple format so that they can take responsibility for access and support?
- I feel affluent areas are kept tidier than non affluent areas. I don't feel like GMBC are doing anything about it.
- Causes – rat infestation for example impacts on health.
- Impact of fortnightly bin collections. Disability based need, was told to pay £30.00 for an additional bin if incontinent and need more.
- How many people are becoming ill through prescribed medicines? Killing people with pills where there is no evidence of its impact.

## Table 8- Northumberland Tyne and Wear Trust (NTW)

**Janet Thomson, NTW Service Manager for Community Services in Gateshead and Michael Glickman, Healthwatch Board member.**

The public who engaged with The Trust were very specific in their comments and a summary of their main points are raised as follows:-

- Isolation of people with hearing loss, unable to access services and more prone to social isolation
- Use of jargon and acronyms is confusing i.e. NTW, CCG etc.

- It is difficult to navigate through mental health services without prior knowledge
- Communication breakdowns between service users and providers and poor communication between organisations i.e. Voluntary organisations and NHS services for example.
- Works both ways because not all NHS services are aware of voluntary services
- Sunderland and South Tyneside has single point of contact for mental health but not Newcastle and Gateshead - GCCG
- Important that single point of contact is a Freephone number and callers are not put on hold
- Need to have long term follow up for mental health therapies to ensure that they have been effective. Returning patients should not be treated as new patients but referred to appropriate alternatives
- Need effective support and monitoring after treatment has concluded
- Some MH patients prefer to talk to non- professionals which is a strength of the VCS i.e. peer and mutual support groups.
- Difficulty accessing services
- Service changes make it difficult to identify correct point of contact particularly for low level needs
- Some GP's charge to complete risk assessments for mental health self referrals to Gateshead Clubhouse.
- Importance of looking after mental health of staff too
- No intention of changing services for Learning Disabled community until current services are evaluated but national requirement to review all long term residential residents with a view to community placements and ensuring services meet national standards.
- Trying to streamline assessments by joint appointments with Drs and Nurses.
- Reminders before appointments to promote attendance.
- Target 3 -4 weeks for initial appointment. It is currently 10 weeks. This is down from 18 weeks (national target)
- Saturday clinics are popular and may extend.

**Response:-** The Trust has promised to consider these points and build them into future developments.

# 6. What Next?

The comments, issues and experiences expressed in this report will be shared with the appropriate person from the organisation who attended the event.

The report will also be raised at a strategic level which will include the Gateshead Health and Wellbeing Board, Gateshead Care, Health and Wellbeing Overview and Scrutiny Committee, Newcastle and Gateshead Clinical Commissioning Group meetings. This will ensure we meet our obligation as a critical friend and we will hold the necessary bodies to account to support the improvement in health and social care services across Gateshead.

Healthwatch Gateshead expects to revisit this report in 6 months time to receive updates on the agreed actions and progress.  We will then report the results through our social media, extensively in our work plans and other appropriate media.

The contents of this report will be shared with Healthwatch peers across neighbouring authorities.

The report will be available on Healthwatch Gateshead's website from 16 December 2016 and may also be presented to the following organisations as appropriate for information:

Healthwatch England
Care Quality Commission
NHS England
Gateshead Council - Commissioners

# 7. Thank You

Healthwatch Gateshead Board and Team would like to thank:-

Everyone who attended the event whether as a member of the public, stakeholder or key representative, in particular:-

Healthwatch Gateshead Volunteers, **Freda Bevan** and **Christina Massey.**

Engagement Lead at Newcastle/Gateshead NHS Clinical Commissioning Group, **Norah Stevens.**

Gateshead Council Public Health Lead for Health Improvement, **Catherine Scott.**

**Janet Thomson**, Service Manager for Community Services in Gateshead of Northumberland Tyne and Wear Trust (NTW).

**Clare Ault,** Service Manager for Adult Social Care Assessment and Planning at Gateshead Council.

**Mark Johns** the North East Ambulance Trusts Engagement Manager.

The Health Champion Lead for Newcastle Gateshead Clinical Commissioning Group (CCG), **Steven Bramwell.**

Gateshead Foundation Trust – Queen Elizabeth Hospital, **Joanne Stout** QE Clinical Lead Safecare and **Judith Portlock,** PALS Manager.

And finally, Gateshead Council Bewicks **Catering Staff** for the splendid afternoon tea and service.

# Appendix 1 – Evaluation breakdown

Attendees were asked to complete a short evaluation form on their experience of the event.

| | | |
|---|---|---|
| **Did you think there was ample time to discuss your issues and concerns?** | | |
| Too much time<br>0 | Just right<br>19 | Too little time<br>8 |
| | | |
| **Did you feel listened to throughout the event?** | | |
| Yes<br>31 | No<br>1 | Don't know<br>4 |
| | | |
| **Did you think the correct people /decision makers were in the room** | | |
| Yes<br>28 | No<br>3 | Don't know<br>5 |
| | | |
| **How would you rate the event overall?** | | |
| Excellent<br>10 | Good<br>14 | Average<br>2 |

**Attendees were asked if they had any messages to convey to Healthwatch Board.**

- Keep up the good work x 3
- Thank you for being there
- Excellent event
- Should be held more often, yearly is too long
- Thank you for inviting me. I look forward to final report
- Please include children's services
- More dissemination of information – how, where to get the help and let people know what's going on i.e. health champions.

**Complimentary comments were received on the event, format, timings and refreshments.**

- Very helpful and informative
- Very good mix of people with different issues and no one talked too much
- Excellent, not too formal and a good length of time
- Interesting and informative, friendly and service users input was encouraged

**We also sought comments from attendees to help us improve future events.**

- Larger room needed x 5
- More time to talk about services and go to more tables
- Have more key people for the amount of people attending
- Get people to stand up when reporting back
- Disability awareness training to consider needs of hearing impaired.
- Display stands from other services x2
- Wider range of services present i.e. children's service
- More promotion to key groups i.e. Deaf community
- More time to discuss issues and use knowledge gained to problem solve
- More time needed to offer people advice

**Other comments included**

Very lively event with a wide cross section of people

Scones and tea were delicious

Good event that far more people would have benefitted from
First time I have attended.  I have enjoyed the topics of discussion.

For further information regarding this report contact: -

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