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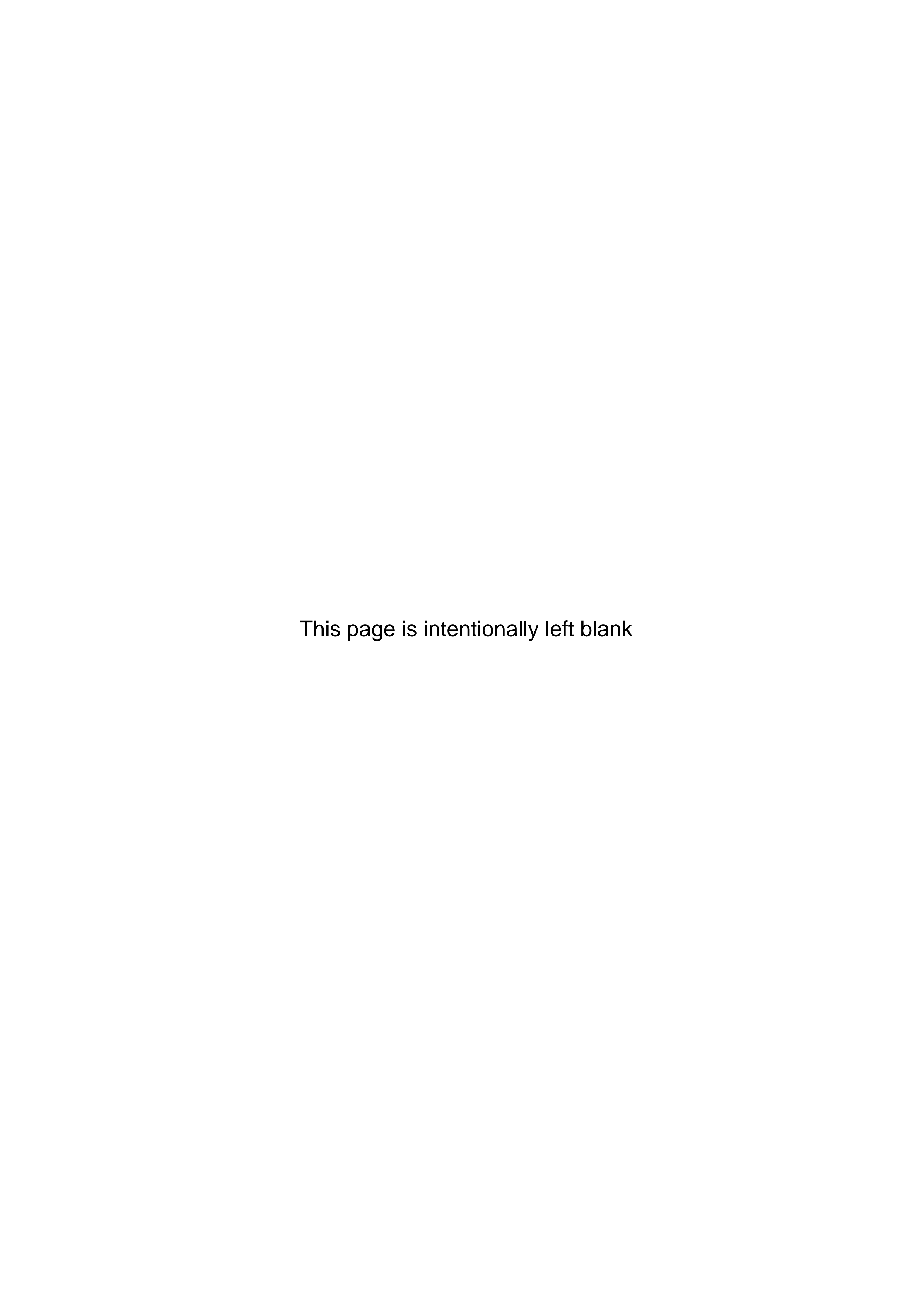
HEALTH AND WELLBEING BOARD AGENDA

Friday, 8 September 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 - 18) The minutes of the meeting held on 21 July and Action List are attached for approval.
3	**Declarations of Interest** Members of the Board to declare an interest in any particular agenda item.
	Items for Discussion
4	**Joint Strategic Needs Assessment Update** (Pages 19 - 36)
5	**Integrating Health & Care in Gateshead** (Pages 37 - 48)
6	**Better Care Fund 2017-2019 Submission** (Pages 49 - 108)
7	**Feedback from Joint Members Seminar** (Pages 109 - 116)
8	**Healthwatch Gateshead Annual Report 2016/17 & Priorities for 2017/18** (Pages 117 - 148)
	Items for Assurance
9	**Pharmacy Applications** (Pages 149 - 150)
10	**Updates from Board Members**
11	**A.O.B**

Contact: Sonia Stewart; email; soniastewart@gateshead.gov.uk, Tel: 0191 433 3045,
Date: Thursday, 31 August 2017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GATESHEAD METROPOLITAN BOROUGH COUNCIL

HEALTH AND WELLBEING BOARD MEETING

Friday, 21 July 2017

PRESENT Councillor Councillor Lynne Caffrey (Gateshead Council) (Chair)

Councillor Paul Foy	Gateshead Council
John Pratt	Tyne and Wear Fire Service
Councillor Ron Beadle	Gateshead Council
Councillor Malcolm Graham	Gateshead Council
Councillor Michael McNestry	Gateshead Council
Dr Mark Dornan	Newcastle Gateshead CCG
Dr Bill Westwood	Gateshead Federation of GP Practices
Sally Young	Gateshead Voluntary Sector
Steph Edusei	Gateshead HealthWatch

IN ATTENDANCE:

Alison Dunn	Gateshead Citizens Advice Bureau
Susan Watson	Gateshead NHS Foundation Trust
Matthew Liddle	Gateshead Council
Wendy Hodgson	Gateshead Healthwatch
Andy Graham	Gateshead Council

APOLOGIES: Councillor Mary Foy and Councillor Martin Gannon
Ian Renwick, Alice Wiseman, Sheena Ramsey and Sir Paul Ennals

HW147 MINUTES

RESOLVED - That the minutes of the meeting held on Friday 23 June be agreed as a correct record, subject to it being noted that Sir Paul Ennals was in attendance at the meeting but was not listed.

Matters Arising

The Board were advised that as per the suggestion from the previous meeting that the Homeless Health Needs Assessment was taken to the Board of the Gateshead Housing Company. The Gateshead Housing Company Board were keen to work with the Health and Wellbeing Board on progressing this work.

It was noted that the report was also taken to the Gateshead Care Partnership and the Mental Health Programme Board at which it was also well received.

HW148 ACTION LIST

It was noted that the Substance Misuse Strategy was approved by Council on 20 July.

Concern was expressed about the Deciding Together, Delivering Together work and the expectation of up to date figures on CAMHS Service waiting lists.

It was suggested that Chris Piercy be invited to bring an update to this Board in September / October.

The Chair advised that she would be speaking to NTW and South Tyneside FT regarding their non-attendance at the Board.

RESOLVED - That actions and updates since the last meeting be noted.

HW149 DECLARATIONS OF INTEREST

HW150 CONTRIBUTION OF THE VOLUNTARY AND COMMUNITY SECTOR TO IMPROVING HEALTH AND WELLBEING IN GATESHEAD

The Board received a presentation from Sally Young, who had been asked to report on the current contribution of the Voluntary and Community Sector (VCS) in Gateshead. There is a perception that the VCS is being asked more and more to complement existing services, and this raises some concerns about their capacity to provide this support.

The Board were advised that there are likely to be between 700-1000 groups, activities and organisations making up a complex VCS in Gateshead which employ between 3000-4000 people working alongside a number of volunteers. A further 500 charities are not based in Gateshead, but provide activities within the area. It is estimated that 34% of Gateshead residents volunteer. It was noted that the majority of VCS funding does not come from the public sector, for example, one charitable organisation with a turnover of £300,000 receives £10,000 from the LA. It is estimated that 7 out of 10 VCS organisations saw an increase in demand for services in the past year.

The Biggest Challenges highlighted include:

- The impact of welfare reform
- Increased poverty in communities
- Reduction in provision of statutory services
- Having to pay for things that were once free
- Lack of jobs / employment opportunities / sanctions

In terms of organisational challenges the following were highlighted:

- Funding
- Recruitment and retention of volunteers, especially in terms of volunteers being asked to take on additional work in areas they are not necessarily

familiar with
- Coping with increased costs
- Maintaining sustainability

The role of the VCS in improving health, wellbeing and care has developed enormously in the last twenty-five years. It has multiple roles, often dependent on the size and nature of the organisation; these include:

- As a service provider
- As a mechanism for bringing patients, users, and carers together e.g. support groups, peer experience
- As an advocate for individuals, groups and communities who are often excluded
- Through the use of volunteers to enhance services and experiences
- As a partner in decision-making
- As a source of information, knowledge and expertise on particular communities (e.g. contributor to the JSNA)
- As an improver of the physical environment
- As a campaigner for environmental and other improvements

However most of these activities require capacity and resources, whether it is goodwill, time, space, volunteers, finance etc. and there is a concern, that VCS organisations will be expected to substitute for paid public sector staff. The shift towards social prescribing is of increasing concern as resources seem to be invested into sign-posters / navigators/ directories indicating where services are, but not into the services themselves. A clear definition of social prescribing isn't available and leads to inconsistencies.

There have been some successful examples of asset transfers from the public sector to voluntary organisations, but these take time and a lot of resources. Initially public sector (mainly council) staff were able to invest time in these and provide support and a safety net, however the more recent transfers are not as sustainable.

Experience has demonstrated that what makes local organisations work well is the involvement and support of local people. This can take time, involve community development, be focussed on a need, and the end result has got to be what that community wants. The contractual cycle can sometimes conflict between what a commissioner wants to purchase and what an organisation believes is necessary for delivering to its community. Artificial structures parachuted in, that don't have local ownership or buy-in, are unlikely to work.

In 2010, the Government proposed the opening up of public sector contracts to the voluntary sector. These included major contracts on the Work Programme and the Criminal Justice system. In reality, the vast majority of these contracts are now delivered by private sector international companies e.g. Serco, A4E and G4S and the voluntary sector has had a few painful experiences as end providers. A number of medium-sized organisations do not feel able to bid for public sector contracts as these have become larger and often the requirements are onerous and disproportionate to the contract value. As public sector funding has shrunk further, a number of organisations (voluntary and private), are removing themselves from

social care provision. Very recently Lifeline, a major charity (£60million) providing drug and alcohol services (albeit not in Gateshead), went into receivership.

The amount of volunteering in Gateshead is much higher than the UK, with Gateshead Council reporting that *"34% of Gateshead residents regularly taking part in an activity".* There is clearly a strong base to build upon, and councillors and council officers are involved with and aware of the sector. Newcastle CVS has built up a good rapport with a number of voluntary and community organisations in Gateshead.

There have been major shifts in public sector organisations with more to come, and this has meant a loss of some partnerships, relationships and understanding of each other's challenges and difficulties. This could be the right time to forge a new relationship, refresh the Gateshead Compact (which is a statement of the relationships) and work together across the wider partnership to improve health and wellbeing in Gateshead.

In terms of Next Steps, Sally felt that there was a need to look at relationships between the Local Authority, the Voluntary Sector and other statutory partners to regain and rebuild the trust. It was also felt that there was a need to look at whether there was real investment in the voluntary sector and to look at what the sector can offer. It was also suggested that procurement processes be looked at to see if in some cases they can be simplified.

RESOLVED - (i) That the information in the presentation and report be noted.
(ii) That a half-day session be organised to look at and re-define relationships with the VCS, including the Gateshead Compact.

HW151 GATESHEAD HEALTH NEEDS ASSESSMENT - BLACK AND MINORITY ETHNIC POPULATION

The Board were advised that this report was brought to the Board for an update in June and a number of actions were set. It was always the intention to bring a final version to the Board as there was a need to access and analyse further relevant Primary Care data. This has now been completed thanks to data provided by the CCG.

The main issue from the Needs Assessment is that the prevalence of risk factors in Gateshead appear to be lower than the national figures. It is likely that the main reason for this is the younger age profile in BME populations, but it may also be access to or use of services by them, for instance, the low uptake of Stop Smoking Services. There also appears to be an issue with low recording of ethnicity in some GP practices.

The Needs Assessment has been restructured, adding an executive summary and in response to the need for a workable action plan, the recommendations have been reviewed to include lead bodies/organisations with responsibility for the recommendation.

The Board was asked to receive and endorse the Needs Assessment with a formal update from partner organisations on their progress in implementing the recommendations to be brought to the Board in three months time.

The following comments were made in relation to the report:

- Healthwatch Gateshead advised the Board that as they were now working across both Newcastle and Gateshead and they have a joint staff team they may be able to assist in reaching into / engaging further with BME Groups.
- It was suggested that language and translation may be an issue in terms of accessing services
- In terms of the BME carers, a prevalence of 1.1% is reported, but there was debate about this as figures from the Gateshead Carers Association would suggest this to be higher. It was agreed that this would be acknowledged in the final copy to be available on the JSNA.
- Also Gateshead Carers have a group from Eretria set up who could easily be accessed for information to feed into future work.
- The report was commended and it was felt that the recommendations go a long way to helping BME communities access services.
- It was noted that the CCG have acted on some of the points raised, however it was suggested that it would be useful to know how partners plan to achieve the recommendations.

RESOLVED - (i) That the BME Needs Assessment be endorsed.
(ii) That partner organisations represented on the Board provide a progress update on implementing the recommendations in 3 months.

HW152 HEALTH AND LIFESTYLE SURVEY 2016 FINDINGS

The Board received a presentation which provided feedback on a Health and Lifestyle Survey undertaken by the Council in 2016. The Council used its online Viewpoint Panel to undertake the survey. The survey was undertaken between 16 March and 30 April 2016 and 1 November – 18 December 2016. The reason behind undertaking the survey is that good health is important for happiness and a general feeling of well-being. A healthy population is in a better position to enjoy life, live longer, to be more productive and to contribute towards economic growth. The Council is responsible for providing public health services and this survey was designed to explore attitudes to making healthy lifestyle choices, future areas of health promotion and to identify inequalities in health.

In total over the two phases of the survey 881 people responded to the survey.

73% of respondents said they were in good or very good health with a further 20% who said their health was fair. 7% said they were in poor or very poor health. Although 73% said they were in good health, only 64% thought they were fit. Respondents who smoke do not get the recommended level of exercise or who have

excess weight are significantly less likely to feel fit than on average. The perception of fitness differs by gender with 41% of women saying they feel unfit, compare with 31% of men. It also appears, though not definitive that men may feel less fit as they grow older whereas women are the opposite and actually feel fitter they older they get.

Only 9% of respondents said they smoke regularly or occasionally. This is very low when compare with national smoking prevalence surveys and suggests that the Viewpoint Panel is biased toward non-smoking. 33% said they used to smoke but do not smoke at all now. Young people are more likely to smoke than older ones, with 12% of those aged under 35 currently smoking, compared to 3% of those aged 65 and over. There is also a significant 'social gradient' for smokers, with a gap of 11 percentage points between those living in the most and least deprived areas.

90% of respondents drink alcohol, but younger people under the age of 35 are significantly less likely to drink weekly or more often at just 32%, compared with 62% of those between the ages of 35 and 64 and 67% of those aged 65 or over. Men are significantly more likely to drink weekly or more often than women, and this is particularly the case for those aged 65+ with 82% of older men drinking that regularly compare with 47% of older women. There is a social gradient evident in those who drink weekly or more often with those in the 20% most deprived areas significantly less likely to do so (39%) than those in the 40% least deprived areas (70%).

Fruit and vegetables are a vital source of vitamins and minerals and should make up just over a third of the food we eat each day. Just under half (48%) of respondents are eating 5 a day. Indicatively, women aged 65 or over. 73% of older women have 5 a day which is significantly higher than any other aged and gender group. In comparison, only 44% of older men have 5 a day.

4 questions were asked about overall personal wellbeing. The questions asked were about satisfaction with life, happiness, anxiety and feelings of doing things that are worthwhile.

The headline results from these indicators are shown as follows:

Overall, how satisfied are you with your life nowadays?)	**49%** satisfied / dissatisfied **20%**
(Overall, how happy did you feel yesterday?)	**50%** happy / unhappy **23%**
(Overall, how anxious did you feel yesterday?)	**65%** not anxious / anxious **20%**
(Overall, to what extent do you feel the things you do in your life are worthwhile?)	**58%** worthwhile / not worthwhile **15%**

The final results have been reported to the Director of Public Health and the information will be used as evidence in Gateshead's Joint Strategic Needs Assessment which identifies key strategic priorities to improve the health and wellbeing of the population.

It was felt that the information provided was very useful, however, it was noted that

by their nature these types of surveys attract a particular section of the population. It was agreed that there needs to be some caution with the information provided, however, it was felt that overall it was a good indicator.

The Citizens Advice Bureau suggested it may be possible to run a version of this survey with their clients. There was also a discussion about using the survey on other subsets of the population, e.g. Ward Based.

RESOLVED - That the information in the presentation be noted.

HW153 A YEAR OF ACTION ON TOBACCO AND SMOKING: FIVE BY TWENTY FIVE

The Board received a report to seek their views on undertaking a “Year of Action” to highlight the harms arising from tobacco use, and what’s happening in Gateshead to counteract them.

The Annual Report of the Director of Public Health for 2015/16 focused on the harms and inequalities arising from tobacco use in Gateshead and recommended maintaining momentum on action to minimise these harms. In keeping with that recommendation, the Public Health team has outlined a “Year of Action” to highlight the harms arising from tobacco use, and what’s happening in Gateshead to counteract them.

The purpose of this Year of Action is to maintain and raise the profile of the impact of tobacco in Gateshead, and to galvanise action at all levels (ie. community, organisational, sector-specific) to combat harms.

The proposal is to undertake a series of monthly activities that would be used to generate press/media interest and provide a platform for the communication of key messages.

Key messages would include the impact on health and financial inequalities and harm reduction, encouraging people not to start smoking, protecting others from second-hand smoke, and promoting support for those wanting to stop smoking. The overall message is the desire to achieve a smoking rate in Gateshead of 5% by 2025 – “five by twenty five”.

Activity each month would be promoted through the production of press releases, short videos and other activity that would be made available through Gateshead Council’s social media and the Public Health Team’s “One You Gateshead” social media channels. Suggestions for these are included in Appendix 1.

The impact of the “Year of Action” would be determined by information gathered from social media sources (ie. unique views, shares, likes, retweets etc), by comments received, and by changes in access to/uptake of stop smoking services.

Some of the following ideas were highlighted from the calendar:

- Promotion of the Rebranded Stop Smoking Service

- Celebrating 10 Years of Smoke Free Public Buildings
- "Burning Injustice" tobacco poverty. Cost to social care and the NHS

It was suggested that there was a need to keep other organisations informed with this and supply resources where available in order for them to also be involved in the initiative. It was suggested that the fire service, the CCG, and CBC should be included as potential partners. It was noted that Paul Gray is the contact within Public Health.

RESOLVED - That it be noted that the Board fully supported the campaign.

HW154 BETTER CARE FUND FOLLOW UP REPORT TO QUARTER 4 RETURN

The Board received an update report on progress against the national conditions and metrics linked to the BCF. The report also set out the planned steps towards progressing these areas of work.

National Condition 4 (ii) – Are you pursuing Open APIs (ie systems that speak to each other)

The long term next steps are in the further development of the Great North Care Record. This is being developed at a regional level with significant input from health and social care organisations from Newcastle and Gateshead. It is anticipated that we will soon be able to make use of open APIs from Primary Care clinical systems as part of the national GP Connect Programme. Health and Social Care Network connectivity is being explored and an initial fact finding meeting has taken place, led by the Council's ICT services. This is as a result of the proposed co-location of the 0-19 public health nursing service and the Council's children's services.

National Condition 4 (iv) – Have you ensured that people have clarity about how data about them is uses, who may have access and how they can exercise their legal rights.

This is an ongoing piece of work which will need to be a regular feature of communications to the people of Newcastle Gateshead. We are currently seeking case studies to help us explain messages about data and technology in ways which are relevant to our populations and professionals.

The next step is to develop a clearer plan in relation to communications which will happen at a local level to complement communications from the regional Great North Care Record level.

National Condition 6 – Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans.

As a Care Home Vanguard Programme, we are currently identifying what developments will be completed and what will be progressed further at the end of the Vanguard period. In particular, we are focusing on taking the learning from providing enhanced care to older people living with family in care homes to their own

homes. This already involves much of our BCF initiatives and will continue to be improved upon wherever necessary.

National Condition 7 – Agreement to invest in NHS commissioned out-of-hospital services.

As with the frailty developments identified, this will involve many of our BCF initiatives and will continue to be improved upon whenever necessary. This includes a whole system integrated approach that ensures the voluntary care sector is also appropriately involved.

The quarter 4 BCF return either reported 'no improvement in performance' or 'on track for improved performance, but not to meet full target for the following metrics:

Estimated diagnosis rate for people with dementia

It is understood from a clinical audit completed as part of the Care Home Vanguard Programme that around 7% of care home residents are likely to have dementia but are not yet formally diagnosed. As a result, a bespoke diagnosis pathway has been developed in order to address this.

Delayed Transfer of Care (DTOC)

Work has been undertaken between the Council and the Trust to ensure that there is a coordinated and agreed approach to DTOC (as analysis identified that there had been some changes to recording, which had not been agreed across the system).

The CCG, LA and Trust worked together during the winter period to develop a different approach to facilitating home care packages from hospital. This was piloted as the "bridging service", and is in the process of being evaluated. The high level feedback, however, was positive and we are looking to develop a longer term model, through the improved Better Care Fund.

Patient/Service User Experience metric

In 2017, NG CCG in partnership with their key stakeholders have developed a Long Term Condition Strategy which seeks to improve care delivery and self-management of LTCs right across disease progression from diagnosis to end of life, including a specific focus on frailty.

Reablement

Going forward, where there is a requirement to provide urgent support (eg to support discharge from hospital or end of life care) and only the reablement service can provide this, we will look to make sure that such referrals are not recorded as reablement, as they are not truly reflective of the service and therefore should not be counted as such. From the analysis of those people who were admitted to reablement in order to prevent a hospital admission but subsequently deteriorated and were then admitted to hospital, we will ensure that the lessons learned from the analysis are developed into an action plan. Within any changes, we need to balance

our approach in order to prevent a situation occurring whereby the system becomes risk averse and does not accept referrals from those people with higher level needs.

The Board were advised that in September there will be the new re-iteration of the plan which the Board will have an opportunity to comment on.

RESOLVED - that the information contained within the report be noted.

HW155 UPDATES FROM BOARD MEMBERS

Newcastle Gateshead CCG

The Board were advised that the assurance ratings for CCGs were to be published, this was going to be done in a very low key way. However, Newcastle Gateshead CCG were to be listed as requiring improvement in their finances.

It was suggested that the Board expressed its concern that the CCG has to return a given percentage back to the centre. Whilst it is appreciated that this is a national process, it is bound to have an effect on the morale of people working in the services.

Healthwatch Gateshead

The Board were advised that Wendy Hodgson has been appointed as the Operations Manager for Healthwatch Gateshead.

Item 2b

GATESHEAD HEALTH AND WELLBEING BOARD
ACTION LIST

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Matters Arising from HWB meeting on 21st July 2017			
Action List	Update on CAHMS waiting list and plans to address this to be brought to the Board in October.	Chris Piercy	To feed into the Board's Forward Plan
Contribution of the VCS to Improving Health & Wellbeing in Gateshead	That a half-day session be organised to look at and re-define relationships with the VCS, including the Gateshead Compact	Partner organisations / VCS	Ongoing
BME Needs Assessment	That partner organisations represented on the Board provide a progress update on implementing the recommendations in 3 months.	All partner organisations	To feed into the Board's Forward Plan
Matters Arising from HWB meeting on 23rd June 2017			
Gateshead Health & Care Workforce: Challenges and Opportunities	A report to be brought to a future Board meeting on an Organisation Development plan currently being developed for the local health and care system. Workforce agenda to be a regular agenda item for future Board	Jackie Cairns All	To feed into the Board's Forward Plan

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
	meetings. This should include contributions to regional work through the Local Workforce Action Board/Group.		
Gateshead Homelessness and Multiple and Complex Needs: Health Needs Assessment	That the findings and recommendations arising from the health needs assessment be rolled out across the local health and care system and that a workshop is held in the Autumn to progress this work. The report's findings should be presented to The Gateshead Housing Company. The findings of the report to be brought to the attention of central government. An update to be given to the Board within the next six months on progress in implementing key recommendations within the document.	All	To feed into the Board's Forward Plan. Council leadership session on the report has been organised. Arrangements are being made to present the report to The Gateshead Housing Company
0 to 19 Service Remodelling and Procurement	Any comments to be forwarded to Lynn Wilson prior to consideration by Cabinet on 18th July.	All	**Completed**
Better Care Fund Quarter 4 return 2016/17	To be covered under matters arising at the 21st July Board meeting.	John Costello and Hilary Bellwood	**Completed**

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Matters Arising from HWB meeting on 28th April 2017			
Neighbourhoods & Communities Model	Comments of the Health and Wellbeing Board to be noted as part of the overall feedback received and the model altered accordingly.	Julie Ross	**Completed**
Childhood Obesity: Year 6 Data Update	That a report be received at the June Board meeting outlining a potential future model for delivery of 0 to 19 public health services.	Alice Wiseman	**Completed**
Final Gateshead Substance Misuse Strategy & Action Plan	That future reports be received by the Board so that it can scrutinise and provide challenge against progress made.	Joy Evans/Alice Wiseman	To feed into the Board's Forward Plan
Deciding Together, Delivering Together: Update	That further updates be brought to the Board as they become available. That a report on CAMHS waiting times for Gateshead residents be brought to a future Board meeting.	Julie Ross/Ian Renwick NHS Newcastle Gateshead CCG	To feed into the Board's Forward Plan
Matters Arising from HWB meeting on 3rd March 2017			
Updates from Board Members	Consider findings of VCS study 'Doing Good in Gateshead'	Sally Young & VCS colleagues	**Completed**

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
	at a future Board meeting.		
Health Protection Assurance report	Bring back a report to the Board regarding Excess Winter Deaths.	Gerald Tompkins	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	**Completed**
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	**Completed**
BME Needs Assessment	An analysis of primary care data to be undertaken to investigate important risk profiles for this population. An action plan to be developed to propose solutions to ensure BME communities receive important messages regarding access to appropriate services. The action plan to be implemented in	All	**Completed**

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
	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.	Director of Commissioning & Quality Assurance	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	On the agenda of the 8th September Board Meeting
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	A further report to be brought back to the	Sally Young	A report on the contribution of the

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Partnerships and Investment in VCS in Health & Care Sector	Board in three to six months' time.		VCS to improving health and wellbeing in Gateshead was considered at the 21st July Board meeting
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

Item 4

HEALTH AND WELLBEING BOARD
8 September 2017

TITLE OF REPORT: **Gateshead Joint Strategic Needs Assessment (JSNA) Update/ Refresh**

Purpose of the Report

1. To update Gateshead's Health and Wellbeing Board (HWB) on progress made against areas of action identified in the Gateshead Joint Strategic Needs Assessment (JSNA) paper to the HWB in September 2016. This includes potential areas for development identified by Board members at the meeting.

2. The paper also seeks the views of the Board on priority areas for the coming year.

Background

3. Guidance[1], developed as a result of the Health and Social Care Act (2012), highlighted the 'equal and joint' duty of the Clinical Commissioning Group (CCG) and Local Authorities in preparing the JSNA. The guidance also endorses the JSNA's key role in informing joint health and wellbeing strategies, to be developed by Health and Wellbeing Boards.

4. The Joint Strategic Needs Assessment (JSNA) is the process through which local authorities, the NHS, service users and the community and voluntary sector research and agree a comprehensive picture of health and wellbeing needs and helps guide commissioning decisions in the locality.

5. A multi-agency steering group continues to oversee the development of this work-stream thus enabling the HWB to discharge its duties outlined under the Health and Social Care Act 2012. Membership of this group has been reviewed and updated but this is a continual process.

Progress made against areas of action identified in the Gateshead Joint Strategic Needs Assessment (JSNA) paper to the HWB in September 2016

Action 1 - To review and update the 'expert authors' list. The Steering Group will contact partners as necessary to ensure the list is up to date and complete, and to secure the outstanding updates required.

[1] DH (2013) 'Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. Published online at: http://healthandcare.dh.gov.uk/jsnas-jhwss-guidance-published/

6. Work has been undertaken to secure support from a range of partner organisations in the development of the sections of the JSNA with nominations and agreement coming forward for "Expert Authors". Identification of Expert Authors has been completed except for the following sections:
   - Expert Authors still to be agreed: Domestic Abuse victims, End of Life Care, Vulnerable Children and Young People, Vulnerable Older People, Illicit Drug use and Neurological conditions. Members of the JSNA Steering group have been tasked with identifying appropriate authors.
   - Expert Authors identified and work in progress: Carers, Homeless, Special Educational Needs and Disabilities (SEND), Migrants, Offenders, Travellers, Crime, Injuries & Falls and Immunisations & Vaccinations
   - There have been discussions on reviewing the section on Poverty and the need for the Migrants section to be expanded to include Asylum Seekers and Refugees and the leads for this work have been identified and work in progress. It has also been suggested that a musculoskeletal section be developed, which would link to the priority around frailty.

7. Support sessions have been facilitated by JSNA leads to help Expert Authors in the development of new or update of existing sections, as some were written in 2015 when the site was first launched. This means the data referenced can date back to 2011.

8. In particular, Expert Authors have been encouraged to review their section to include a greater focus on tackling health inequalities and to ensure that there is meaningful information contained within all sections, including "what would success look like" and "challenges".

Action 2 - To build on the qualitative work undertaken by a range of voluntary sector providers, in order to bring additional richness to the JSNA.

9. The Learning Disabilities section has been further developed over the past year, incorporating video and written case studies provided by the Involvement Now team.

10. The Smoking section has been updated with information developed in the promotion of the Gateshead Director of Public Health annual report 2016 "Tobacco: A smoking Gun" and includes video case studies of young people, local people and health professionals.

11. Health Needs Assessments have been completed for three Communities of Interest in the past 12 months (Homeless, Black and Minority Ethnic Groups and Carers) and another is being undertaken for people with Physical Disabilities and Sensory Impairments (PDSI). These all involve service users inputting their knowledge and views in relation to the needs of their particular community, which in turn will influence the commissioning of services. In addition to making these detailed health needs assessments available to download from the JSNA, an abridged version of the information will be used to inform the 6 block summary for the relevant section.

Action 3 - To consider how to integrate intelligence on Gateshead's assets into the JSNA.

12. An agreement has been reached with Newcastle CVS in relation to joint developments to link the Gateshead JSNA to Our Gateshead. This has been achieved through links to Our Gateshead from the relevant sections of the JSNA. For example the smoking section contains a link to groups and support for smoking cessation and the suicide section contains a link to bereavement support. Work is also being undertaken to link community assets delivered by Gateshead Council and local NHS services to the JSNA.

13. JSNA leads have facilitated Our Gateshead to support digital mapping of safe places in Gateshead for people with Learning Disabilities. 'Gateshead People' developed a paper based map and this function will help make this resource available for all internet users.

14. The JSNA Steering Group has been discussing the potential to enable public input to the JSNA. The JSNA leads are investigating the potential tools available through the Council's new digital platform and will explore opportunities to enhance the JSNA and make it possible to engage public input.

15. Public Health England are developing an indicator set to support community based approaches to health titled "Positive Intelligence". This will be incorporated in due course.

Action 4 - To keep the topic areas covered by the JSNA under review.

16. The 11 JSNA priority areas agreed by the HWB in September 2016 were:

Best Start in Life

- I. Education and Skills
- II. Emotional Health and Wellbeing
- III. Starting and Staying Healthy and Safe

Living Well for Longer

- IV. Economic Factors
- V. Emotional Health and Wellbeing
- VI. Tobacco Harm
- VII. Alcohol Misuse
- VIII. Healthy Weight and Physical Activity

Older People

- IX. Frailty
- X. Long-Term Conditions
- XI. Emotional Health and Wellbeing

17. These priorities have been reviewed for the updated JSNA and remain relevant to the work of the HWB. The strategic priorities take into account:
    - The severity and scale of the issue
    - How it impacts on Gateshead
    - An understanding of what can be changed through local action and how that action is related to other issues (impact)
    - Having a strong evidence base for action (see Appendix 1)

Progress against additional areas of development suggested by HWB members at the September 2016 meeting

Suggestion 1 - Develop a film on 'How to use the JSNA'

18. A script has been developed to promote the Gateshead JSNA involving Dr Mark Dornan, GP and Alice Wiseman, Director of Public Health. Filming is scheduled to take place later this year.

Suggestion 2 - Look to pull together information on getting support with benefits claims in time for the roll out of Universal credit.

19. Research was carried out by Northumbria University in partnership with Gateshead Advice Bureau looking at the value of benefits advice and the findings were very positive, offering another potential opportunity or route way to offer packages of support for benefits claims and Universal Credit.

20. Discussions have been held with the "Expert Authors" of the Poverty section of the JSNA to ensure that the JSNA references the impact and support for people arising from the roll out of Universal Credit in October 2017.

21. The links to Our Gateshead discussed in paragraph 12 above also offer opportunities to identify resources to support benefits claimants with the changeover to Universal Credit.

Suggestion 3 - Engage appropriate members of Migrant communities in development of the Migrant health section of the JSNA.

22. Agreement was secured for key organisations / people working with Migrant communities to develop this section and a request was made to extend this to Refugees and Asylum Seekers. This work has not been taken forward to date as we have not yet identified an appropriate expert author

Suggestion 4 - Get agreement, and plan, a Members seminar on the JSNA.

23. A member's seminar has been arranged for Wednesday 4 October 2017 and will focus on using the JSNA to identify key health issues in members' wards. This will be a 1 hour interactive session.

Suggestion 5 - Explore Physical Disability and Sensory Impairment (PDSI) issues.

24. A Health Needs Assessment (HNA) of adults with PDSI will be carried out in 2017/18 by a member of the Gateshead Public Health team. This will feed into the Gateshead PDSI group and will be used to develop a work programme into the future.

Suggestion 6 - Discuss ways to incorporate intelligence on Gateshead's assets, community infrastructure and support into the JSNA to support the importance of social networks in the wellbeing of members of the community.

25. See paragraphs 12 to 15 above.

JSNA Website usage statistics

Google analytics have been used to analyse usage statistics of the JSNA web pages for the 9 month period from November 2016 to July 2017. Some of the key points are:

(Comparison figures for the same 9 month period in 2015/16 are shown in smaller font and brackets)

- 21,259 (19,310) page views or hits and 14,192 (11,356) unique sessions
- Average of 78 (70) page views per day and 52 (41) unique sessions
- 60% (49%) of page views from users outside of the council
- 67% (54%) of unique sessions from users outside of the council
- 30% (4%) of users view the JSNA using a mobile device
- .
- The 'Living well for longer' section is the most frequently accessed of the life course needs assessments (2,680 hits) compared to 'Best start in life' (1,541 hits) and 'Older people (1,276 hits).
- Of the other Topics sections, 'Communities of Interest' attracts the most hits (2,796), followed by 'Illness and Death' (2,632), 'Economy, Transport, Housing, Environment, Crime and Poverty' (2,558), 'Behaviour and Lifestyle' (1,586), 'Population and Deprivation' (1,284) and 'Locality and Ward Profiles' (463).
- The most popular sections within the detailed narrative topics are 'Gateshead Data', 'Groups most at risk' and 'What are we doing about it and why'.
- The 'Why is it important', 'What would success look like' and 'Challenges' sections attract much fewer views.

Next steps

26. Continuing support from all HWB partners is essential to ensure that the JSNA remains a relevant and current tool, providing a comprehensive understanding of needs for those involved in securing and improving the health and wellbeing of the Gateshead population.

27. We are working to incorporate intelligence within the JSNA about how community initiatives/assets are helping to support local health and wellbeing needs

28. The next steps for the Steering Group will be:
    - Continue to engage 'expert authors' in developing and reviewing the content of the JSNA;
    - To add more examples of the 'lived experience' of local people in the form of case studies to bring additional richness to the JSNA;
    - Continue to integrate intelligence on Gateshead's assets into the JSNA and engage public involvement as outlined in point 14 above.
    - To invite Health and Wellbeing Board members to suggest areas for Deep Dive work such as that recently carried out in relation to Homelessness.

Recommendations

29. It is recommended that the HWB Board:

    - Note the progress on the continuing development of the JSNA;
    - Note and support the planned next steps in developing the JSNA;
    - Agree to retain the existing strategic priorities for September 2017 onwards;
    - Consider topic areas for a Deep Dive to be undertaken in the coming year; and
    - Receive an update report in September 2018.

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alicewiseman@gateshead.gov.uk

Evidence and rationale for prioritisation

(Source: Gateshead JSNA website as at August 2017 unless otherwise stated)

A. Best Start in Life

Education and skills

1. The JSNA recognises the need for education and skills to be viewed across the life course, underpinning the future life chances of each individual. A high percentage of young people and adults who are out of work in Gateshead lack basic employment skills. These include a lack of motivation, self-confidence, communication and interpersonal skills and employability skills.

2. Levels of early years development is improving, with 68% of children achieving a good level of development at age five, this is just below the national average of 69.3%.

3. Educational inequality starts early. For children who receive free school meals, 52.9% achieved a good level of development, which is again just below the national average (54.4%). Nationally there is a gap of around 10% achieving a good level of development at the end of reception between the richest and poorest areas (based on IMD 2015 deprivation).

4. Although young people in Gateshead are slightly below the national average when entering primary school, the progress they make throughout the school system, both primary and secondary, means that they outperform the national average when they leave school. This is demonstrated by the fact that 65% of pupils achieve grade C or better in English and Maths, above the national average of 59% and in the new 'Attainment 8' measure pupils achieved a score of 49.9, above the national average of 48.5.

5. However, there are still too many young people progressing to post-16 without the necessary standards in Maths and English. This is particularly the case amongst vulnerable learners, with only 41% of 'disadvantaged' pupils achieving grade C or better in English and Maths, below the national average of 43%.

6. In the new 'Progress 8' measure for Year 11 pupils (aged 15/16) a score of 1.0 means pupils make on average a grade more progress than the national average; a score of -0.5 means they make on average half a grade less progress than the national average. In Gateshead, disadvantaged pupils had a -0.64 progress 8 score, which is significantly lower than the score for all other pupils of 0.07.

7. In the last few years the number of children with a statement of Special Educational Needs (SEN)/ Educational Health & Care (EHC) Plan has increased and was 927 in 2017. This is similar to the national and regional average.

8. The number of pupils with SEN but without a statement has steadily decreased and now stands at 3,471. This is similar to the national but lower than the regional average.

9. The largest categories of special educational need in Gateshead are:

   - Moderate learning difficulties
   - Social emotional mental health
   - Speech language and communication needs
   - Specific learning difficulties
   - Autistic spectrum disorder

10. The estimated proportion of 15 year olds in Gateshead who entered 'Higher Education' by age 19 in 2014/15 was 36%. This compares with an England average of 38% and a North East average of 35%. The proportion in Gateshead has increased over time from 30% in 2006/07. Over the same period, the gap between pupils eligible for free school meals and their peers has increased slightly from 21 to 23 percentage points.

11. Gateshead adults are performing above the national average for attainment of level 2 qualifications and above. However, only 53.5% of Gateshead adults attained level 3 qualifications and above compared to 56.9% nationally and 30.2% attained level 4 and above compared with 38.2% nationally[2].

12. The local economy is continuing to undergo a number of challenges, one being unemployment in young people. Post 16 learning and training is an important stepping stone into the world of work. We need to ensure that the skills developed, the choices made, and the pathways followed are realistic and effective at preparing young people for an increasingly competitive jobs market. Progress is being made as the number of young people completing apprenticeships is increasing - 2014/15 saw the highest number of completions to date in Gateshead at 1,400.

13. It is also recognised that people are now working into their older age and that many need to reskill to be able to compete in a changing workplace. In particular there is a need to build digital skills in older people as communication methods are changing.

14. The JSNA focus on the need for education and skills across the life course is as much about securing the individuals economic future as it is about building the Gateshead community and links strongly into economic wellbeing.

Emotional Health and Wellbeing

15. Giving every child the best start in life is crucial to reducing health inequalities across the life course. Research shows that emotional wellbeing in childhood and young

[2] Adult Skills, Annual Population Survey, ONS Jan 2016 – Dec 2016 (NOMIS website)

adulthood is one of the most important factors in predicting whether an individual will be socially mobile and experience good mental health in later life.

16. Children who live in poverty are significantly more likely to experience poor mental as well as physical health. Living in poverty can make it difficult for children to sleep and eat well, which in turn makes it difficult for them to concentrate at school. Research found that children in poor households are three times as likely to have mental health problems as children in well-off households[3].

17. Good emotional health is the result of who we are and what happens to us in our lives. For children, this may be impacted on by poor attachment, poor parenting, traumatic experiences, physical ill health or negative environment. Children have different levels of resilience. Risk factors limiting resilience are:

    - Parental death, illness or mental illness
    - Repeated early separation from parents
    - Overly harsh or inadequate parenting, abuse or neglect
    - Parental criminality
    - Parental job loss and unemployment.
    - Discrimination on grounds of ethnicity, race, gender, sexuality or disability

18. There are specific groups of children who may be more vulnerable and in need of safeguarding, such as looked after children, young carers and children in poverty, and these children may have needs across more than one of these areas.

19. The emotional health and wellbeing of young people is fundamentally linked to child poverty and the economic factors which impact on their family. We know that positive emotional health builds resilience and helps to secure a young persons future health.

20. The 2014/15 ‘What About YOUth’ (WAY) survey reported that 58.4% of 15 year olds in Gateshead had been bullied in the previous couple of months, significantly higher than the England average of 55% and other nearby local authorities like Newcastle (50.1%) and North Tyneside (51.6%).

21. In a local survey of Gateshead primary school pupils (years 4 to 6) during 2016/17, 60% of pupils had a high self-esteem score (based on 4 questions about friends, relationships and self-perception). However, girls scored lower than boys at 57% compared to 62%.[4]

22. In 2015/16 there were 189 young people aged 10-24 admitted to hospital for self-harm. As a rate per 100,000 (DSR) this was 555.9, significantly higher than the England average of 430.5. Gateshead has consistently been higher than England over recent years

[3] Meltzer, H et al (2000) The Mental Health of Children and Adolescents in Great Britain
[4] Gateshead School Health and Wellbeing Survey 2016/17

Starting and staying healthy and safe

23. From the moment of conception, through to birth and the first year of life every aspect of a baby's environment influences its physical, emotional and social development. The importance of the first 1001 days has been clearly highlighted. [5]

24. Lifestyle choices at an early age are a good predictor of lifestyle choices later in life. It is very important that young children are encouraged and supported to lead active lifestyles, built into their daily lives, and that this continues across the life course. Gateshead continues to face challenges around obesity, healthy eating, low physical activity, sexual health and risky behaviour in some young people. The needs of our most vulnerable children and young people warrant particular attention.

25. The 2014/15 'What About YOUth' (WAY) survey reported that 24% of Gateshead 15 year olds had undertaken 3 or more unhealthy 'risky' behaviours from a list that included smoking, drinking, using cannabis or other drugs, an unhealthy diet and lack of exercise. Compared with the national average of 16% and the North East average of 21% Gateshead's average is significantly higher.

26. The JSNA recognises the ongoing need to prioritise child health and work with parents and families to improve health outcomes and reduce inequalities. Child poverty is a recurring issue and links into other priority topics such as economic factors, lifestyle choices and adult mental health and wellbeing.

B. Living Well For Longer

Economic Factors

27. The UK is experiencing radical welfare reform amid a period of slow recovery from recession and continued austerity. This includes the imminent introduction of 100% digital universal credit claims together with introduction of a local housing allowance cap for under-35s in social housing from April 2019. There are concerns about the impact this may be having on the physical and mental health of vulnerable people.

28. Gateshead is the 73rd most deprived local authority in England, out of 326 local authorities. 23,571 (12%) people in Gateshead live in one of the 10% most deprived areas of England. 49,790 (25%) live in the 20% most deprived areas.

29. The most recent data on local levels of child poverty available is from 2014, when there were 8,840 or 22.2% of children in Gateshead in poverty, an increase of 645 children from the previous year; this was significantly higher than the England average of 19.9%. The North East average was 24.3%. There is a concern that the increase in zero hours and part time contracts is having a negative impact on Gateshead families (this is often referred to as 'in work poor'). The Income Deprivation Affecting Children Index (IDACI) ranks Gateshead as 78th out of 326

[5] http://www.1001criticaldays.co.uk/buildinggreatbritonsreport.pdfc

local authorities in England. 28% (9,991) of dependent children aged 0-15 live within one of the 20% most deprived areas in England in terms of IDACI.

30. Economic wellbeing is the priority need for a large number of people in Gateshead, there is a strong association between wealth and health. People on low incomes are more likely to experience poor health compared to those on higher incomes, and research shows that a range of conditions have a strong relationship with deprivation, including: chronic respiratory disease, and alcohol related conditions, diabetes, heart disease and mental illness.[6] The reasons for these relationships are complex and linked to wider societal issues such as employment type and status, housing, transport, education, and access to health services.

31. The proportion of claimants receiving Jobseekers Allowance or Universal Credit had been reducing in recent years. However, from the end of 2015 onwards the proportion of claimants has levelled out and as at June 2017 there were 3,595 claimants. However, as at November 2016 there were a further 10,070 residents claiming Employment Support Allowance or Incapacity Benefit, with another 1,170 claiming Disability benefits and 2,960 carers claiming an out of work benefit.

32. The Gateshead Local Economic Assessment 2014 demonstrates the need to prioritise economic wellbeing. The issue is not just about employment and income but extends to our ageing population, the changing skills required of our future workforce, the number of people with long term conditions who cannot access suitable employment, the impact of zero hours contracts, transport and access issues and the need to attract business and cultural investment into Gateshead to improve the economic outlook for the whole population.

Mental Health and wellbeing

33. As already identified our mental health and wellbeing is fundamentally linked to our socio economic position. The benefits of positive mental health and well-being are wide ranging and significant both for individuals and for society as a whole. Positive mental health is associated with an increase in life expectancy, improved quality of life, improved physical outcomes, improved education attainment, increased economic participation, and positive social relationships.[7]

34. Mental ill health represents up to 23% of the total burden of ill health, and is the single largest cause of disability in the UK. It covers a wide range of conditions such as depression, anxiety disorders and obsessive compulsive disorders, through to more severe conditions like schizophrenia. The cost of mental ill health to the economy in England have been estimated at £105 billion (of which 30 billion is work related), and is the single largest area of spend in the NHS, accounting for 11 per cent of the NHS secondary health care budget. It is predicted that treatment costs will double in the next 20 years.[8]

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[6] Health inequalities and determinants in the physical urban environment: Evidence briefing. Marcus Grant, Caroline Bird and Penny Marno, March 2012.
[7] Royal College of Psychiatrists (2010) No Health without public mental health: The case for action.
[8] Department of Health (2011) No health without mental health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages.

35. Just over 8% of people in the NewcastleGateshead CCG area had a diagnosis of depression in 2015/16. This figure continues to rise. In Gateshead it was estimated that there were 22,447 people with a generalised anxiety disorder or mixed depression and anxiety disorder in 2012, a figure which is also likely to have increased.

36. The NewcastleGateshead CCG area has a very high rate of antidepressant prescribing compared both with the England average and with areas of similar deprivation and characteristics.

37. The rate of admissions for self-harm are significantly higher in Gateshead than in England overall.

38. The groups with a greater risk of developing mental health problems in Gateshead include people from BME communities, children from troubled families, carers, offenders, those who have been subjected to sexual assault or domestic abuse, the homeless, asylum seekers and some veterans and their family members.

39. The JSNA recognises the need to prioritise mental health and wellbeing for our population and its link to health inequalities in Gateshead.

Tobacco Control and Smoking

40. It is estimated that 17.9% of Gateshead's adult population smoke. This increases to 31% for those adults in routine and manual occupations. There is a general downward trend in smoking prevalence.

41. Smoking is the single largest cause of preventable mortality in England. Approximately 8.5 million people in England smoke and about half of all long-term smokers will die from smoking with half of those in middle age. Tobacco use is one of the Government's most significant public health challenges and causes over 80,000 premature deaths in England each year, of which 443 will be in Gateshead.

42. Smoking is estimated to cost the NHS in England £2.7 billion a year and £13.7 billion in wider costs to society through sickness, absenteeism, the cost to the economy, social care, environmental pollution and smoking-related fires.[9] This burden impacts on every GP surgery and hospital, every local authority and every family whether they smoke or not. In Gateshead, the smoking attributable hospital admissions rate is 2,784 per 100,000 compared to the national rate of 1,726 per 100,000.

43. Over a quarter of all cancer deaths can be attributed to smoking. These include cancer of the lung, mouth, lip, throat, bladder, kidney, stomach and liver.[10]

44. Smoking is closely related to lung cancer, causing nearly 9 out of 10 cases and in Gateshead there is a significantly higher rate of people with lung cancer than across

[9] http://www.ash.org.uk/files/documents/ASH_774.pdf
[10] Smoking Statistics ASH June 2016

England as a whole. As the highest smoking rates are in the most deprived areas, it is no surprise that lung cancer also strongly correlates with areas of deprivation, with wards in the most deprived quintile having a rate more than twice that of the least deprived quintile.

45. Chronic obstructive pulmonary disease (COPD) is the second most common cause of emergency admission to hospital and one of the most costly diseases in terms of acute hospital care.[11] This is primarily a ‘smokers’ disease.

46. At delivery, 13.2% of all women giving birth in Gateshead were known to smoke. This is significantly higher than the England average of 10.6%.

47. Parents who smoke in front of their children significantly increase their child's risk of disease and ill-health through passive smoking and also increase the potential risk of the child becoming a smoker themselves.

48. In the 2014/15 ‘What About YOUth’ (WAY) survey, 9.8% of 15 year olds in Gateshead reported smoking regularly, with a further 2.6% smoking occasionally. The combined figure of 12.4% is the highest rate in the North East and is significantly higher than the England average of 8.2%

49. The JSNA recognises the continued need to focus on tobacco control and smoking due to its health and economic impact on Gateshead.

Alcohol Misuse

50. Harmful use of alcohol results in 3.3 million deaths each year worldwide and affects not only the physical and psychological health of the drinker but the health and well-being of people around them. The harmful use of alcohol is a causal factor in more than 200 disease and injury conditions including alcohol use disorders and epilepsy, cardiovascular diseases, cirrhosis of the liver and various cancers. Other issues associated with alcohol are violence, child neglect and abuse and absenteeism in the workplace. Harmful alcohol consumption causes death and disability relatively early in life.[12]

51. The (age-standardised) rate of alcohol-related hospital admissions in Gateshead is 1,015 per 100,000 population (DSR). This is significantly higher than both the regional average (852) and the England average (647). The general trend in alcohol related hospital admissions is up and the gap between Gateshead and the England average is getting wider.

52. Liver disease is one of the few major causes of premature mortality that is increasing in England (including Gateshead). Major causes include obesity, undiagnosed hepatitis infection and harmful alcohol use. Between 2013 and 2015 there were 140 deaths from liver disease among people aged under 75 in Gateshead, with 9 in 10

[11] NHS Information Centre - Hospital Episode Statistics & QMAS database, 2010/11. (PHE North East England Respiratory Profile: Gateshead CCG
[12] World Health Organisation, February 2011, Alcohol Fact sheet available at: http://www.who.int/mediacentre/factsheets/fs349/en/index.html

considered to be preventable. In recent years, much of the increase is attributable to a sharp rise in deaths of women. For example, in 2004-06 there were just 26 female deaths due to liver disease, rising to 57 in 2013-15, whilst the number of male deaths has decreased in the same period from 95 to 83.

53. In 2015/16 there were 237 hospital admissions episodes for alcohol related mental and behavioural disorders due to the use of alcohol. As a rate per 100,000 (DSR) this was 120, compared with the England average of just 80.

54. Alcohol dependency is more prevalent among the homeless population especially rough sleepers. Drug and alcohol abuse especially when combined with a mental illness are linked to homelessness as causal risk factors but also as the consequences of being homeless.

55. The JSNA is prioritising alcohol, not only due to its link with so many negative health consequences but because the harmful use of alcohol also brings significant social and economic losses to individuals and society at large.

56. 12% of all crime recorded in Gateshead in the last 12 months was deemed to be alcohol-related (this is recorded at the discretion of the police officer dealing with the crime). More specifically, 34% of violence against the person offences were deemed to be alcohol-related and a fifth of criminal damage offences were also believed to have been influenced by alcohol.

57. According to estimates from Balance, alcohol related harm in Gateshead costs around £336 per head (taking into account costs to the NHS, crime and licensing, social services and the workplace).

Healthy weight and physical activity

58. Maintaining a healthy weight and being physically active on a regular basis both have positive effects on physical and mental health and life expectancy. These effects are achieved mainly through the prevention of premature mortality and/or disability due to preventable disease and improving an individual's sense of purpose and feeling of happiness.

59. The impacts of healthy weight and physical activity are so great that the World Health Organisation (WHO) currently ranks physical inactivity and obesity as the fourth and fifth leading risk factors for global mortality[13]. Globally, physical activity is becoming a priority as a method of health improvement and disease prevention and models of social prescription are being adopted by GPs and health professionals.[14]

60. Healthy weight and physical activity amongst adults also affects the health of children and wider family. Children are likely to inherit the health behaviours of their parents in relation to food and physical activity.

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[13] World Health Organisation Fact Sheets 2009

[14] Halpin HA, Morales-Suárez-Varela MM, Martin-Moreno JM. Chronic disease prevention and the New Public Health. Public Health Reviews 2010;32:120-154.

61. In Gateshead 69.4% of adults are obese or overweight according to survey data, significantly worse than the England average of 64.8%. A wide range of health conditions may result from being overweight or obese; these include heart disease, diabetes, hypertension, breast and prostate cancer, arthritis, physical disabilities, stress, anxiety and depression.

62. Local survey data highlights wide variations of adult obesity across Gateshead with the highest levels in the most deprived wards. For example in the most deprived areas of Gateshead the proportion of obese adults is almost double that in the least deprived areas. There were also variations across age groups, with highest levels of obesity in those aged 55 to 64 and lowest levels among 18 to 24 year olds.

63. Of children attending Gateshead schools, 22.3% of 4-5 year olds increasing to 37.9% of 10-11 year olds were classified as overweight or obese (excess weight). This compares to the England averages of 22.1% and 34.2% respectively. For both age groups, there has been little variation in recent years. A high percentage of those children are likely to become obese and overweight adults unless they can access sufficient support to make lifestyle changes for themselves and their families.

64. Child obesity data at ward level suggests that there are variations across Gateshead, with higher rates in a number of the more deprived areas and lower levels in less deprived areas.

65. It is recognized that by encouraging our population to become more physically active there are a range of mental and physical health benefits. By encouraging individuals to make active travel choices i.e. walking, cycling or using mass transport options, we may also benefit from reduced traffic congestion and improvements in air pollution.

66. The JSNA is prioritising healthy weight and physical activity as it will have an impact across a range of health and social / economic factors.

C. Older People

Frailty

67. The population of Gateshead (around 201,600 people) experiences wide variations in health outcomes across different groups and communities. The Gateshead population is ageing and it is projected that by 2039 there will be an additional 14,400 people aged 65 years or older in Gateshead, an increase of 38%.

68. Much of the debate about our ageing society has focused on the costs of ageing in respect of pensions, healthcare, welfare payments or social care. This has reinforced the idea that as people get older, they become more of a burden or drain on society

and the cost of supporting them outweighs the financial and social contribution they make to our community.[15]

69. Research shows that older people make a positive contribution to the UK economy and as the number of people over 65 increases and people remain healthier for longer, opportunities to make a positive contribution through work or volunteering are growing.[15] This is demonstrated by the Gateshead commitment to community capacity building and its engagement with older people.

70. The key challenges facing older people in Gateshead are outlined in the Gateshead Strategy for Older People 2014-2017. The themed work in the strategy focuses on promoting wellbeing and helping people to stay healthy and engaged.

71. Social isolation is associated with poor physical, mental and emotional health including increased rates of cardio-vascular disease, hypertension, cognitive decline and dementia. Individuals who are socially isolated are between two and five times more likely to die prematurely than those who have strong social ties.[16] The risk of social isolation increases with age. In Gateshead in 2011, 12,138 (34.4%) people 65 years of age or older were living alone and therefore could be at risk of social isolation.

72. People with stronger social networks are more likely to be healthier and happier. Those with weaker social networks can become isolated, and as a result, more likely to suffer from malnutrition, have an increased risk of hospital admission, and require more support and intervention from the local health and care services.

73. After adjusting for age, the rate of emergency admissions for injuries due to falls in people 65 years of age or older is significantly higher in Gateshead than in England overall. It is predicted that there will be a 37% increase in the number of people aged 65+ affected by falls and a 42% increase in the number of hospital admissions for falls by 2035.

74. The rate of hip fractures in people 65 years of age or older is slightly higher than the England average; there were 251 admissions for hip fracture in this age group in 2015/16.

75. In 2015/16 502 people (0.3%) aged 50+ in Newcastle and Gateshead CCG area had osteoporosis. This is the same as the England average.

76. The JSNA is prioritising the needs of older people because they are a large section of the population and have much to offer our future community health and wellbeing. A focus on housing, community, transport, education and skills and access to safe and good quality health and social care services will help to reduce social isolation and increase opportunities for older people. There is recognition of the need to focus on residents' capabilities, not their dependencies, and a commitment to prolonging independent living as they age.

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[15] Valuing the Socio-Economic Contribution of Older People in the UK March 2011

[16] Marmot M (2010), Fair Society, Healthy Lives. The Marmot Review.

Long term conditions

77. 52,679 or 1 in 4 people in Gateshead have one or more long term conditions. People with long term conditions account for about 70% of the total health and care budget in England, equating to £7 out of every £10 spent.

78. We are seeing an increasing number of individuals with multiple and complex needs, who are being identified earlier, at the same time as our population is becoming older. This presents an opportunity for individuals to better manage their condition and takes pressure off acute health and social care services.

79. Gateshead has a higher than average number of unplanned admissions into hospitals and there is an identified overreliance on hospital care. The rate of presentations at primary and secondary care services is putting pressure on the health and social care system with associated risks to patients, staff and Carers.

80. Of the 52,679 people with a long term condition in Gateshead, 8,274 have three or more long term conditions. The risk of an unplanned hospital admission increases if an individual has more than one long term condition.

81. Early intervention and effective care management for those with long term conditions can prevent flare-ups and reduce the number of acute episodes that may result in hospital admissions.

82. The JSNA is highlighting the need to focus on long term conditions and promote self-care, screening and early identification in order to ensure the best quality of life and care for those with long term conditions and alongside ensuring that the health and social care system can support the increasing demand for services.

Mental Health and Wellbeing

83. The changes that often come in later life such as retirement, the death of loved ones, increased isolation, and medical problems, can lead to depression. This can impact on a person's energy, sleep, appetite and physical health.

84. The estimated number of those aged 65+ with depression in 2017 was 3,345. It is predicted that this will increase by 30% (1015) by 2035. Similarly, the number with severe depression (1,056) is predicted to increase by 36% (376) over the same period.

85. It is estimated that there were 2,632 people aged 65+ with dementia in 2017. This is predicted to increase by 54% (1,432) by 2035. 1,116 of those with dementia were aged 85+ in 2017, and this is predicted to increase by 91% over the same period.

86. The JSNA recognises that while a significant number of people do develop dementia or depression in older age, decline in mental wellbeing should not be viewed as an

inevitable part of ageing. Many factors affecting mental health and wellbeing for older people are the same as for the general population.

HEALTH AND WELLBEING BOARD
8th September 2017

TITLE OF REPORT: **Integrating health and care in Gateshead**
REPORT OF: **Julie Ross, Director of Integration across Gateshead and Newcastle**

Purpose of the Report

This report sets out the current thinking of the health and care system leaders in Gateshead about the opportunities for integrating services with the explicit aim of improving the health and wellbeing outcomes of our population.

The report describes the shared vision and areas for early integration identified by health and care partners and seeks the views of the Health and Well Being Board about taking forward this work in the borough.

Executive summary

It is difficult to travel far or discuss public sector cuts and reform without hearing the word – or philosophy – '***integration'*** mentioned. It is broadly accepted that, if the providers concerned can come together to meet the interests of the service user, by providing seamless pathways of care with the minimum number of points of transfer, this will provide safer, more effective, and more cost efficient delivery of appropriate care. At its ultimate effectiveness, all providers will do only what they need to do before patients are pulled into the next stage of their pathway, based on careful pre-planning before it begins and throughout, including clear plans for discharge and follow up.

The deliberations about this topic in Gateshead have developed in three parallel pieces of work over the last year:

1. The operation of the Gateshead Care Partnership since October 2016.
2. The informal health and wellbeing board pre meeting of senior officers from the statutory bodies represented at the board, since April 2017.
3. The Accountable Officer Partnership across Gateshead and Newcastle published a 'statement of intent' (January 2017) describing its ambition to bring together health and care services.

In summary, we have whole system support for an integrated approach to health and care in Gateshead, shared by accountable officers, their commissioners and their providers, to meet the following **three objectives**:

1. To shift the balance of services from acute hospital care and crisis interventions to community support with a focus on prevention and early help.
2. To support the development of integrated care and treatment for people with complicated long term health conditions, social problems or disabilities.
3. To create a better framework for managing the difficult decisions required to ensure effective, efficient and economically secure services during a period of continued public sector financial austerity.

The health and care leaders in the borough have described an effective approach to **strategic commissioning** with three components:

1. A whole system vision, described on a long term basis and enacted through a corresponding contracting arrangement.
2. An outcomes based commissioning model so providers are free to innovate and work differently, accepting they must deliver the commissioner set outcomes and the NHS constitution and associated metrics.
3. Minimal transactions between commissioner and provider, accepting the principle that the outcomes will drive transformational change. Central to this is the need for system wide data sharing arrangements/ protocols

Our corresponding description of an **integrated provider** is:

1. A group of system enablers who are charged with making changes together, adopting a 'wellness and recovery planning' model.
2. Operating on a system wide basis and delivering universal services, whilst also focusing on agreed priority groups for whom we take a multi-disciplinary approach to planning and securing care.
3. Challenging each other where professional boundaries get in the way of doing what's right, stopping services that are not working and testing new ways of working.

Caveats. The paper sets out the early thinking across Gateshead health and care system about the potential opportunities offered by integration. There is of course further work required to build a sustainable way of working for the future and we have set out below a number of immediate 'caveats' to the current thinking.

- ***Ambition*** - The paper sets out an initial first step rather than the overall ambition for integration in Gateshead - an incremental approach to system integration is planned.
- ***Scope*** - the current paper is limited as it only focuses on the opportunity with the Gateshead Care Partnership rather than a whole system view which could include third sector and other private businesses (e.g. nursing care). Whilst the initial focus is health and social care, there are discussions starting around potential implications for other services such as housing and employment support.
- ***Funding*** - The paper hasn't overtly addressed the issue of funding other than to suggest a shift in the 'balance of services from acute hospital care and crisis interventions to community support with a focus on prevention and early help. We recognize that optimization of the integration agenda is only as good as getting the money to flow to the right places with a focus on improving outcomes for people and not organizational sovereignty. Further work is planned to address this point.
- ***Commitment*** - We have a shared vision based on making a positive difference for service users and not just for organizations and will need to test this commitment over the coming months; for example, if we focus on services for people with learning disabilities in the first instance, we could test both the organizational commitments to working together and the impact this would have on the population we all serve.
- ***Monitoring progress*** – there are a number of national frameworks available against which we could measure our progress to integrating services. We would plan to select one of those frameworks and continually assess our progress against it.

1 Background

It is difficult to travel far or discuss public sector cuts and reform without hearing the word – or philosophy – '***integration'*** mentioned. The actual meaning of the word in this context is the subject of some debate, and it is clear that it has the potential to exist at many different levels, from the relatively simple step of having a pharmacy co-located with a GP practice (which might also have, for example, a dedicated practice nurse or health visitor), to something much bigger involving the coming together of multiple organizations or stakeholders under an umbrella of 'integration'.

Often running hand in hand with talk of integration comes the issue of care ***pathways***. The notion of 'pathways' is not, in itself, a complex one. A 'pathway' is simply a single word to describe the patients' journey through the system; but in practice, these can be extremely complex and lengthy, with multiple organizations having an input, often without slick and clear handover processes in place (or appearing not to be).

Evidence tells us categorically that the greater the number of points of handover, either within or between organizations, the directly proportionately greater is the degree of risk of something untoward happening to the service user. In addition, fragmentation between organizations can create perverse financial incentives within the system, where money becomes the driving factor, rather than safeguarding the best interests of patients and service users.

Current thinking puts the Integration and Pathways agendas together. It is broadly accepted that, if the providers concerned can come together to meet the interests of the service user, by providing seamless pathways of care with the minimum number of points of transfer, this will provide safer, more effective, and more cost efficient delivery of appropriate care. At its ultimate effectiveness, all providers will do only what they need to do before patients are pulled into the next stage of their pathway, based on careful pre-planning before it begins and throughout, including clear plans for discharge and follow up.

Gateshead already enjoys many positive examples of partnership working, sharing resources to achieve common goals and outcomes, underpinned by a common ethos and set of values which put the people we are here to serve at the centre of what we do. Whether we actually call this 'integration' or not, it is without doubt that this strength of relationships and spirit of co-operation provides a perfect platform for formal integration to take place.

The organizational system architecture in Gateshead alone, lends itself to an accountable care arrangement:

- Unitary local authority;
- Single, co-terminus provider of secondary care;
- Single provider of tertiary care;
- Single CCG – although covering two LA areas
- Single provider of community based services;
- Multiple, but broadly coordinated, mental health providers;

The deliberations of health and care senior leaders in Gateshead have developed in three parallel pieces of work over the last year:

1. The operation of the Gateshead Care Partnership since October 2016, as the interagency provider vehicle which oversees the implementation of the recently secured community health services contract for the borough. The contract is held by Gateshead Health NHS Foundation Trust but is managed through the Gateshead Care Partnership incorporating Gateshead Health FT, CBC Ltd, NTWFT and Gateshead Council.

2. The informal health and wellbeing board pre meeting of senior officers from the statutory bodies represented at the board, since April 2017. This group has considered and debated the various implications of integrating commissioning across health and care as well as building upon the Gateshead Care Partnership foundations to create a wider provider vehicle. During this period the officers of the organisations represented have also asked GCP to take on responsibility for delivery of the Borough's People, Place and Community (PCC) programme.

3. The Accountable Officer Partnership across Newcastle and Gateshead (comprising the six accountable officers and their most senior directors,, the two directors of public health and the system appointed director of integration) published a 'statement of intent' in January 2017 describing its ambition to bring together health and care services; the accountable officers have subsequently described in some detail their respective aspirations for whole system aspiration. In Gateshead, all four accountable officers described a whole system integration approach as the most likely to reap benefits for the population we serve.

In summary, we have whole system support for an integrated approach to health and care in Gateshead, shared by accountable officers, their commissioners and their providers.

It is of note that the solutions proposed in this paper relate to the Gateshead geography only. We recognize the continued need to work collaboratively with our geographical neighbours (particularly Newcastle) for issues such as cross boundary flow and acute care collaboration; this work is not described any further in the present paper.

2 The purpose of integration in Gateshead

The NHS and Local Authority leaderships' considerations are about how best to secure and arrange the services for the resident population to meet the following three objectives:

1. To shift the balance of services from acute hospital care and crisis interventions to community support with a focus on prevention and early help.

2. To support the development of integrated care and treatment for people with complicated long term health conditions, social problems or disabilities.

3. To create a better framework for managing the difficult decisions required to ensure effective, efficient and economically secure services during a period of continued public sector financial austerity.

The following table describes the headline parameters of 'logic' of our thinking to date.

Language	We need to make sure we share a common language – "Gateshead Care Partnership" is the term that describes provider collaboration; "Gateshead health and care system" is a term that describes provider and commissioner collaboration. In other words, we aren't using 'accountable care' in any language.
Outcomes	We want the care and health commissioners to describe the population outcomes that must be delivered and liberate the Gateshead Care Partnership to determine how best those outcomes should be achieved.
Gateshead	We want to work at a Gateshead footprint to deliver community based services, recognizing the need to collaborate with geographical neighbours (like Newcastle) for services that operate at a broader footprint, such as acute care and mental health inpatient care.
Idiom	We believe that 'form follows function', so our focus is on the model of care we want to deliver rather than the organizational structures that could deliver them.
Collegiate	Our delivery model is best served by us all working together and with an 'enabling' mind-set in how we arrange and deliver services.

2.1 Our compiled vision statement

Avoiding duplication of effort, maximizing our collective impact and getting on with the job in hand are three important principles that have driven the thinking in Gateshead so far. In line with that approach, the health and care system has agreed a one page summary of all the various vision statements, memoranda of understanding, compacts and behavioural charters that have existed in the borough for some time.

This one page summary doesn't replace any vision statement that may exist in individual organizations – it simply shows that however we choose to construct the various sentences in our own organizational documents, we all share a common goal and ways of working. We therefore don't need to create a new vision document for this work.

Gateshead Health and Care System

CBC health

Vision

Every part of the health, social care and third sectors can work together to enable the people they serve to live longer, healthier lives, supported by the very best services available.
(From AOs Statement of Intent)

Outcomes

High level, set by strategic commissioners around such areas as:

- Improving population health and wellbeing
- Delivering high quality, co-ordinated care
- Improving quality of life and experience of care

What do we want?

- Sustained improvement in people's health and wellbeing / greater equality of outcomes
- High quality, efficient health and care services / parity of esteem
- An increasingly integrated system of health and social care and effective delivery model
- Community services integration with primary care, social care and third sector in localities / consolidate community services
- Be responsive to the needs of users / support communities to be more responsible for the achievement of our shared objectives
- Create a financially sustainable health and care system
- A workforce able to deliver our model of care
- Statutory responsibilities to be met

Behaviours

- An openness to change
- Visible leadership, direction and commitment
- A commitment to take a strategic view
- A commitment to protect and support
- Be accountable – communicate and work openly
- Equality, mutual respect and trust
- Positive and constructive / a willingness to work with and learn from others
- A willingness to compromise
- Engage and consult with patients, service users, carers, staff and the public

What will it feel like for local people?

- Right person, right time, right place
- Remove hand-offs
- Remove duplication of services
- (Other descriptors to be identified)

NHS partners: Newcastle Gateshead Clinical Commissioning Group, Northumberland, Tyne and Wear NHS Foundation Trust and Gateshead Health NHS Foundation Trust

3 Strategic commissioning arrangements

The health and care leaders in the borough have described effective strategic commissioning with three components:

- A whole system vision, described on a long term basis and enacted through a corresponding contracting arrangement. (see section 2.1)
- An outcomes based commissioning model so providers are free to innovate and work differently, accepting they must deliver the commissioner set outcomes and the NHS constitution and associated metrics.
- Minimal transactions between commissioner and provider, accepting the principle that the outcomes will drive transformational change. Central to this is the need for system wide data sharing arrangements/ protocols.

3.1 Outcomes based commissioning

The Gateshead Care Partnership could be commissioned, jointly by the CCG and Local Authority, to deliver a range of care and health outcomes and be measured simply on the achievement of the associated outcome metrics. Any contract would of course require compliance with the NHS constitution and all other statutory obligations and delivering these would be the responsibility of the providers (as is the case at present) and overseen by their regulators.

Focusing on outcomes would mean the providers, through Gateshead Care Partnership, are free to innovate and work differently as commissioners would no longer have a transactional focus, but would focus on the transformation of services measured through the impact of provision. There are many outcomes frameworks available from other areas that would appropriately be adapted for use locally, and a sample of one framework is set out below simply for reference:

Commissioners identify the outcome statement

And set metrics to measure their achievement.
First order metrics: 1 – 3 year period
Second order metrics: 3 – 10 year period

	Outcome	First order metric	Second order metric
Improving population health and well being			
A1	The health and care system to improve the overall health of the population	Excess winter deaths (persons)	Mortality rate from causes considered preventable.
A2	People are supported to lead healthy lifestyles and are protected from illness	Smoking prevalence (adults)	Alcohol – related hospital admissions (persons)
A3	The health and care system works with others	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Proportion of people who use services who reported that they had as much social contact as they would like.
Delivering high quality, coordinated care			
B4	People have access to services when they need them	The ability to get an appointment or speak to someone in primary care.	Common surgical procedure rates
B5	The health and care system works to reduce unplanned hospital admissions and the time people spend in hospital	Inequality in avoidable admissions/for urgent care sensitive conditions	Emergency admissions for acute conditions that should not usually require hospital admissions (persons)
B6	People are supported to recover from illness or injury and stay healthy after treatment	One year survival from all cancers (persons)	create new measure: other long term condition
B7	People receive services which are coordinated and person centred	Were you involved as much as you wanted to be in decisions about your care and treatment?	Delayed transfers of care
B8/9	People are supported to maintain their independence and manage their own health	Long term support needs met by admission to residential and nursing care homes (aged 65 and over)	Proportion of people who use service who have control over their daily life.
B10	People are cared for in a safe environment and protected from avoidable harm	NHS Safety thermometer (VTE, pressure ulcers, catheter UTIs, falls)	Incidence of healthcare associated infection: C Difficile

3.2 Minimizing transactions, maximizing transformation

If commissioners are to concentrate primarily on setting health and wellbeing outcomes for the providers to deliver, their behaviours will also need to fundamentally change so the transaction dominated contracting arrangements between commissioner and provider are replaced with outcomes based contracts that demand the transformation of services – however the provider chooses to do that.

Coupled with that change in behaviour, we will need to create a health and care system based on a transformed payment mechanism to address the following four points:

- **The balance of spend….**The unintended consequences of the 'payment by results' financial mechanism in the NHS is that funding for most services provided in acute hospitals is demand led, whilst community services and mental health services have fixed budgets. The result, particularly in the current climate of public sector austerity, is a tendency for funding to be directed into crisis services and away from lower level community based services.

- **The rules about spend**… which differ between the health and care system as the NHS is free at the point of delivery; social care is means tested and dependent on eligibility criteria. Whilst these are of course statutory requirements, we must be mindful of their impact in any integrated system.

- **The patients / citizens on whom we spend….**The current funding mechanisms are based on the implicit assumption that most NHS activity comes in the form of one off episodes of treatment for people who are otherwise healthy. In reality, the bulk of NHS spending is supporting people with complicated long term needs, who are best service by coordinated long term support rather than multiple disconnected episodes of treatment.

- **The financial stability of organisations….** The infrastructure costs, particularly of hospital based care, are generally fixed (or marginally variable); any shifts of resource to community settings will need to be mindful of the continued need for hospital services and therefore the financial stability of organisations across the system.

The Gateshead Health and Care system leaders have recognized the need to develop this line of thinking further. Creating a financial mechanism that addresses the above four points and creates a system in which money flows easily and effectively between organizations, is of course challenging. Dedicated work will be required to undertake this work.

The way in which money can flow in a newly designed system is a critical consideration and further work is required on this point.

4 Integrated provision arrangements

We believe Gateshead Care Partnership should be seen as:

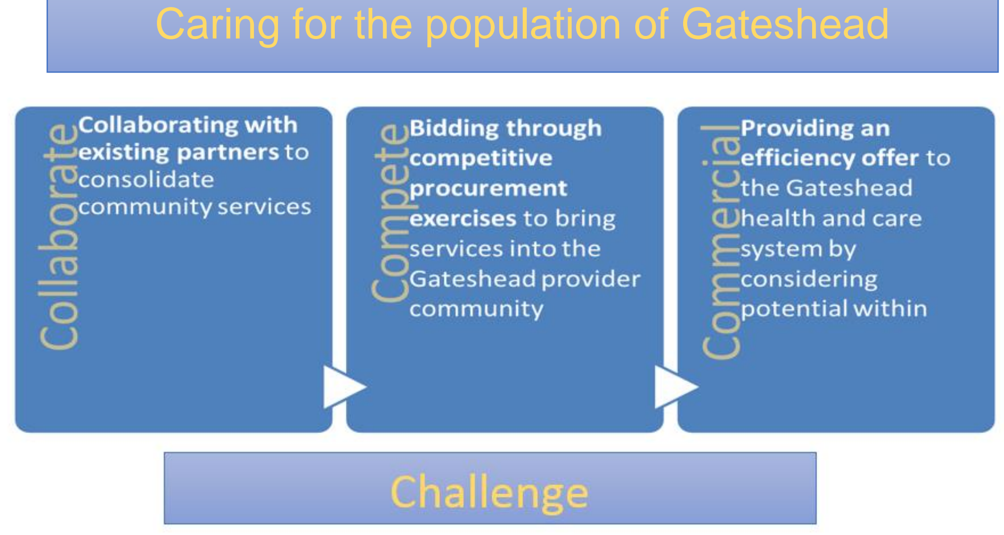
- A group of system enablers who are charged with making changes together. Adopting a 'wellness and recovery planning' model which focusses on the whole person/ family and what we can do together.
- Operating on a system wide basis (i.e. across all care and health partners) and delivering universal services, whilst also focusing on agreed priority groups for whom we take a multi-disciplinary approach to planning and securing care. We will develop services that generate truly 'owned' and comprehensive care plans that deliver the outcomes with the patient.
- Challenging each other where professional boundaries get in the way of doing what's right, stopping services that are not working and testing new ways of working. Supported by a shared improvement method and shared data sharing/ information governance arrangements (both require development locally).

All major providers of health and care are represented at the Gateshead Care Partnership.

General practices provide the cornerstone of any new health and care arrangement – providing services to all those who are unwell or think they are unwell, in settings very close to people's homes. Practices in Gateshead are committed to integration and are thinking about how they can operate at scale, with neighbouring practices, to offer a wider range and more sustainable primary care offer, within its unique NHS business model, delivered through a nationally negotiated contract (known as GMS or PMS). The nationally negotiated contracts are not within the remit of the Gateshead commissioning system and this will not change without practice consent or a change in national policy.

4.1 Extending the provider collaboration

The Gateshead Care Partnership believes patient/ population care is a shared priority and that working together across our organizational boundaries will deliver better patient care than working individually. The partnership board has identified its areas for future focus as shown in the graphic below and explained in more detail in the subsequent paragraphs. The priorities require formal approval by the board in time.



Collaborating with existing partners to consolidate community services

- A 'care closer to home' model of collaboration between the in house council domiciliary care provision (which caters for the highest 20% need group), community nursing, community psychiatric nursing, care call etc.
- A combined and integrated approach to urgent and same day response services, bringing together existing GP walk in centres, ambulatory care, extra care, same day appointments, rapid response, psychiatric liaison services
- A community based allied health professional base, bringing together the various funded and provided occupational health and equipment services in the first instance and then potentially expanding to a wider range of services.
- Coordinated care planning across all patient groups but beginning with a specific focus on old age/ frailty, older people's mental health, diabetes, respiratory, rheumatology

Bidding through competitive procurement exercises to bring services into the Gateshead provider community.

Providing an efficiency offer to the Gateshead health and care system by considering potential within

- The existing infrastructure configurations
- The training and education of the work force and in collaborations with the third sector.
- Opportunities to support and develop local commercial companies (be they in domiciliary care or other fields) could also be explored.
- Bringing together community and hospital based services (paediatrics, long term conditions, drug and alcohol, care of the elderly (physical and mental health) etc.

4.2 Priorities for action

The Gateshead People, Care and Communities Model provides the overarching direction for the Gateshead Care Partnership and aims to develop: *"A place based system where everyone, young and old will be supported to live, work and age well as individuals and as part of their community. If needed, care and support, supporting physical, mental and social needs, will be easily accessible and coordinated close to or at a person's home."*

The Gateshead care Partnership was tasked to take forward the progression of the People, Care and Communities Model in Gateshead. From initial discussion the following priority areas have been identified:

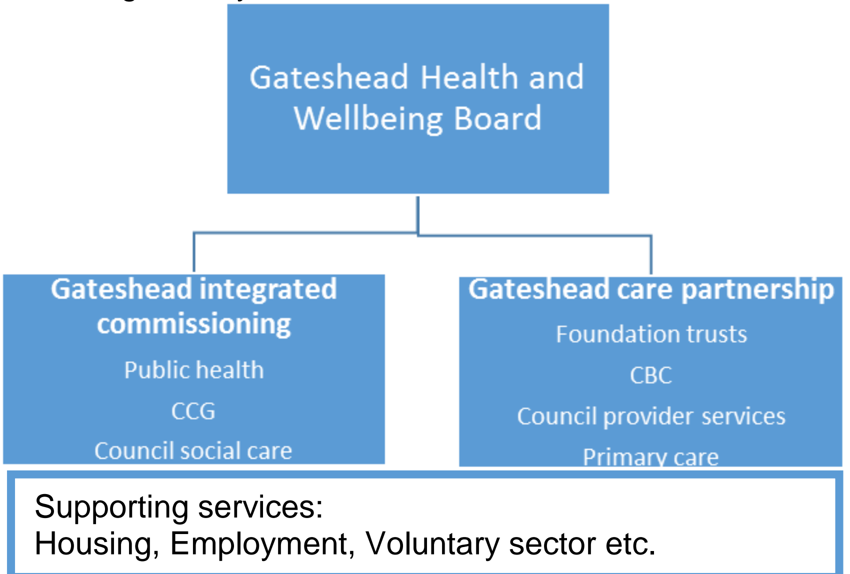
- People with complex needs;
- Frailty;
- End of life care;
- Medically unexplained conditions;
- Children's services.

Other areas to be considered include:

- SEND;
- Transitions (from children's services to adult services)
- CAMHS;
- Learning Disabilities

5 Governing a new health and care system arrangement

Under the auspices of the Health and Wellbeing board, the arrangement of commissioning and provision across care and health services could be reconfigured to deliver the integrated system



This diagram shows both the commissioner and provider partnership reporting into the Health and Well Being Board. This is indeed consistent with the statutory obligations of the health and well-being arrangements of each area – as they are required to have oversight of the health and care system as well as providing direction about the priorities for the resident population.

The structure avoids the traditionally hierarchical reporting arrangements between commissioners and providers – reflecting the different but complementary roles of each in the new way of working.

- The strategic commissioner, in understanding the overall population needs, sets the health and wellbeing outcomes to be achieved within an n identified financial envelope.
- The collaborative provider arrangement delivers those outcomes across all the organisations within its parameters and undertakes much of the transactional/ contract management work traditionally associated with commissioners.

- The proposed commissioning and provider structures both recognise that the third sector and health watch could offer valuable additions to the arrangements and discussions are underway with these bodies to work out the best way to capitalise on the services they provide.

Proposal. **I**t is proposed that the Gateshead health and care system leaders, who have compiled this report, come together in a formal group under the auspices of the health and wellbeing board, in order to further develop the proposals for the integration of health and care services in the borough. Further proposals should be brought back to the board over the coming months for consideration.

Recommendations
The Health and Wellbeing Board is asked to:

- Provide feedback and comment upon the content of this paper, with specific reference to its view about the potential for integrating health and care services as part of an incremental approach to the overall integration of services in the borough.
- Approve the creation of a time limited health and care system leader group to further develop the proposals, which would report regularly to the health and wellbeing board. The board is asked to delegate authority to this group to develop comprehensive and costed proposals.

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

Item 6

HEALTH AND WELLBEING BOARD
8th September 2017

TITLE OF REPORT: The Gateshead Better Care Fund Submission 2017-19

Purpose of the Report

1. To seek the approval of the Health & Wellbeing Board to the Better Care Fund submission for Gateshead (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 the health and care economy. A BCF Plan was initially developed for the period 2014-16 and a second Plan was developed for 2016/17.

3. The 2017-19 Integration and BCF national policy framework was published in March 2017, followed by supporting planning guidance in July 2017. The guidance set out the requirement to develop a two-year BCF plan for the period 2017-19. This incorporates the new improved BCF (IBCF) which is made up of the funding allocated in the 2015 spending review and that allocated in the 2017 spring budget. The IBCF grant determination was issued by DCLG in April 2017 which included conditions on the use of the grant.

Gateshead BCF Plan Submission 2017-19

4. The Gateshead BCF submission for 2017-19 has been developed working closely with colleagues at Newcastle Gateshead CCG. Engagement has also taken place with Gateshead Health NHS FT and Northumberland, Tyne & Wear NHS FT. The submission timeline also provides for consideration by the Gateshead Voluntary Sector Health & Wellbeing Advisory Group (paragraph 18 below refers).

5. The submission is in two parts:

   - A Narrative Plan that addresses the key requirements of national planning guidance (the latest version is attached at Appendix 1);
   - A supporting Planning Template which sets out further detail on metrics, proposed expenditure and national conditions (attached at Appendix 2).

6. The key thread which runs through our submission is that the BCF forms part of a broader picture in working towards the integration of health and social care services for the benefit of local people and therefore should not be seen isolation. Our

submission for 2017-19 references work to develop an out-of-hospital model for Gateshead (People, Communities & Care):

- Building upon our 2016/17 submission, the BCF will transition into the Gateshead People, Communities & Care (PCC) model.
- Work programmes/schemes funded through BCF will naturally 'migrate' to the 'care and support' component of our PCC model (and more specifically the 'intermediate care' component).
- Work is also underway to consider a system 'outcomes framework' for our PCC model.

Resources

7. The total BCF pooled fund can be summarised as follows:

- 2017/18: £22.8 m (£5.9m relates to IBCF)
- 2018/19: £25.3 m (£8m relates to IBCF)

	2016/17 £000	2017/18 £000	2018/19 £000
Disabled Facilities Grant	1,480	1,602	1,724
CCG Minimum Contribution	9,110	9,273	9,449
Care Act Funding from CCG Minimum Contribution	614	614	614
Social Care from CCG Minimum Contribution	5,284	5,390	5,504
Improved Better Care Fund	-	5,922	8,040
Total Better Care Fund	16,488	22,801	25,331

8. As in previous years, there is a requirement that BCF monies are transferred into one or more pooled funds. It is intended to continue with current arrangements which will be governed by a Section 75 agreement.

BCF Schemes 2017-19

9. Previously, the BCF plan has included 11 core schemes but as these go back to 2014/15 it is now intended to group these under five broad areas which better reflect current arrangements and current priorities:

- Service Transformation
- Market Shaping and Stabilisation
- Managing discharges and admission avoidance
- Planned care
- Service pressures

10. In addition, there is also specific provision for:

- Disabled Facilities Grant
- Carers

11. The BCF submission illustrates how the original schemes have migrated across to the new scheme descriptors, which are also consistent with the scheme descriptors for the Improved BCF.

National Conditions

12. The BCF submission sets out how we will continue to meet national conditions set out in the guidance and how health and social care are working together to deliver them. The conditions are:

    1. A jointly agreed plan
    2. Social care maintenance (NHS contribution to Social Care)
    3. Agreement to invest in NHS commissioned out of hospital services
    4. Managing transfers of care - Implementation of the 'High Impact Change Model'

13. In relation to social care maintenance, the amount transferred from the CCG to the Council has been maintained in line with inflation, as per the national planning guidance minimum increases of 1.79% 2017/18 and 1.9% 2018/19. In addition, the majority of the IBCF is being utilised to meet adult social care pressures, including uplifts in the national living wage, and has allowed scope to begin shaping the provider market.

14. The management of transfers of care is a key national focus and it is already clear that performance will be monitored closely by NHS England. All areas are required to implement a 'High Impact Change Model' for managing transfers of care. Eight high impact changes have been identified around early discharge planning, monitoring patient flows, discharge to assess, trusted assessors, multi-disciplinary discharge support, seven day services, a focus on choice and enhancing health in care homes. BCF plans are required to set out how local partners will work together to implement the model.

BCF Metrics

15. Areas are required to continue to set targets for the following four metrics over the period of 2017-19 plan:

    - Delayed transfers of care;
    - Non-elective admissions (General and Acute);
    - Admissions to residential and care homes; and
    - Effectiveness of reablement.

Plan Delivery and Governance

16. The delivery of the plan will be governed by a Section75 agreement which will set out respective responsibilities of the Council and CCG. Delivery will be overseen by the BCF Programme Board, including senior officers from the Council and CCG. Updates will also be reported regularly to the Health & Wellbeing Board.

Sign-off Arrangements

17. Similar to previous years, there is a requirement that the BCF Plan submission is signed off by the Health & Wellbeing Board, the local authority and Clinical Commissioning Group.

18. The submission deadline to NHS England is 11th September and key dates from the Plan timeline include the following:

	Date of Meeting
CCG Executive	15th & 22nd August
Council's Care Wellbeing & Learning Group Management Team	24th August
Council's Strategy Group	30th August
Joint Portfolio Meeting	4th September
Voluntary Sector Health & Wellbeing Advisory Group	7th September
Health & Wellbeing Board	8th September
Cabinet (retrospectively)	19th September

Assurance/Moderation & NHS England Approval

19. Similar to previous years, Plan assurance will include moderation at NHS regional level. The three assurance categories set out in the planning guidance are:

- Approved
- Approved with Conditions
- Not approved

20. If a Plan is 'Approved' or 'Approved with Conditions', the area will receive authorisation to enter into a formal Section 75 agreement and the CCG authorised to release money from the BCF ring-fence. The notification will make clear any planning requirements that were not met, the actions required to receive full approval, and the date by which this should be done. If a Plan is 'Not Approved', the Better Care Support Team will commence an escalation process to oversee prompt agreement of a compliant plan.

Recommendations

21. The Health and Wellbeing Board is asked to approve the Gateshead BCF submission for 2017-19.

Contact: John Costello (0191) 4332065

Gateshead Integration and Better Care Fund Narrative Plan 2017/19

Area	**Gateshead**
Constituent Health and Wellbeing Boards	**Gateshead**
Constituent CCGs	**NHS Newcastle Gateshead CCG**

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High Level Summary

Development of the Better Care Fund (BCF) Plan

NHS England published the Integration and Better Care Fund Planning requirements on 4 July 2017 for the implementation of the BCF for the period 2017 – 19. The guidance confirms the statutory and financial basis of the BCF, the main conditions of access to the Fund, Improved Better Care Fund (iBCF) and arrangements for the assurance and approval of plans.

Planning requirements

A joint spending plan that meets the national conditions will need to be developed with local partners. In developing the BCF plans for 2017-19 the following will be required, agreed, through the relevant Health and Wellbeing Boards:

i. A short, jointly agreed narrative plan including details of how we are addressing the national conditions; and how BCF plans will contribute to the local plan for integrating health and social care;

ii. A completed planning template, demonstrating:

- Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;
- A scheme-level spending plan demonstrating how the fund will be spent; and
- Quarterly plan figures for the national metrics.

Our approach

We tend not to differentiate between BCF and the wider approach to transformation and integration but there are specific national requirements which have been addressed.

We have tried to take a pragmatic approach and have therefore:

- Brought our narrative up to date in relation to new models of care (People Communities and Care) and some specific relevant pieces of work i.e. Intermediate Care.
- Not made fundamental changes to the pre - existing BCF "schemes". Existing funding, held within the BCF Pooled Budget, maintains core elements of both community health and social care services, some of which are already subject to intensive redesign e.g. Intermediate Care. Although we have not rewritten the schemes the transformation activity is happening or planned.
- The CCG and LA have participated together in national webinars to develop our understanding of the "goals" and "rules" in relation to **IBCF**

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- The CCG and LA have developed, and tested out with providers new schemes using IBCF temporary funds and have maintained an open and honest dialogue throughout, consistent with the culture the AOs supported us to develop eg. Statement of Intent.
- New schemes will be implemented and tested out to ensure they achieve maximum value from being positioned in a multi - agency context.
- The setting of BCF targets has been discussed in both the A&E Delivery Board and the local Governance system, and consensus reached.
- Work on the High Impact Changes (national condition 4) has been done by an operational sub group of the A&E Delivery Board and forms one of the appendices to the BCF Plan.
- The revised narrative and planning template addresses the KLOES.

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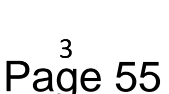

Contents

High Level Summary 2
Development of the Better Car Fund (BCF) Plan 2
Contents 4
Approval and sign off 5
Introduction 6
Section 1 Narrative plan 7
Local vision, needs assessment and review 7
People, Communities and Care Model 7
Diagram 1 - People Communities and Care model Gateshead 8
1.2 Needs assessment and review 10
Diagram 3: BCF 2016/17 transition 11
Diagram 4: BCF 2017/19 transition 12
Intermediate Care in Gateshead 12
What has worked well – building on our highlights and successes 14
Better Care Fund approach 2017/19 17
Agreed approach to use of Improved Better Care 18
Agreed approach to use of Disabled Facilities Grant (DFG) 19
1. 3 National Conditions and narrative 20
Annex B: Maintaining progress on the 2016-17 national conditions 27
1.4 Risk assessment and management 32
Management of risk – financial and delivery .... **Error! Bookmark not defined.**
Assessment of risk 33
Section 2 Planning Template 36
2.1 Confirmation of funding contributions 36
2. 2 Programme Governance 38
Strategic ownership and leadership 38
2.3 National Metrics 41
A Non-elective admissions: 41
C Effectiveness of reablement: 42
D METRIC Delayed transfers of care (DTOC) plan 43
Section 3 Supporting documents 45

DRAFT

Approval and sign off

BCF plan signed off by	**Councillor Lynne Caffrey Chair Gateshead Health and Wellbeing Board.**
Date of Health and Wellbeing Board agreement	**8 September 2017**
Who has signed up to the BCF plan	**Gateshead Health NHS Foundation Trust** **Gateshead Local Authority** **NHS Newcastle Gateshead CCG** **Northumberland Tyne and Wear NHS Foundation Trust**
A&E delivery board discussion dates	**16 August 2017**

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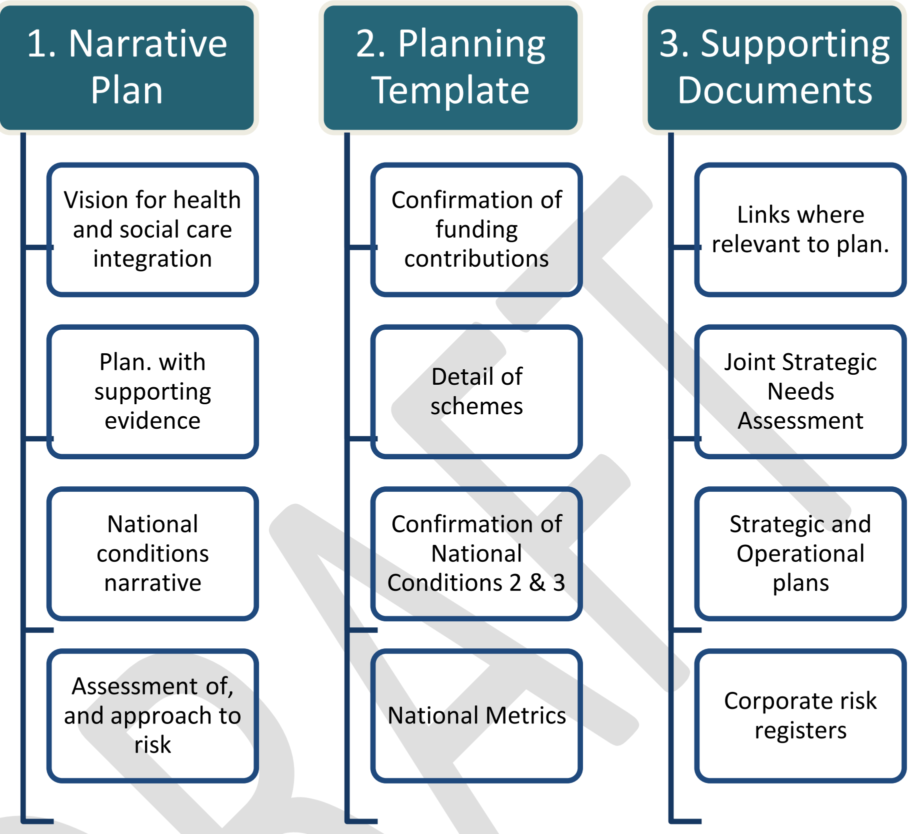
Introduction

The Gateshead Better Care Fund Plan is divided into the following sections:

Diagram 1: Better Care Fund Plan structure



This plan responds to the three sections of the Better Care Fund plan as follows:

The Narrative Plan section (pages 7 to 34) provides the main content of this document.

The Planning Template section (pages 35 to 43) refers to the confirmed funding contributions and details of schemes.

The Supporting Documents section (pages 44 to 56) includes both embedded documents and links to published documents.

Section 1 Narrative plan

Local vision, needs assessment and review

In this section we describe the local vision for health and social care services in the Gateshead system, the plans for transformation of services, implementing the vision of the Five Year Forward View and integration of health and social care services by 2020.

We set out the background to the local health and care economy and describe our plan to develop and implement our new model for care outside of hospital. There is also recognition of the challenges we face across our local health and care economies, as articulated within our local Joint Strategic Needs Assessment (JSNA).

We also review previous BCF plans, our progress against those plans, and how this has informed our current plan for 2017/19.

Our vision for health and social care was articulated within our original BCF submission (Part 1, section 2). It has subsequently informed the development of our strategic plans across our health and care economy in the Operational Plan for 2017/19, the Newcastle Gateshead chapter of an emerging Sustainability and Transformation Plan (STP) for Northumberland Tyne and Wear and North Durham (NTWND) (2016/17 to 2020/21) and more recently, the development of our local model for care outside of hospital; - People, Communities and Care.

Our BCF plan remains a core vehicle of our local economy's approach to future Health and Social Care integration (and wider) as set out in Vision 2030.

Vision 2030 is Gateshead's Sustainable Community Strategy which sets out the following ambitious and aspirational vision for Gateshead:
"Local people realising their full potential, enjoying the best quality of life in a healthy, equal, safe, prosperous and sustainable Gateshead."

http://www.gateshead.gov.uk/People%20and%20Living/communitystrategy/Vison2030.aspx

People, Communities and Care Model

At the heart of this vision is a recognition that our Health and Social Care system requires new models of care delivery across care settings with a focus on 'care outside of hospitals'. This, in turn, needs to be underpinned by a sustainable system which has 'prevention' and 'early intervention' at its core supported by 'connected communities', where people, families and communities have strong, empowering and enduring relationships. In summary, this describes our newly designed 'People, Communities and Care' (PCC) model, articulated in the following diagram:

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Diagram 1 - People Communities and Care model Gateshead

See Section 3 full size copy

The **People, Communities and Care (**PCC) 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.

Transforming health and care services needs to start with the creation of a model that is well understood and agreed by all parties; having achieved that understanding and agreement, we now need to move to an implementation phase where we systematically create the out of hospital system that ensures we maximize the ability of our population (across all ages) to live independently and in their own homes – receiving hospital treatment only when it really is needed and there is not viable alternative.

The implementation must also build upon the already well established working arrangements across Gateshead – there are not only good interagency relationships at all levels of organisations, but also great examples of joint working and innovation to be capitalised upon; for example, the development of the Gateshead Care Partnership.

The Gateshead Care Partnership is an innovative partnership formed between Gateshead Health NHS Foundation Trust, Gateshead Local Authority, Northumberland Tyne and Wear NHS Foundation Trust and CBC Health, to deliver integrated community services for Gateshead residents.

How our People, Communities and Care Model operates

People Empowerment and Connected Communities **- 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.**

Care and support **- 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. Professionals will be asked to collaborate with colleagues and help wrap their services around the person.**

Out of hospital care and support will be underpinned by a 'joined-up' system, with services across general practice, community services and social care delivering support to people that is coordinated and person-centred:

- ✓ General Practice - with growing demand and increasing complexity of illness being managed out of hospital the aspirations of the GPFV, are key to general practice being able to play an integral part in the development of our vision for out of hospital services. The CCG is already investing directly in transformation in general practice, funding transformation teams in both Gateshead and Newcastle. The aim is to support general practice to develop a vision for working at scale and new models of care and to support the development and implementation of the General Practice Forward View (GPFV) initiatives.

- ✓ Community Services and Intermediate Care - the developing models for community provision and a strong, responsive intermediate care system as well as the emerging same day accessibly urgent care model will further provide good foundations for the development of the out of hospital model.

- ✓ Social Care and Voluntary Community Social Enterprise (VCSE), in particular carers organisations, strengthening and supporting our social care and VCSE sector together with a robust, responsive and sustainable domiciliary and reablement care will be a crucial part of our PCC model.

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Impact for our population – what will be different

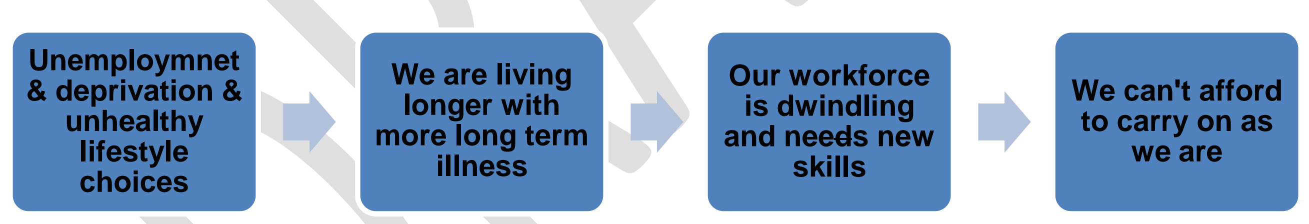
It is crucial this work is seen part of a whole 'system' model - embraced and implemented across all stakeholders and our public and patients. Therefore, the PCC model will be designed to deliver improved outcomes for the population in terms of their personal health and wellbeing behaviours as well as improve the quality of care delivered and help us meet our current funding challenges within the system. We will strive to exceed National standards around quality and safety and achieve recognised 'best practice' measures and metrics already in place within the current system.

Further work is underway to consider a system 'outcomes framework' for the PCC model, including patient experience, and (informed by National and regional work). Key metrics to assess impact of our Intermediate Care system will be go beyond the National BCF measures and reflect National work on outcomes around Intermediate care. (National Audit of Intermediate Care.) See Section 3 supporting documents for the audit framework (audit report expected Autumn 2017).

1.2 Needs assessment and review

The following highlights the key issues and challenges we face:

Diagram 2: The challenges for Gateshead



As in previous years, partners in Gateshead have committed to work together through a single policy approach, underpinned by the Joint Strategic Needs Assessment (JSNA). This takes an integrated and holistic approach to the wellbeing and health of people in Gateshead. The key ongoing challenges and emerging issues to health and wellbeing in Gateshead are presented across the life course. http://www.gateshead.gov.uk/Health-and-Social-Care/JSNA/home.aspx

The JSNA enables us to understand the key issues facing people in Gateshead and is used to identify key strategic priorities to improve the health and wellbeing of our population and includes a range of quantitative and qualitative data that we will be using to track changes to wellbeing and health at a population level, with a particular emphasis on social inequity in wellbeing and health. This approach recognises that

health (and ill-health/disease) arises from a complex interaction of different factors which are not limited to the work of health and care services alone.

The following sections of our JSNA highlights our:

- Local demography and future demographic challenges
- Current state of the health and adult social care market
- Key issues and challenges

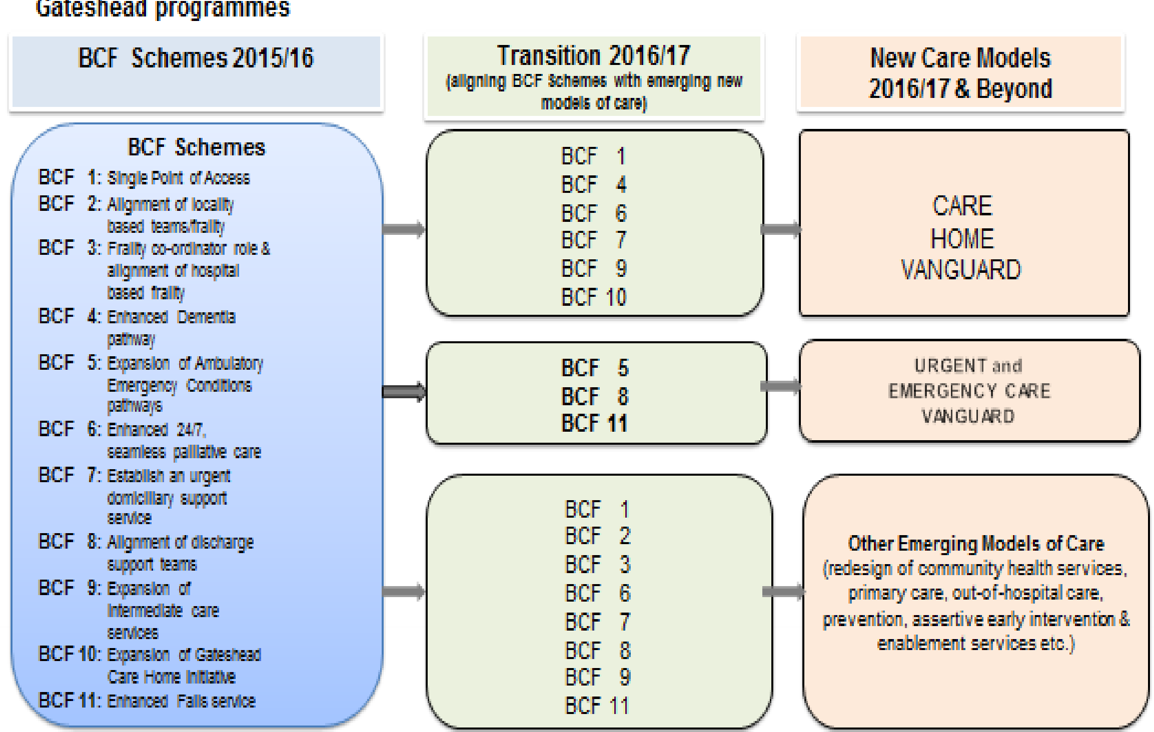
http://fingertips.phe.org.uk/profile/health-profiles/data#page/1/gid/1938132701/pat/6/par/E12000001/ati/101/are/E08000037/iid/1730/age/1/sex/4

http://www.gateshead.gov.uk/Health-and-Social-Care/JSNA/Topics/Population-and-Deprivation/Demography/Demography.aspx

Review of our previous Better Care Fund Plans

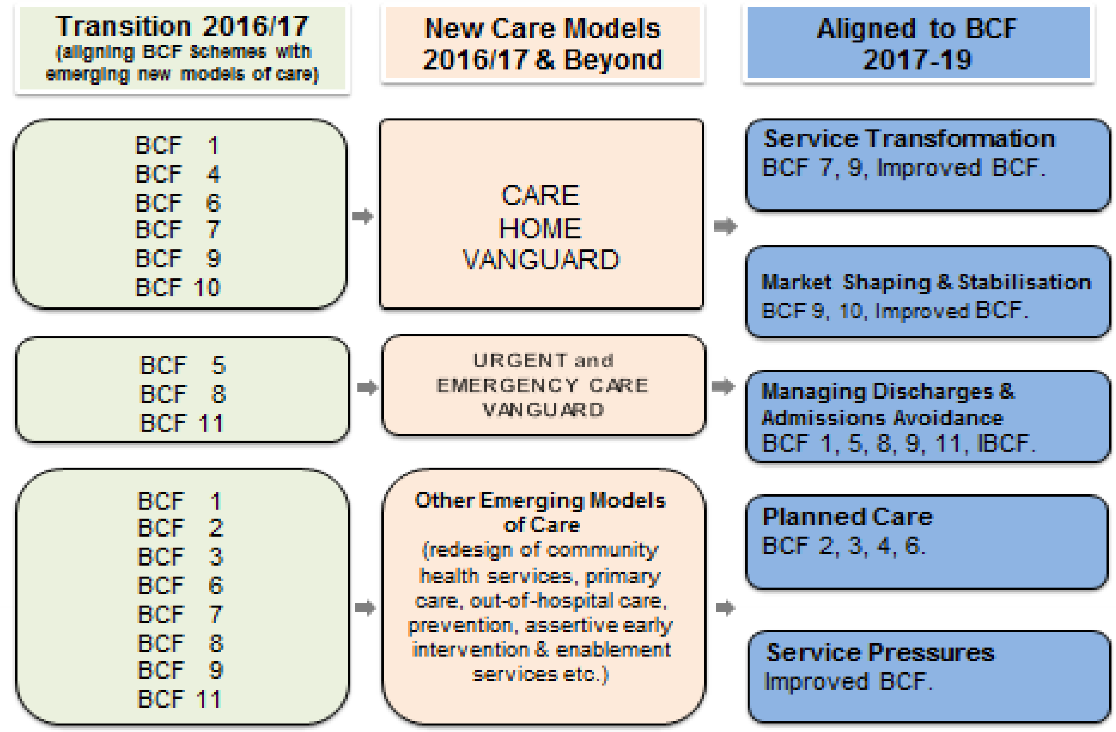
In building upon our BCF submission for the period 2014/15 to 2015/16 and working towards our longer term aspirations, 2016/17 represented a transition year where our 11 BCF schemes were aligned with our emerging new models of care (see illustration below).

Diagram 3: BCF 2016/17 transition



Our BCF Plan for 2017-19 further builds upon this approach. The illustration below demonstrates how the original BCF schemes have been re-aligned against key initiatives linked to our new models of care.

Diagram 4: BCF 2017/19 transition



Moving beyond 2016/17, our BCF (aligned merging new models of care) will transition into the PCC model being developed and implemented across the Gateshead system. Work programmes within original BCF plans naturally migrate into the 'care and support' component of our PCC model and more specifically could be considered under the '*intermediate care'* system umbrella term.

Intermediate Care in Gateshead

As a system we recognise that here are five key points within a person's journey where they could benefit from intermediate care:

- When there is a high risk of decline in independence, health and wellbeing resulting in the need for long term support;
- When they are already receiving support and there is a change in their level of independence;
- When there is potential that they may be admitted to hospital;
- To support timely discharge; and
- When there is a potential admission to a care home.

Therefore, as a major part of the PCC model, the intermediate care system in Gateshead means that services are:

- Targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care.
- Provided on the basis of an evidence based comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery. Comprehensive assessment and care planning to cover physical, mental and social needs
- Have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home.
- Are time-limited, normally no longer than six weeks (though there are sometime exceptions) and frequently as little as one to two weeks or less.
- Involve practitioners and organisations working with a single assessment framework, single records and shared protocols.
- Ensure an integrated and holistic approach to physical and mental health care needs that is closely aligned with other mainstream health and social services such as elderly care, psychiatry of old age, housing, primary care etc.

The new model can then use the expertise of the multi-disciplinary team to agree the most suitable intervention for each individual – maximising independence and quality of life for people of all ages, whilst ensuring cost effective use of resources. We have adopted a 'think home' first model for assessment and have agreed a shift to an assessment culture that responds to the question “why not home?”

Getting the model right in Gateshead means that people will:

- Improve and/or maintain their independence, health and wellbeing
- Have a managed decline in independence, health and wellbeing
- Have their ability to live independently maximised
- Avoid unnecessary hospital admission
- Be in hospital no longer than is necessary
- Avoid premature admission to long term residential care

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Diagram 4: Intermediate Care Model – Gateshead

Primary Care Teams | Community Teams (health and social care) | Hospital Teams | A&E | Any Care Professional

Referral

Single point of access/ Intermediate Care Team

MDT Decision Making

Intervention

Step up and step down

Own Home independent	Home with follow up care (health and/or social)	Assessment Bed	Intermediate Care Bed	Care Home	Palliative Care	Pressure Placement Bed	Hospital

What has worked well – building on our highlights and successes

Improvement in our BCF performance metrics has been demonstrated in most areas against a backdrop of demographic and financial pressures, although the performance trajectories have not been met in all areas.

Highlights - Local learning event

We hosted a local learning event in Gateshead Newcastle on 9th May, meeting with the central BCF team and wider North East BCF colleagues.

We used this opportunity to highlight the excellent integrated working happening across the Gateshead local health and care economy showing both the pro active and reactive elements and how these link with BCF and progression to the Out of Hospital Model (People, Communities & Care).

As a system we gained a huge amount from having the opportunity to talk to the central team who said it was useful to see at first hand the Intermediate care schemes and they were very impressed by the clear dedication and commitment of all the staff. We discussed with the team some of the complexity, challenges and blockages in the system.

Successes include

- Admissions into residential or nursing care

From April 2016 to March 2017, there were 324 permanent admissions into residential or nursing care. This represents 839.3 admissions per 100,000 population (based on 2014 population projections) showing a significant improvement in performance compared to the same point last year of 433 (1144.4 per 100,000 population) and has seen the year-end target of 388 admissions being achieved (1,005.1 per 100,000 population). The improvement in performance can be attributed to the introduction of a panel process in April where service managers have closer scrutiny and control over new admissions.

- Non Elective activity

Cumulative data for 2016/17 shows that Non Elective activity is below planned trajectory across the Gateshead HWB footprint, with 21,883 actual admissions against a plan of 22,979.

- Dementia

Dementia diagnosis has improved throughout 2016/17 despite a slight dip below the 70% target in Q4 to 69.9%. The rate is currently above the national standard and work continues to recover the rate seen earlier in 2016/17. In terms of continuous improvement the Care Home Vanguard team have identified from a clinical audit that 62% of people in care homes have a formal diagnosis of dementia, but considering those living with cognitive impairment without a formal diagnosis this figure could be around 72%.

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

Achievements include:

The Care Home Project (Gateshead and Newcastle) is already delivering improvements in outcomes for the Care Homes residents. The figures below relate to Gateshead :-

- A&E attendances – 3.4% reduction comparing 2015/16 to 2016/17 for the care home population. For the wider population (over 65s) this has increased by 3.1%. Learning to date suggests that in order to identify who has the most complex needs it is becoming important to separate out the age bands into 65-79 and those over 80. Coupled with the introduction of eFI (electronic frailty index) in primary care this should facilitate the identification of those who would benefit most from case management.

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- Non elective admission reduction –28.3% reduction in non-elective admissions. Learning to date highlights the most common reasons are UTI (17.4%) and Chest infections (10.9%).
- Prescribing nutritional supplement reduction – current evaluation highlights a sustained reduction -13.7%
- Prescribing of low dose antipsychotic meds continues to see a significant sustained reduction (4%)
- Outpatient appointments reduction – the anticipated reduction has not been seen; more work needs to be done in order to understand the age group dynamic, and specialities considered in data collection to date.

Progress against 2016/17 BCF performance metrics

Reablement - The indicator value for Q4 stands at 80.8% (147 out of 182) for all of those aged 65 and over that were discharged from hospital into reablement and still at home 91 days later. The value is lower than the same period last year, which was 85.6% (184 out of 215) and is also below the challenging target of 87.5%. Please see explanation and actions being taken to address this issue under the Supporting Metrics Tab."

DTOC - Total delayed days for 2016/17 was 6372 against a trajectory of 3330. The plan for the year has therefore not been achieved.

The plan for delayed discharge has not delivered the anticipated level of improvement, more work needs to be undertaken to understand this more fully. This will include an analysis of the patient profile of this cohort.

We have discussed DTOC in more detail in the section covering National Condition 4, including our assessment against the High Impact Change Model and our collaborative and integrated approach being taken in Gateshead by all stakeholders and providers to reduce delays.

Challenges and concerns

As austerity measures bite ever deeper, we must avoid cost shift and look at risk share to maintain the good relationships and ways of working that have developed over the last few years as the BCF plans have been developed.

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Better Care Fund approach 2017/19

BCF is part of the transformational work taking place in the Newcastle Gateshead Health and Care economy to develop new models of integrated delivery and integrated commissioning based on the needs of communities.

Progress continues to be made in steering the transition of the BCF schemes towards new models of care such as the Care Homes and Urgent Care Vanguards, redesign of community health services, primary care, out-of-hospital care, and prevention/assertive early intervention. This work will contribute to reducing health inequalities in the Gateshead population.

This work is also consistent with our STP and, in particular, our aspirations for Prevention, Health & Wellbeing, Out of Hospital care, Mental Health and broader acute hospital collaboration.

As we have stated above, our BCF plan is in the process of transition to the developing PCC model. The 2017/19 plan is a therefore a transitional plan and future BCF plans will follow the PCC format in full.

The Gateshead Care Partnership (GCP), representative of the Gateshead Council, Gateshead Health NHS FT, Northumberland Tyne & Wear NHS FT and Gateshead Community Based Care, is the key delivery vehicle for the transformation of community health services in Gateshead and oversees the implementation of the community health services contract.

It also has a lead role to play in taking forward the implementation of our out-of-hospital (People, Communities and Care) model for Gateshead.

GCP has built good working relationships with statutory and other partners across the Gateshead health and care economy in helping to shape delivery arrangements in line with our joint aspirations for the health and wellbeing of local people and our vision for health and social care.

Our approach to design and implementation of our PCC model will use methodology for 'change' that is:

- Underpinned by our ***'system integration'*** principles articulated within the Accountable Officer '**Statement of intent**';
- Aligned to our adapted ***'10 step'*** approach to designing and implementing new model of care, and

- In line with 'best practice', using and exploring evidence-based intervention. In doing so, we will use local, national and international experience to shape our PCC going forward. For example, the '***what good looks like' suite*** **of 'best practice'** interventions from the national new care model programme

See section 3 for these documents

Key schemes/pathways descriptors

Although, we are taking a whole-model approach, as well as focusing the intermediate care system, it is important to recognise 'key pathways' within the model that will be principally responsible for achieving the prescribed BCF measures and National conditions.

A brief description of our schemes /pathways is found in Section 3, Appendix 1 Table 1 for both existing and new iBCF schemes. The schemes are also mapped to the People Communities and Care model against the BCF National guidance on scheme types and aligned to the National BCF conditions.

Agreed approach to use of Improved Better Care fund money to increase capacity and stability in the care market

It should be noted that Gateshead, through the Gateshead Care Partnership is developing a service delivery model which will focus on early intervention, prevention and enablement. Alongside this there will be an imperative for keeping people in their own home for as long as possible through maximising the use of assistive technology and development of alternative interventions. The impact of the projects outlined above on reducing DTOCs will ensure people are discharged in a more timely way and also to the most appropriate place.

With this in mind the number of home care packages is likely to increase but the extent of this is still being considered as through the new delivery model the actual home care hours may be maintained; the new delivery models are still developing.

In relation to residential care there is a commitment to reduce the numbers of people in care by at least 5%, this would equate to 40 people over 2017/18, which is challenging and requires a system wide approach as outlined above. The Council and CCG are committed to optimising the use of the funding and therefore projects will be evaluated as they progress and monitored through the wider BCF governance framework.

Section 3, Appendix 1 Table 1 identifies the broad schemes within the BCF plan that will be used for market shaping and stabilisation investment in the Adult Social

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Care market, especially residential and home care to increase capacity and drive up quality.

Agreed approach to use of Disabled Facilities Grant (DFG)

There is a growing evidence base about the role that housing can make to good health and wellbeing. Suitable housing can help people remain healthier, happier and independent for longer, and support them to perform the activities of daily living that are important to them – washing and dressing, preparing meals, staying in contact with friends and family.

Housing therefore has real a contribution to make to sustaining and improving outcomes for adults in Gateshead and is recognised as an important element of our Better Care Fund (BCF) planning process.

The Council will review alternative housing options when considering the adaptation required and whether there is an already adapted property within a reasonable distance. A strategic review of housing adaptations including equipment services will be undertaken during the BCF plan period to ensure efficient use of resources including assessment capacity across health and social care.

With an aging population and more people dealing with long term conditions the majority of adaptations are carried out for those aged 65+. Often a fall or fall related injury will be a trigger point to requesting a home adaptation.

Whilst the increase in DFG specific funding has continued year on year and into 2018/19, work is required to align the infrastructure in relation to occupational therapist capacity.

DFG in Gateshead

In 2016/17 326 Disabled Facilities Grant adaptations were undertaken, the forecast for 2017/18 is 340.

The most common adaptations are level access, showers and stair lifts.

The Council also funds adaptations related to Council houses with 353 adaptations in 2016/17.

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1. 3 National Conditions and narrative

The following section describes how we will deliver on the 4 priority national conditions and the 3 previous national conditions for 2017/19 by summarising our:

- *Progress to date*
- *Actions to achieve national conditions*
- *Alignment with existing plans*

National condition 1: A jointly agreed plan	
Progress to date	The Gateshead BCF plan has evolved over the last few years. Our BCF plan started with 11 schemes, which naturally migrated into our evolving new models of care as part of our BCF submission for 2016/17 and more recently resulted in the development of the People, Communities and Care out of hospital system model. On 28 April 2017, the Health & Wellbeing Board considered a model then known as 'Communities and Neighborhoods', designed to shift care outside of hospital and closer to people's homes as part of the overall work to integrate health and social care across the borough. The board provided comprehensive feedback on the model, as did the other stakeholder meetings during March and April of 2017. The feedback was considered and incorporated into a refined model – which was retitled 'People, Communities and Care'. **Table 9 in Appendix 3 of Section 3** identifies the comprehensive stakeholder conversations held.
Actions to achieve national conditions	Our BCF plan for 2017 to 2019 was submitted for consideration and approval by Gateshead's Health & Wellbeing Board on 8th September 2017, prior to submission to NHS England. The BCF Plan has been developed in tandem with Operational Plans for 2017/18 the NTWD Sustainability & Transformation Plan and the wider regional planning work underway. Progress in implementing our BCF Plan for 2017-19 will be reported regularly to the BCF Programme Board and Health & Wellbeing Board as required.
Alignment with existing plans	This narrative should be read in conjunction with a number of documents with associated links as identified in section three of this narrative plan**.**

National condition 2: NHS contribution to social care is maintained in line with inflation	
Progress to date	Maintaining a stable and social care sector is clearly crucial to the success of our BCF plan. Therefore, as a local health and care economy we will continue to invest in social care.
Actions to achieve national conditions	Protecting social care services is fundamental as we start to build a sustainable local health and social care system. This change programme will be driven through the development of our PCC model together with wider strategic planning. **Social care services will be protected as we:** • Meet needs of individuals and their carers under the Care Act (2014) • Strengthen our focus on secondary and tertiary prevention for those with long term / complex conditions • Improve our Early Help offer • Provide a more comprehensive • Reshape services through the Gateshead Care Partnership • Deliver the outcomes of the High Impact Change Model Newcastle Gateshead CCG has complied with National Condition 2 and maintained its contribution to adult social care in line with inflation. The contribution of £5.898m in 2016/17 has been increased to £6.004m (1.8%) in 2017/18 and then to £6.118m (1.9%) in 2018/19. These sums are equal to the amount confirmed in the planning template. The quoted contribution in 2016/17 was already in excess of the required minimum NHS to Social Care transfer due to the Care Act funding and schemes commissioned with the LA from the CCG minimum, however the 1.79% increase to this total will not destabilise the local care and health system. The contribution continues to be spent on social care services that have some benefit to health and support the overall aims of our Better Care Fund Plan.
Alignment with existing plans	**Section 3 Appendix 1 Table 2** identifies schemes which support our planned change (including investment) into the social care sector through 2017 to 2019.

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National condition 3: Agreement to invest in NHS commissioned out of hospital services	
Progress to date	Priority has been given to developing out of hospital services to ensure that effective care can be provided to patients in their own home or as close to home as possible. Community teams will be integrated to effectively fulfil their role as the first point of access for patient care. This work in 2016/17 has focused on the development of a standardised intermediate care model to ensure patients are able to be discharged from hospital when medically fit and can be cared for outside -the acute sector. Through the STP process, there is a recognition that investment in Out of Hospital services is fundamental to sustainability of the whole system, therefore ongoing modelling and redesign will help prioritise what level of investment is required to deliver this shift. Workshops have taken place since October 2016 to agree the Out of Hospital model for the STP footprint with representatives from health and social care involved in this key piece of work.
Actions to achieve national conditions	**Appendix 1 Table 3** identifies schemes which support our planned changes (including investment) into the NHS commissioned out of hospital services through 2017 to 2019. In agreeing the targets for the non elective admissions metrics we have analysed previous performance and reviewed a realistic assessment of the impact of BCF initiatives **(as described in Section 2.3).**
Alignment with existing plans	The schemes funded in 2016/17 were reviewed in light of the national requirements around NHS commissioned out of hospital services, delayed transfers of care and also maintaining social care expenditure in line with inflation. The full minimum contribution is allocated to schemes for 2017/18, and the local spending target around commissioned out of hospital services is being achieved in Gateshead plans. There are currently no funds in the plans that are deemed at risk for 2017/18, however the risk sharing agreement included in 2016/17 that has been subject to audit will essentially be rolled forward and amended where necessary. In reviewing the requirement for a risk sharing arrangement we have included an

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	analysis of previous performance and a realistic assessment of impact of BCF initiatives. Schemes in 2017/18 continue to be funded broadly in line with 2016/17 as part of the transition to new models of care.

<table>
<tr><th colspan="2">National Condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care</th></tr>
<tr><td colspan="2">This high impact change model aims to focus support on helping local system partners minimise unnecessary hospital stays and to encourage them to consider new interventions for future winters. It offers a practical approach to supporting local health and care systems to manage patient flow and discharge and can be used to self-assess how local care and health systems are working now, and to reflect on, and plan for, action they can take to reduce delays throughout the year.

Section 3, Appendix 2, provides a current assessment of where the Gateshead system is in implementing the High Impact Change Model (HICM). The model identifies eight system changes which will have the greatest impact on reducing delayed discharge. Ensuring people do not stay in hospital for longer than they need to is an important issue for the Gateshead health and care economy.</td></tr>
<tr><td>Progress to date</td><td>DTOCs - Total delayed days for 2016/17 was 6372 against a trajectory of 3330. The plan for the year was therefore not achieved. There appears to be a range of issues that are contributing to the lack of improvement in performance in delayed transfers, which we have reviewed as a matter of urgency, including an analysis of the patient profile of this cohort.

Work has been undertaken with key partners to understand bed utilisation and the barriers to discharging patients once medically fit. A joint local plan of action (including Newcastle local Health and Care economy) is being developed which will be influenced by the need to implement 7 days working and the 8 High Impact Changes

Actions (along with the other recommendations of the UEC Review). Discussions have taken place across the Gateshead footprint to ensure a standardised approach in order to reduce the number of delayed discharges.</td></tr>
<tr><td>Actions to achieve national conditions</td><td>A collaborative and integrated approach is being taken in Gateshead by all stakeholders and providers who are committed to promoting rapid and supported discharge from hospital to the most appropriate place for both Gateshead and out of area patients - in a planned manner rather than an extended length of stay in an acute hospital bed.

This will have a positive impact on further reducing DTOCs. All relevant projects outlined above have been mapped to the High Impact Change model to ensure we are allocating resources appropriately to deliver the model. Specific provision is made to implement the trusted assessor model, different models of assessment and develop a 7 day discharge to enablement</td></tr>
</table>

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	process. There is a systemic problem in Gateshead regarding the stability and capacity of the home care market, there is specific provision with the plan to address these issues together with working in partnership with our strategic health partners through the Gateshead Care Partnership to reshape community services provision including services directly provided by the Council Work has been undertaken between the LA and the Trusts to ensure that there is a coordinated and agreed approach to DTOC (as analysis identified that there had been some changes to recording, which had not been agreed across the system). The CCG, LA and Trusts worked together during the winter period to develop a different approach to facilitating home care packages from hospital. This was piloted as the "bridging service", and is in the process of being evaluated. The high level feedback was positive and we are looking to develop a longer term model, through the improved Better Care Fund. Ensuring people do not stay in hospital for longer than they need to is an important issue for the Gateshead health and care economy. Whilst much progress has already been made to improve patient flow across the whole system through the implementation of the key actions specified in the High Impact Changes model, it is intended that each year the local health economy will further develop and enhance the services available so that they progress by at least one 'step' per year (e.g from Established to Mature). **Section 3 Appendix 1 Table 4** identifies schemes which support our planned change (including investment) into delivering the High Impact Change Model for Managing Transfers of Care through 2017 to 2019, although other BCF and iBCF projects will have indirect contributions to these changes. Additionally it should be noted that there is a range of work on this area currently sitting outside of the BCF, and which have been referred to already in the document eg. GPFV and regional work eg Urgent and Emergency Care Network. This work is closely inter-related with our BCF plan because providing care closer to home will reduce the demand on other services.

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Alignment with existing plans	Work continues to be undertaken with key partners, and discussions continue across the Gateshead footprint to ensure all work is aligned with plans and a standardised approach is in place in order to reduce the number of delayed discharges. A copy of the Gateshead Delayed Transfer of Care (DToC) Action Plan 2016/17 can be found in **Section 3.** The plan provides a detailed analysis of the actions implemented during 2016/17 to further ensure optimum health care provision. Business processes have already been robustly reviewed and embedded within every day working practice to ensure consistent, accurate and timely recording, validation and reporting mechanisms - in line with statutory definitions for a 'delay' and with national best practice for completing the statutory return.

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Annex B: Maintaining progress on the 2016-17 national conditions

Although no longer national conditions we have described in the following section our plans to take forward these policy priorities and critical enablers for integration, including how they are aligned with key schemes/pathways mapped to the People Communities and Care model.

B1 Agreement on the delivery of 7 Day Services
Improving services through the implementation of the 7- day service clinical standards remains an important priority and we are working to make progress on implementing the 4 priority clinical standards, supported by NHS England and NHS Improvement. Good progress has been made in developing 7 day working - a key focus for the CCG and its partner organisations both to effectively utilise resources as well as to provide patient centred, convenient services routinely at weekends, involving the entire team in service delivery. Plans have been developed and are being implemented, which will be further enhanced based on the recommendations of the UEC Review/ 8 High Impact Actions and local needs assessments to ensure that co-ordinated multi-agency, multi-disciplinary care is available 7 days a week. Progress made in 2016/17 • Extended opportunities for 7 day discharge ('perfect week', MADE) in line with the High Impact Actions - key services are now available. • Learning from Prime Minister's Challenge Fund in Gateshead to roll out extended access in Primary Care - primary care access is available in both Newcastle and Gateshead for patients who need to see a GP but who are unable to access their registered practice including during out-of-hour periods and weekends. • Enhanced community provision which integrates with urgent and planned care services • Think Pharmacy First Scheme continuing to be enhanced including streaming from ED to local community pharmacies in order to reduce demand for minor ailments across the system. The Local A&E delivery board will continue to oversee achievement of the A&E target and delivery of the 5 elements of the A&E Improvement Plan; ensuring implementation of the key actions specified in the Rapid Improvement Guidance for Streaming, Flow and Discharge, working collaboratively with NEAS to assist them in delivering the Ambulance Response Programme as well as working as a key member of the Regional UEC Vanguard to deliver the Integrated Urgent Care Standards across the STP footprint.

DRAFT

Section 3 Appendix 1 Table 5 identifies schemes which support our planned change (including investment) into the delivery of 7 Day Services including how they are aligned with key schemes/pathways mapped to the People Communities and Care model.

B2 Better data sharing between health and social care, based on the NHS number:

Following initial stakeholder events held in 2015, significant progress has been made to develop more robust plans for delivering information sharing between stakeholders, including across health and social care. The CCG has co-ordinated the development of the Newcastle Gateshead Local Digital Roadmap, which outlines the ambition across Newcastle Gateshead to deliver a paper free care system by 2021. Stakeholder organisations were involved in developing this joint plan which was completed in June 2016.

The Newcastle Gateshead Local Digital Roadmap sets out ambition across several universal capabilities for shared information across care settings. The deployment of the Medical Interoperability Gateway (MIG) and Messaging Exchange for Social Care and Health (MESH) are key systems needed to achieve successful sharing of information between Gateshead Social Care and NHS partners.

The local Gateshead Information Network (GIN) continues to meet regularly and covers a range of health, social care and third sector providers. Recently it has been agreed to hold joint meetings with Newcastle, to form the Newcastle Gateshead Information Network, who will oversee the implementation of the Local Digital Roadmap. Progress has been made in the provision of patient communications at a regional level, with posters, leaflets and a patient helpline for queries around information sharing going live in September 2016.

Implementation of projects to deliver this agenda continues with sharing of patient records from primary care to our local Mental Health provider making progress, and engagement work currently being carried out with practices. This will involve sign up to an Information Sharing Gateway – a single portal to allow organisations to easily manage their information sharing agreements.

This will provide a direct link between mental health care and GP records established at the point of direct care with the patient, using a solution called the Medical Interoperability Gateway (MIG). Information sharing is also being established for all local acute trust providers, who each have plans in place to begin accessing primary care records at the point of care (with urgent and emergency care settings being a high priority).

DRAFT

In addition, Gateshead and Newcastle Councils are working with Health Care Gateway (MIG supplier) and the Social Care system suppliers on an integration piece with the aim of presenting Social Care practitioners with GP record information via an agreed dataset and conversely, GPs with Social Care record information. Building on the work being undertaken across organisations to facilitate the use of the MIG into social care services, officers are considering options in terms of smaller scale pilots, which will be able to test the system; identify benefits and address any operational issues. There is a view that linking this with the existing Care Homes Vanguard work may be beneficial.

The GIN meetings bring together technical experts alongside frontline staff to discuss the mapping of systems currently in use across health and social care. Through this network there is regular discussion on how to move towards system integrations, including a working towards the Open API standards.

All NHS organisations use the NHS Number as the main identifier, all organisations have processes in place to identify and fill gaps in usage of the NHS number. Usage of NHS number as the single identifier in Social Care is increasing with 90% of active social care clients in Gateshead having a matched NHS number. Work is ongoing within social care to increase this by mapping business processes and working with frontline staff to promote its use.

In the last six months Newcastle Hospitals NHS Foundation Trust and Northumberland Tyne and Wear Mental Health trust have both been identified as Global Digital Exemplar sites. This may present opportunities to further this area of work and this is being explored.

Section 3 Appendix 1 Table 6 identifies schemes which support our planned change (including investment) into the delivery of Better data sharing between health and social care, based on the NHS number including how they are aligned with key schemes/pathways mapped to the People Communities and Care model.

These changes will enable us to connect existing services to reduce duplication and improve the experience of service users/patients. Care will be delivered more safely because professionals will have access to up to date information about the people they are caring for.

In 2017/18 we will continue to:

- Work with health and care teams to understand requirements for and barriers to data sharing and to test out how we address any system and mode of operation issues.
- Implement our digital roadmap for information sharing.
- Use technology to support reduction of unnecessary NELs, 7 day working,

DRAFT

out of hospital services, and timely discharge.

- Engage our local population on data use, access and legal rights.

B3 A joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care there will be an accountable professional

All funding for integrated packages of care are jointly agreed between CCG and LA leads. There are well established panel arrangements in place to ensure that there is a joint approach to assessments and care planning, and appropriate funding allocated. The process for jointly reviewing eligibility is also jointly agreed. Case management of CHC eligible individuals is (previously commissioned from the LA), is transferring back to the CCG; plans are being developed to ensure that the transfer of this work is managed in a safe and seamless way.

Community matrons are also key to the development of integrated packages of care; this is of particular significance in the management of long term conditions and where there is a dominance of complex specialist health care needs.

Single Point of Access and IT development work further support joint care planning arrangements, as will the redesign of community services.

As identified within our original BCF submission (Part 1, Annex 1, Scheme 4), there are a range of services within health and social care and across NHS and voluntary providers that support patients with dementia. We are continuing to work with providers to align patient referral pathways around consistent service delivery.

Local work has also been undertaken to support General Practices to identify and manage patients with dementia (e.g. care planning training). Dementia is a specific workstream of the Gateshead Newcastle Care Homes Vanguard and a service review is underway within old age psychiatry in Gateshead Health NHS FT aiming to enhance pathways in conjunction with primary care.

Section 3 Appendix 1 Table 7 identifies schemes which support our planned change (including investment) into the delivery of assessments and care planning including how they are aligned with key schemes/pathways mapped to the People Communities and Care model.

B4 Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans:

Newcastle Gateshead has well established governance arrangements supporting 'Better Care'. There is joint ownership across both Health and LA commissioners and providers to lead on the development and implementation of the plans.

DRAFT

Ongoing discussions around service redesign with a shift in 'closer to home' provision are transparent and the implications for acute and non-acute providers both in Health and Care are understood. A shift in the 'national conditions' to explicit funding to support community health (including social care) underpins the ethos to Better Care, coupled with ring-fenced investment.

The current governance arrangements in 'Better Care' and wider system contractual and planning discussions (STP development) have enabled us to collectively understand the consequential impact on providers on our strategic plans and sign off is undertaken in the Accountable Officers Forum; this being a meeting of all of the NHS and LA Chief Executives in the health and social care economy.

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1.4 Risk assessment and management

The following section the agreed approach to risk is set out, and the risks of our plan are identified, along with mitigating actions to be undertaken by the partners.

The BCF (and from 17/18 the iBCF) are covered by a S75 Agreement signed by the local authority and CCG but shared with provider partners for their involvement in governance and risk management arrangements.

The current Section 75 agreement outlines the following in terms of risk share:

- Pooled Fund Management
- Overspends
- Underspends

A copy of the agreement can be found in Section 3.

These arrangements are increasingly important given the context of further financial pressure across all partner organisations. Partners have been active in sharing and understanding financial risks and pressures across all organisations and are clear that long term benefits will only be achieved by working together.

Each partner has an efficiency programme in place to support achievement of in year and medium term financial balance with appropriate internal governance arrangements to provide assurance on delivery. In addition there is recognition of increased pressures on resilience across the whole health and social care system, noting the key roles of general practice and the voluntary sector.

Key risks and associated mitigating measures reflect the direction of travel being taken by our local system and the role of our BCF plan for 2017/19 in facilitating the transition to new care models and broader transformational change. These risks are consistent within partner organisations.

The risks have been assessed in terms of main delivery risk and current market position and rated as red, amber or green.

Assessment of risk

Risks	*Mitigation*	*RAG rating*
Relationship challenges – commissioner and providers	Our local system has good working relationships in place across the local health and care sector. Our Health and Wellbeing board and Accountable Officers Group have further developed working relationships allowing for appropriate and timely escalation of issues that need resolving but also allow for alliances and relationships to be strengthened.	
Cultural changes required and change to working behaviours/skills not adequately addressed.	There is a continuing need for work to be undertaken with all stakeholders and employees across the sector to address this requirement which is key to successful transformational change.	
IT infrastructure/sharing arrangements are not fit for purpose to support plan delivery.	Robust IT programmes are in place with multi-stakeholder arrangements. Gateshead Information Network (GIN) has a clear strategy with outcomes and are working towards an aligned system that allows a whole–system approach to care delivery.	
There is a disconnect between commissioner and provider plans	Our plans for 2017-19 have been developed in the context of a whole system view consistent with our Health and Wellbeing Strategy. Consideration has and continues to be given to the impact on providers with a view to jointly defining our direction of travel on health and care integration and transformation. Providers are core and key to all service changes and are actively co-producing the system transformation and how delivery will be implemented. The Joint Integrated Care Programme Board will have a focus on	

DRAFT

Risks	*Mitigation*	*RAG rating*
	planning for long term sustainability that links with the AOs group and our Health & Wellbeing Board.	
Financial risks including risk of cliff edges at the end of the funding period.	Locally, our transformational approach seeks to reduce this risk to the authority and the local system. Nationally, we are aware of the need for a longer term settlement from Government.	
The plan and supporting initiatives do not enable resources to be redirected towards redesign of care pathways towards closer-to-home care	Our plans are designed for the best interest of patients and the public to make a sustainable local health and care economy. Pathways have an evidence base, are best practice concepts and are what works locally. Changes are being considered in relation to whole-system transformation and new funding /payment systems (e.g. new models of care) that will allow risk sharing arrangements with providers, new service configurations (e.g. alliance networks) and focus on rewarding value-based outcomes across health the social care economy.	
Pressures on the acute sector are not reduced and demand continues to grow across the system with significant and continued financial consequences	Our transformational plans have a strong focus on prevention, wellness and are adopting alternative pathways of care with investment into the out-of-hospital sector. Aligning health and social care efforts with a big push towards wellness, we will hopefully start to see a reduction in 'needs' and an expansion in wellness. Focusing on the high demand cohorts for the acute sector (e.g. older people) will hopefully start to reduce activity as alternative pathways of care start to come on line. Through our most senior forum e.g. Accountable Officers Group we will manage system and service resilience whether through pressures such as surge, financial or through transformation.	

DRAFT

Risks	Mitigation	RAG rating
Financial pressures in CCG budgets as a result of demographic growth and living wage.	CCG QIPP programmes in place with a PMO established to drive implementation and provide assurance on delivery.	
In Primary Care there is a significant increased workload so that Practices are already under critical pressure to maintain current access and care. Workforce gaps particularly GP and Practice nurse; likely to get worse due to demographic workforce skewed to near end of career; and failure to recruit new GP and Nurses in sufficient numbers. No growth in funding to Practices for last 10 years (though some limited and/ or short term funding GPFV)	The CCG is actively engaged in workforce strategy development as members of the Health Education England (HEE) local workforce action board and group. Based on emerging evidence and best practice from the groups above, the CCG is developing workforce solutions to fit the developing out of hospital model, looking at potential skill mix options and integrated roles. This includes access to International Recruitment to increase workforce capacity. Use of HEE NE workforce tool to understand /assess the workforce profile of our practices will allow us to develop future CPD needs and allow us to map the workforce in Newcastle Gateshead	

RAG ratings

Red – significant risks remain which could impact on delivery of the BCF plan and objectives

Amber – progress being made but a degree of risk remains which could impact on delivery of the BCF plan and objectives

Green – no concerns highlighted which could impact on delivery of the BCF plan and objectives

DRAFT

Section 2 Planning Template
2.1 Confirmation of funding contributions

The following section summarises the planning template which will be submitted alongside our narrative as part of the overall BCF plan.

The funding contributions for the BCF have been agreed and confirmed, including agreement on identification of funds for Care Act duties, Reablement and carers breaks from the CCG minimum. The excel Planning Template confirms the financial details for the following areas

- Care Act
- Carers' breaks
- Reablement
- DFG
- iBCF

The use of this funding is described in the table below:

The amounts in the planning template comply with BCF minimum funding requirements, including;

- Mandated local contributions for Implementation of the Care Act, Reablement and Carers Support
- Minimum contribution to Adult Social Care has been maintained in line with inflation, based on 1.79% uplift in 2017/18 and 1.9% uplift in 2018/19
- Funding for NHS Commissioned Out of Hospital Services had been maintained above the ringfenced minimum, as in 16/17.
- Disabled Facilities Grant as per minimum contributions set out in the template

DRAFT

- Plans for the use of the full IBCF grant meet all of the purposes set out in the grant determination and there has been no offset against the contribution from the CCG minimum.

Stakeholders have been involved in the production of the BCF and iBCF schemes for 2017/18 and support the approach taken. The iBCF final schemes were agreed by the CCG and the Local Authority in August 2017.

iBCF Funding
Plans for the use of iBCF money meet all of the purposes set out in the grant determination ie:

- Meeting adult social care needs
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- Ensuring that the local social care provider market is supported

There has been no offset against the contribution from the CCG minimum.

Details of the BCF schemes and iBCF schemes can be found in **Section 3 Appendix 4 .**

DRAFT

2. 2 Programme Governance

The following section sets out the governance arrangements for integration work in Gateshead, within which context the BCF will sit.

Strategic ownership and leadership

In January 2017, the six accountable officers across Newcastle and Gateshead (three main foundation trusts, two councils and one CCG) signed a 'statement of intent' that describes their shared commitment to working together across organisational boundaries to improve population health and social care outcomes and create:

- A continuing and sustained improvement in the health and wellbeing, evidenced by greater longevity and better outcomes from health and social care interventions.
- Greater equality of outcomes delivered through the highest quality health and social care.
- An appropriately integrated and well planned, effective delivery model for health and social care, which is efficient in its use of resources.
- A delivery system that is responsive to the needs of users in the short term and additionally, in the longer term, supports communities to be more responsible for the achievement of these objectives.

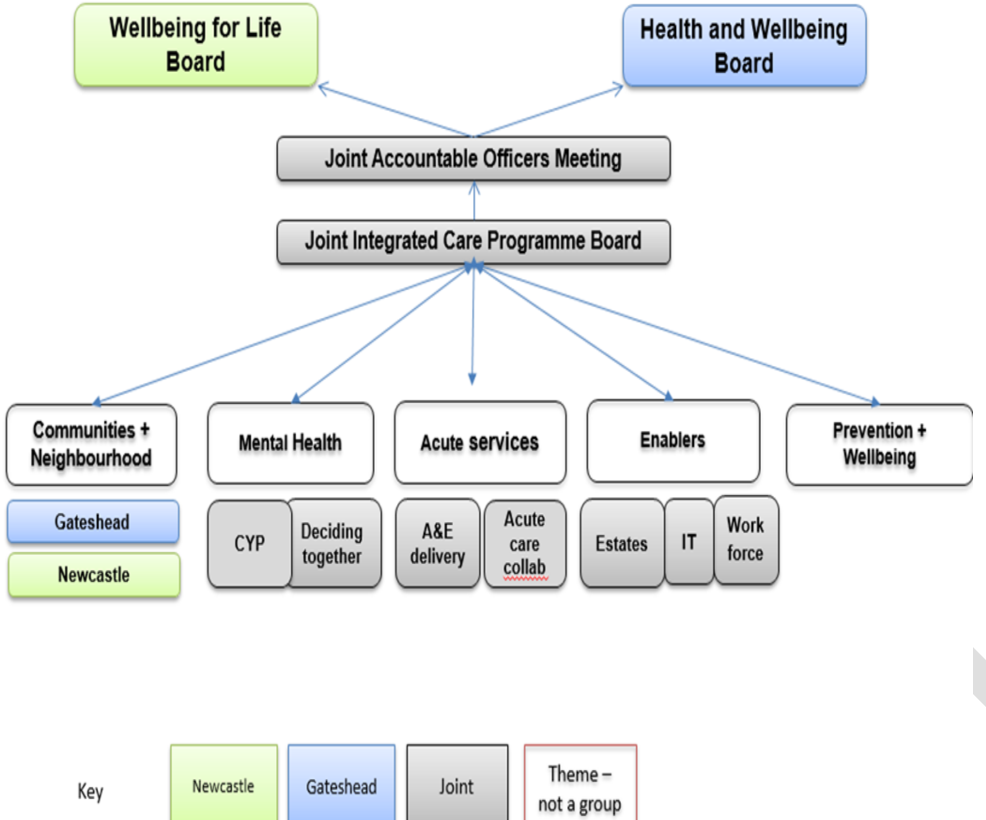
The statement of intent is based on the Canterbury model of Distributed Leadership; a copy can be found in **Section 3**.

Using the working title of 'Accountable Care Partnership' the accountable officers are leading the integration work in Gateshead and in Newcastle under the auspices of the Gateshead Health and Wellbeing Board and Newcastle Wellbeing for Life Board. To ensure the work moves forward with pace, a jointly funded post of Director of Transformation and Integration has been appointed who reports to all 6 Chief Executives and has lead director responsibility for the main integration programmes currently underway.

We are already seeing the benefits of having this innovative post in place in terms of supporting the system The diagram below describes Newcastle Gateshead system governance and how the PCC work programme (incorporating BCF) will be designed, implemented and monitored.

DRAFT

Diagram 5: Integration Governance Arrangements



The Joint Integrated Care Programme Board will enact the shared strategic vision for health and social care across the Gateshead and Newcastle health and care economy, as described in the statement of intent (January 2017) as follows:

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

The Board will oversee the planning, transformation and delivery of high quality, integrated health and care services. It includes representation from:

- Newcastle Gateshead Clinical Commissioning Group
- Gateshead Metropolitan Borough Council
- Newcastle City Council
- Newcastle upon Tyne Hospitals NHS Foundation Trust
- Gateshead Health NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust
- North East Ambulance Service NHS foundation Trust
- Community Based Care Gateshead
- Newcastle GP Federation

- Bluestone consortium
- Newcastle Council for Voluntary Service (on behalf of Newcastle and Gateshead VCS)
- Healthwatch Newcastle
- Healthwatch Gateshead

The Joint integrated Care Programme Board will report progress to the Joint Accountable Officers Meeting. It will also make recommendations to the Joint Accountable Officers Meeting and, in turn, the relevant decision making arrangements within each partner agency.

A Section 75 agreement has been concluded in previous years in line with required levels and is in draft for 2017/18 between Gateshead Local Authority and the CCG.

BCF Reporting - Add the wider BCF governance framework.

Progress in implementing our BCF Plan for 2017-19 will be reported regularly to the BCF Programme Board and Health & Wellbeing Board as required. The BCF Programme Board will monitor progress against our schemes and plans to meet the national conditions, as well as performance against key metrics linked to the BCF. It will also monitor the Expenditure Plan in line with the arrangements set out in our Section 75 agreement.

The Health & Wellbeing Board will receive regular updates on our BCF Plan, performance against key BCF metrics and planning returns to be submitted to NHS England.

DRAFT

2.3 National Metrics

The following section summarises our targets across the 4 national BCF metrics, and our plans for achieving them.

In agreeing the targets for the following metrics we have identified the process followed, including analysis of previous performance and a realistic assessment of the impact of BCF initiatives:

A Non elective admissions
B Admissions to residential and care homes
C Effectiveness of reablement
D Delayed transfers of care

Summary of BCF metrics

Better Care Metrics	2016/17 Baseline	2017/18 Target	2018/19 Target
Total non-elective admissions to hospital (general & acute) all age per 100,000 population	21,883	22,208	22,579
Permanent admissions for older people (aged 65 and over) to residential and nursing homes, per 100,000 population	855.6	950.5	854.4
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	80.8%	85.7%	87.9%

Delayed transfers of care (delayed days) from hospital per 100,000 population (18+)	Q1	Q2	Q3	Q4
2016/17 Baseline (Quarterly Rate)	884.8	1007.6	1142.1	919.6
2017/18 Target (Quarterly Rate)	851.0	646.9	625.8	625.7
218/19 Target (Quarterly Rate)	625.7	625.7	625.7	625.6

A Non-elective admissions:

Cumulative data for 16/17 show that Non Elective activity is below planned trajectory across the Gateshead HWB footprint, with 21,883 actual admissions against a plan of 22,979. The CCG total NEA plan for 2017/19 is taken from the latest CCG NEA

DRAFT

plan figures aggregated to quarterly level, and calculated Non Elective activity plans are based on the Commissioner Operational Plan submissions for 17/18

- The CCG NEL plan is based on:
    - 2016/17 Forecast Outturn (at the time)
    - Plus 2.4% Growth as per STP assumptions
    - Adjustment for changes to Spec Services IR rules
    - Reduction for QIPP schemes and Vanguard impact

As part of our planning round this has been checked against signed contract and therefore should tally with the activity expectations across all Secondary care providers.

B Admissions to residential homes and care homes:

For April 2016 to March 2017, there were 328 permanent admissions into residential or nursing care. This represents 855.6 admissions per 100,000 population (based on 2014 population projections) showing a significant improvement in performance compared to the same point last year of 433 (1144.4 per 100,000 population) and has seen the year-end target of 388 admissions being achieved (1,005.1 per 100,000 population). The improvement in performance can be attributed to the introduction of a panel process in April where service managers have closer scrutiny and control over new admissions.

Given that the 2016/17 performance represents a significant improvement on 2015/16, the challenge will be to maintain this. The permanent admissions plan has been set for 17/18 as 950.5. This is an increase in admissions from 2016/17 but takes into account the fact that we have already seen an increase in admissions for the first 4 months of this period. The plan would be to achieve 16/17 rate in 18/19 (854.4 – 336 admissions). This is still significantly better than the 16/17 plan.

The panel continues as a gatekeeper to all residential placements to ensure continuity and rigour for the application of alternatives to residential placements and to also review the referral pathway to determine whether BCF initiatives had been or could have been deployed.

C Effectiveness of reablement:

Performance for Q4 2016/17 was 80.8% (147 out of 182) for all of those aged 65 and over that were discharged from hospital into reablement and still at home 91 days later. The value is lower than the same period 2015/16, which was 85.6% (184 out of 215) and below the challenging target of 87.5%.

DRAFT

Given the reduction in performance levels in 16/17 to 80.8%, the plan for 2017/18 is to reach the 2015/16 performance level at 85.7% and then in 2018/19, sufficiently improve to reach 16/17 plan of 87.5%.

Working in a cycle of continuous improvement, and taking the learning from clinical audits, formal evaluations and anecdotal evidence a number of changes have occurred in the past year. This has resulted in some services integrating to standardise practice and mitigate against the risk of fragmentation. Adult social care has therefore developed a new enablement model which significantly increases the reablement capacity at a Single Point of Access and provides multi-disciplinary interventions to clients entering into the system. The new and extended model recognises the need for both home based and bed based services to develop and maintain independence.

The model has been established through the repositioning of long term domiciliary care services from being delivered by in-house services to being delivered by the independent sector and diverting released resource to focus upon prevention, intervention and rehabilitation.

D METRIC Delayed transfers of care (DTOC) plan

This section needs to be reviewed alongside the section on **National Condition 4 Delayed transfers of care.**

On July 3rd 2017, Jeremy Hunt released a ministerial statement outlining the importance mimimising delayed transfers of care so that no-one stays in a hospital bed longer than necessary: it removes people’s dignity, reduces their quality of life; leads to poorer health and care outcomes for people; and is more expensive for the taxpayer.

The 2017/18 mandate to NHS England outlined the clear expectation that delayed transfers of care (DToCs) should equate to no more than 3.5% of all hospital beds by September 2017. Since February 2017, there have been significant improvements within the health and care system nationally, with a record decrease in month-on month delayed discharges in April 2017.

On this basis discussions have taken place with system partners in order to agree the trajectories outlined below and in line with the national expectations described within the mandate.

In line with the trajectories previously set, the following rationale has been used in setting the trajectories for the 2017/19 plan. The agreed trajectories are:

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Gateshead **Social care attributed delays** need to reduce from approx 7 people on average delayed per day to 4 people on average delayed per day by September and maintained through the year. This equates to approx 120-130 per month (depending on rounding and days in the month this varies). This will ensure Gateshead social care attributed delays are meeting the national requirement of 2.6 delayed days per day per 100,000 population by September. Given the challenges to achieve this reduction, the plan is to maintain this level throughout 2017/18 and 2018/19.

For Gateshead HWB **NHS attributed delays** for Gateshead, the rate of approx 202 delayed days per month needs to be maintained.

Actions to ensure delivery of the DToC metric are covered in detail in the section National Condition 4 Implementation of the High Impact Change Model.

DTOC technical detail

DTOCs – Total delayed days for 2016/17 was 6372 against a trajectory of 3330 and therefore the plan for the year has not been achieved.

The plan for delayed discharge has not delivered the anticipated level of improvement, more work is being undertaken to understand this more fully. This will include an analysis of the patient profile of this cohort.

As per the NHS England 2017/18 Mandate, total DToC (NHS, adult social care and jointly attributable combined) should be reduced by September 2017, and the overall reduction in DToC should be equal (50%:50%) between the NHS and social care.

Given that Gateshead Health NHS FT DTOC performance falls below the minimum threshold for NHS attributed delays of 3.5% (2.2% Q4 16/17 baseline), trajectories have been set so that this level is maintained to September 2017 and beyond.

In terms of social care attributed delays, the best performing LAs have 2.6 people delayed in hospital per 100,000 adults due to social care. Social care delays above the 2.6 per 100,000 requirement are to be reduced, in line with the 2017/18 mandate As at the February 2017 baseline, the rate of social care attributed delayed days is 4.1 per 100,000 in Gateshead. This is to be reduced to a rate of 2.6 per 100,000 population and trajectories have been set to maintain this level, in line with the NHS 17/18 Mandate.

Section 3 Supporting documents

Name	Location
Page x Diagram - People Communities and Care model Gateshead	People%20Communities%20and%20Care
National Audit of Intermediate Care Framework document 2017 Report expected September 2017.	Copy of NAIC 2017 - Provider data specifica
Accountable Officers Statement of Intent Principles and system integration principles	Statement%20of%20Intent%20Final%20
Adapted Principles - 10 step approach to creating a new model	Revised%2010%20steps%20to%20a%20
What good looks like suite of best practice	What_does_good_look_like_document_FI
Section 75 agreement	NHS%20Newcastle%20Gateshead%20C
Table 1 description of key schemes/pathways mapped to the People Communities and Care model, against the 'scheme type' headings within the BCF National guidance and aligned to the National BCF conditions. National conditions Table 2,3,4 Annexe B schemes aligned Tables 5,6,7,8	Appendix 1
Table 9 stakeholder conversations held during the development of the People Communities and Care Model	Appendix 2
Current assessment of implementing High Impact Change Model (HICM	Appendix 3
BCF plan 2014 BCF Plan update 2016	BCF Plan 2014 can be accessed at: http://www.newcastlegatesheadccg.nhs.uk/wp-content/uploads/2015/03/BCF-Gateshead-Part-One-Version_12-Final.pdf

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	BCF Update 2016 Final Gateshead BCF Narrative submission :
NHS Newcastle Gateshead CCG Operational Plan 2017/19 including GP Forward View	The plan can be accessed at: http://www.newcastlegatesheadccg.nhs.uk/wp-content/uploads/2017/04/17-19-NHS-Newcastle-Gateshead-Operational-Plan-FINAL.pdf
Northumberland Tyne and Wear and North Durham Sustainability and Transformation Plan (NTWND STP) (2016/17 to 2020/21)	The STP can be accessed at: http://www.newcastlegatesheadccg.nhs.uk/get-involved/stp/
Accountable Officer Statement of Intent & system integration principles	Statement%20of%20Intent%20Final%20
BCF progress reports to Health & Wellbeing Board	All HWB papers can be access at: http://democracy.gateshead.gov.uk/ieDocSearch.aspx?Err=1&CI=153&SD=01%2f01%2f2017&ED=31%2f07%2f2017&DT=1&WI=0&IID=0&IT=0&IS=&CA=false&SB=true&ST=&ADV=1 BCF Updates were discussed in: March 2017 April 2017 June 2017 July 2017
DTOC – copy of the Gateshead Delayed Transfer of Care (DTOC) action plan 2016/17. The plan provides a detailed analysis of the actions implemented during 2016/17 to further ensure optimum health care provision.	Appendix 2 Gateshead DTOC Actic Appendix 3 DTOC Plan trajectory.docx
Local Digital Roadmap	http://www.newcastlegatesheadccg.nhs.uk/newcastle-gateshead-local-digital-roadmap/

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Appendices

Appendix 1

Table 1 sets out *our* ***key schemes/pathways descriptors****, mapped to the People Communities and Care model, against the 'scheme type' headings within the BCF National guidance and aligned to the National BCF conditions.*

PCC model Component	Scheme Type	Existing BCF	New iBCF	1617 National Condition	1718 National Condition
PE	1. Assistive Technologies				
CC	2. Care navigation / coordination				
CS	3. Carers services	Carers			Invest in Out of Hospital Services Cont to ASC Maintained
CS	4. DFG - Adaptations	DFG			
CC	5. DFG - Other Housing	DFG			
CS	6. Domiciliary care at home	Planned Care Transformation	Market Shaping and Stabilisation Service Pressures	7 Day Services	Invest in Out of Hospital Services Cont to ASC Maintained
Whole Model	7. Enablers for integration	Transformation	Service Pressures Transformation	Data Sharing	Cont to ASC Maintained
CS	8. Healthcare services to Care Homes				
CS	9. High Impact Change Model for Managing Transfer of Care	Managing discharges and Admission Avoidance Planned Care	Managing discharges and Admission Avoidance	Care Planning 7 Day Services	Invest in Out of Hospital Services Cont to ASC Maintained Transfers of Care
CS	10. Integrated care planning	Market Shaping and Stabilisation Planned Care	Managing discharges and Admission Avoidance Service Pressures	Care Planning	Cont to ASC Maintained Invest in Out of Hospital Services
CS	11. Intermediate care services	Managing discharges and Admission Avoidance Market Shaping and Stabilisation Transformation	Service Pressures	Care Planning 7 Day Services	Cont to ASC Maintained Invest in Out of Hospital Services
PE	12. Personalised healthcare at home		Social Care and health personal budget infrastructure		
PE	13. Primary prevention / Early Intervention	Managing discharges and Admission Avoidance	Service Pressures	Care Planning 7 Day Services	Cont to ASC Maintained Invest in Out of Hospital Services
CS	14. Residential placements	Market Shaping and Stabilisation	Market Shaping and Stabilisation Service Pressures	Care Planning	Invest in Out of Hospital Services
PE	15. Wellbeing centres				
	16. Other	Managing discharges and Admission Avoidance			

KEY: PE – people empowerment, CC- connected communities, CS – care and support

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Appendix 1 Table 2 *identifies schemes which support our planned change (including investment) into the social care sector through 2017 to 2019.*

National Condition 2: NHS contribution to social care is maintained in line with inflation

PCC model Component	Scheme Type	Existing BCF
CS	3. Carers services	Carers
CS	6. Domiciliary care at home	Planned Care
Whole Model	7. Enablers for integration	Transformation
CS	9. High Impact Change Model for Managing Transfer of Care	Managing discharges and Admission Avoidance
CS	10. Integrated care planning	Market Shaping and Stabilisation
CS	11. Intermediate care services	Managing discharges and Admission Avoidance
		Transformation
PE	13. Primary prevention / Early Intervention	Managing discharges and Admission Avoidance

Appendix 1 Table 3 *identifies schemes which support our planned change (including investment) into NHS-commissioned out-of-hospital services through 2017 to 2019.*

National Condition 3: Agreement to invest in NHS-commissioned out-of-hospital services

PCC model Component	Scheme Type	Existing BCF
CS	3. Carers services	Carers
CS	6. Domiciliary care at home	Transformation
CS	9. High Impact Change Model for Managing Transfer of Care	Managing discharges and Admission Avoidance
		Planned Care
CS	10. Integrated care planning	Planned Care
CS	11. Intermediate care services	Market Shaping and Stabilisation
PE	13. Primary prevention / Early Intervention	Managing discharges and Admission Avoidance
CS	14. Residential placements	Market Shaping and Stabilisation

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Appendix 1 Table 4 *identifies schemes which support our planned change (including investment) into delivering the High Impact Change Model for Managing Transfers of Care through 2017 to 2019*

National Condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care

Managing Transfers of Care			
PCC model Component	**Scheme Type**	**Existing BCF**	**New iBCF**
CS	9. High Impact Change Model for Managing Transfer of Care	Managing discharges and Admission Avoidance Planned Care	Managing discharges and Admission Avoidance

Appendix 1 Table 5 *identifies schemes which support our planned change (including investment) into the delivery of 7 Day Services including how they are aligned with* key schemes/pathways mapped to the People Communities and Care model.

Agreement on the delivery of 7 Day Services				
PCC model Component	**Scheme Type**	**Existing BCF**	**New iBCF**	**1617 National Conditions**
CS	6. Domiciliary care at home	Planned Care Transformation	Market Shaping and Stabilisation Service Pressures	7 Day Services Invest in Out of Hospital Services Social Care Contn
CS	9. High Impact Change Model for Managing Transfer of Care	Managing discharges and Admission Avoidance Planned Care	Managing discharges and Admission Avoidance	Care Planning 7 Day Services Invest in Out of Hospital Services Cont to ASC Maintained Transfers of Care
CS	11. Intermediate care services	Managing discharges and Admission Avoidance Market Shaping and Stabilisation Transformation	Service Pressures	Care Planning 7 Day Services Invest in Out of Hospital Services Social Care Contn
PE	13. Primary prevention / Early Intervention	Managing discharges and Admission Avoidance	Service Pressures	Care Planning 7 Day Services Invest in Out of Hospital Services Social Care Contn

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Appendix 1 Table 6 *identifies schemes which support our planned change (including investment) into the delivery of Better data sharing between health and social care, based on the NHS number including how they are aligned with* key schemes/pathways *mapped to the People Communities and Care model*.

Better data sharing between health and social care				
PCC model Component	**Scheme Type**	**Existing BCF**	**New iBCF**	**1617 National Conditions**
Whole Model	7. Enablers for integration	Transformation	Service Pressures	Data Sharing
			Transformation	Social Care Contn

Appendix 1 Table 7 *identifies schemes which support our planned change (including investment) into the delivery of* ***assessments and care planning*** *including how they are aligned with* key schemes/pathways mapped to the People Communities and Care model.

A joint approach to assessments and care planning				
PCC model Component	**Scheme Type**	**Existing BCF**	**New iBCF**	**1617 National Conditions**
CS	9. High Impact Change Model for Managing Transfer of Care	Managing discharges and Admission Avoidance Planned Care	Managing discharges and Admission Avoidance	Care Planning 7 Day Services Invest in Out of Hospital Services Social Care Contn Transfers of Care
CS	10. Integrated care planning	Market Shaping and Stabilisation Planned Care	Managing discharges and Admission Avoidance Service Pressures	Care Planning Invest in Out of Hospital Services Social Care Contn
CS	11. Intermediate care services	Managing discharges and Admission Avoidance Market Shaping and Stabilisation Transformation	Service Pressures	Care Planning 7 Day Services Invest in Out of Hospital Services Social Care Contn
PE	13. Primary prevention / Early Intervention	Managing discharges and Admission Avoidance	Service Pressures	Care Planning 7 Day Services Invest in Out of Hospital Services Social Care Contn
CS	14. Residential placements	Market Shaping and Stabilisation	Market Shaping and Stabilisation Service Pressures	Care Planning Invest in Out of Hospital Services

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Appendix 2

Table 9 identifies the stakeholder conversations held during the development of the People Communities and Care Model

Organisation / forum	Date		
Gateshead HWB	April 28	Joint integrated care board	March 23
Newcastle well-being for life	April 4	Gateshead transformation board	March 21
Newcastle people directorate	March 9	Gateshead MBC directorate	April 13
Newcastle portfolio holders	March 16	NUTH trust board	
Gateshead portfolio holders	April 24	NUTH integration group	March 8
Accountable officers meeting	March 31	Gateshead trust board	March 29
Sub AO meeting	March 2	NTW trust board	March 22
Newcastle task force	March 8	NTW transformation team	
CCG internal staff briefing	March 7	LMC/ CCG conversations	March 14
CCG corporate management	March 21	NG CCG governing body	March 28
Newcastle networks	May 16	Newcastle design lab	March 15
Gateshead VS leads	May 16	Newcastle GP federation	April
Vol sector open forum	May 16	Blue Stone consortium	April 26
GP forum	March 8	Estates group	March 13

Appendix 3 Current assessment of implementing High Impact Change Model (HICM) in Gateshead

Impact change	Where are you now?	What do you need to do?	When will it be done by?	How will you measure Success?
Early discharge planning	Mature	Quarterly reviews of the SAFER bundle to ensure it continues to be effectively implemented	March 2018	Electronic Dashboard being piloted which will display live data at ward level to support proactive discharging. Roll out subject to review and funding. Electronic capture and Trust-wide report of EDD, currently monitor use and will start to report delay on date of EDD.
		Monitoring of EDD against actual discharge dates, including changes made during hospital stay	March 2018	Reduction in difference between planned EDD and actual discharge date.
		Integrated community teams to work with practices to identify people at risk of non-elective admission and ensure they have a coordinated plan in place	Ongoing - in place	Availability to view Emergency Care Plans and utilise them.
Systems to monitor patient flow	Mature	Introduce regular monitoring of capacity and demand issues across the system, including primary care and social care	Social care – already in place. Primary care October 2017 (to be in place for winter)	Reduction in admissions and improved system visibility of capacity
		Monitor reasons for delays to identify common bottlenecks	September 2017	Reduction in LOS for specific delays (overall average has potential to increase due to actively reducing avoidable admissions) / reduced number of stranded patients
		Work with services/ teams to develop more effective pathways/ processes to access resources and support which currently cause bottlenecks (e.g. equipment)	Deep dive into DTOCs via surge group during August. SAFER Programme planned for	Reduction in stranded patients i.e. LOS >6 days

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			October.	
		Provide feedback to commissioners regarding any gaps in provision which cause bottlenecks	September 2017	Reduction in LOS. As above
		Ensure pathways in place to support patient flow – e.g. for palliative care and delirium	December 2017	Reduction in LOS. As above
		Ensure effective process around the use of section 2 and section 5, which does not cause delays in social care assessments	March 18	Reduction in LOS. SAFER Programme relaunch in October. LA GOSS system development to electronically refer.
Multi-disciplinary, multi-agency discharge teams (including voluntary and community sector)	Plans in place	Ensure all partners attend ward/board round	October 2017	Effective Board Rounds focused on safer discharging. • Redesign of social care team in hospital (trial planned for August). • SAFER programme
		Develop proposals for the role of the voluntary sector within the discharge team/ process, including attendance at ward round	February 2018	Alignment of EDD and actual date of discharge No delays due to social circumstances
		Agreement of discharge pathways in which community teams have greater involvement in pulling patients out of hospital – linking in with the Unplanned Care model development and Integrated Teams Implementation Group to ensure this is built into plans	December 2017	Reduction in delays for transfer Reduction in stroke patient repatriations to hospital
		Development of a clear process for CHC assessments – linking in with CHC project group	Complete for Gateshead March 2018 for OOA	Reduce LOS by completing assessments outside of acute settings.
Home First Discharge to	Plans in Place	Agree role of integrated teams/ intermediate care/ reablement in supporting people to return home – linking in with the Unplanned	March 2018	Monitor as should see an increased proportion of patients admitted via

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Assess		Care model development and Integrated Teams Implementation Group to ensure this is built into plans		non-elective route discharged to their usual place of residence within 7 days of admission.
		Support the development of the integrated service model for unplanned community services (including intermediate care and reablement) to ensure effective community support for discharge	March 2018	As above
		Ensure therapy provision is available to provide support at home – to prevent admission and support discharge – linking to the development of the Unplanned Care model. If gaps in provision will not be met through this new model flag issues with A&E Delivery Board and commissioners.	March 2018	As Above
		Work with care homes to establish their role in discharge to assess arrangements – linking in with Care Homes subgroup to ensure alignment to care homes plus scheme and developments led by commissioners	March 2018	As Above
Seven-day services	Plans in Place	Link to Unplanned Community services model to ensure coordinated support is available 7 days a week – if this will not be achieved by the new model, flag as issue to A&E Delivery Board and commissioners	March 2018	All partners to confirm ability to complete services 7 days per week; with updates required Dec 17 on progress.
Trusted assessors	Plans in Place	Joint agreement to be reached around the trusted assessors role – what can/ can't be put in place by who, agree processes with commissioning team	March 2018	Remove delays
		Ensure service restarts can be initiated by appropriate teams, to reduce the time taken to reinstate care and support at home – linking with commissioning/ brokerage team	March 2018	Remove delays
		Identify training needs for MDT members to complete trusted assessments, delivery of training	March 2018	Remove delays
		Trusted assessment role to be operational across agreed members of the MDT, with monitoring of appropriateness of care/ support put in place	Operational from April 2018, monitoring April – June 2018	Remove delays
		Agree shared assessment documentation for working with commissioners and providers of services	March 2018	Remove delays
		Single discharge plan to be developed for use by all teams, with agreed processes for sharing the plan with other agencies/ professionals	July 2018	Remove delays
Focus on choice	Mature	Training and communications for hospital and social care staff around setting expectations of patients and the strengths-based	March 2018	Reduced LOS

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		approach		
		Agree standard use of choice protocol, with support from CCG and LA in following the protocol	December 2017	Reduced LOS
		Explore opportunities for greater involvement of voluntary sector, to be fully integrated as part of hospital and community teams	March 2018	Reduced LOS
Enhancing health in care homes	Mature	Care homes subgroup established – bring workstreams together (eg care homes plus, commissioner-led developments, links to community teams)	Ongoing - in place	Improve Patient Journey - system-wide working - reducing admissions
		Monitor care homes with highest non-elective hospital use and ensuring support is provided through primary care and community teams to reduce reliance on hospital	Ongoing - in place	As above
		All patients in care homes to have an Emergency Care Plan in place	Ongoing - in place	As above – no good if it can't be accessed
		Support care homes to review their policies/ support their staff, to manage greater complexity of need	Ongoing - in place	As above

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Appendix 4 BCF schemes and iBCF schemes

Source of Funding	New Scheme	Original Scheme No.	Original Scheme Name	Scheme Value 2017/18	Scheme Value 2018/19
CCG Minimum Contribution	Managing Discharges and Admission Avoidance	1	Single point of access	360,000	360,000
		5	Expansion of Ambulatory Emergency Conditions (AEC) pathways	-	-
		8	Alignment of discharge support teams and coordination officers	725,000	725,000
		9	Expansion of intermediate care services	2,705,000	2,705,000
		11	Establish a seamless falls service	2,630,000	2,630,000
		N/A	Care Act	624,575	636,643
		N/A	Review Existing Service Portfolio Incl remaining Non Elective Activity	4,186,595	4,702,786
	Market Shaping and Stabilisation	9	Expansion of intermediate care services	453,000	453,000
		10	Expansion of the Gateshead Care Homes initiative	791,000	791,000
		N/A	Brokerage	124,000	124,000
	Planned Care	2	Alignment of District Nursing, Community Matrons, and Older People Nurse Specialists and RICC nurses + GP frailty register	56,000	56,000
		3	Elderly care coordinator / Alignment of frailty teams	714,000	714,000
		4	Enhance a seamless dementia pathway across Gateshead	61,000	61,000
		6	Establish a seamless palliative care service	-	-
	Transformation	7	Establish an urgent domiciliary suppport service	340,000	-
		9	Expansion of intermediate care services	-	102,000
		N/A	Post to support Data Integration and performance Analysis	80,000	80,000
	Carers	N/A	Carers	1,036,635	1,036,635
		N/A	Review Existing Service Portfolio Incl remaining Non Elective Activity	390,000	390,000
Local Authority Contribution	DFG	N/A	Disabled Facilities Grant	1,601,988	1,724,289
Improved Better Care Fund	Managing Discharges and Admission Avoidance	N/A	N/A	400,000	565,000
	Market Shaping and Stabilisation	N/A	N/A	2,750,000	4,590,000
	Service Pressures	N/A	N/A	2,300,000	2,155,000
	Transformation	N/A	N/A	472,645	730,219
Grand Total				**22,801,438**	**25,331,572**

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Item 7

HEALTH AND WELLBEING BOARD
8 September 2017

TITLE OF REPORT: **NHS and Local Authority Members Seminars in May and June 2017 – Feedback**

REPORT OF: **Dr. Mark Dornan, GP and vice chair of Newcastle Gateshead Clinical Commissioning Group.**

Purpose of the Report

1. This report provides an overview of the discussions held between NHS and Local Authority leaders during May and June 2017 at two Members seminars which focussed upon the integration of health and care services.

Background

2. Local Authority elected members from both Gateshead and Newcastle councils met with clinical and management leaders of Newcastle and Gateshead CCG on 4 May and 27 June at two Members seminar sessions. Led by Dr Mark Dornan, the seminars comprised presentations outlining the shared challenges of the health and care system (from the increased demand for services to the financial challenges) and wide ranging discussions about our shared priorities across the two sectors and in particular, how working more closely together could help us transform the services for the populations we serve.

3. The informal notes of the two seminars are attached as appendices to the report and are not repeated here, but the main reflections from both seminars are listed below:

   - The NHS and Local Authority priorities are very similar – from focussing on preventative services and prioritising children's health and care, to considering new solutions to the depleting workforce and the demise of community infrastructures.
   - All parts of the public sector are facing huge financial challenges as demand grows and budgets reduce – working together across organisational boundaries and in the interests of the populations we serve, is supported by all of us.
   - The Local Authority has responsibility for a range of services that could positively affect the health of the population – from public parks and spaces to leisure centres and libraries; harnessing the opportunities to improve the overall health and wellbeing of the population by using such services more creatively, was a recurring theme in all discussions.
   - The cost of providing hospital based care is huge in comparison to community based and preventative services; our collective challenge is to find creative ways of reducing demand for hospital services; the resources released as a

result could form a platform for investing in preventative services and other priorities such as primary care, community and mental health services.

4. Prevention was a major theme as we collectively acknowledged Austerity has led to a number a services in this area being stopped or reduced. A priority is considering how mainstream services can still have a preventative focus.

Proposal

5. It is proposed that the NHS and Local Authority leaders continue to meet, on a six monthly basis, to discuss further shared priorities, consider the progress being made in integrating health and care services and identify further opportunities for joint working.

Recommendations

6. The Health and Wellbeing Board is asked to:

(i) Receive and consider the content of the two summary notes attached to this report – which describe the headlines of the conversations held between NHS and Local Authority leaders during May and June 2017.
(ii) Provide guidance and direction about the ways in which the ideas generated could become a reality.
(iii) Determine whether a six monthly meeting arrangement would be appropriate to continue the NHS and Local Authority leadership conversations.

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

Enclosures:

4 May 2017 informal notes of members' seminar
27 June 2017 informal notes of members' seminar

NHS and Local Authority leadership seminar

4 May 2017

INFORMAL notes

"I have never known a time when the relationships have been as close – between the two councils, between health partners and indeed, across the entire system. We are closer together than we ever were. "

Priorities identified

- Reducing inequalities – and we should all recognise that prevention is not just public health's responsibility.
- Structural problems of most of the money going into acute care – we need to look at the individual and work out where the monies should be spent to look after him.
- Early years
- Discharge from hospitals – and people going home to empty houses.
- Linking up with the voluntary sector (like Age UK), could provide us an opportunity to harness the volunteering capacity available. We don't use this very well.

The money

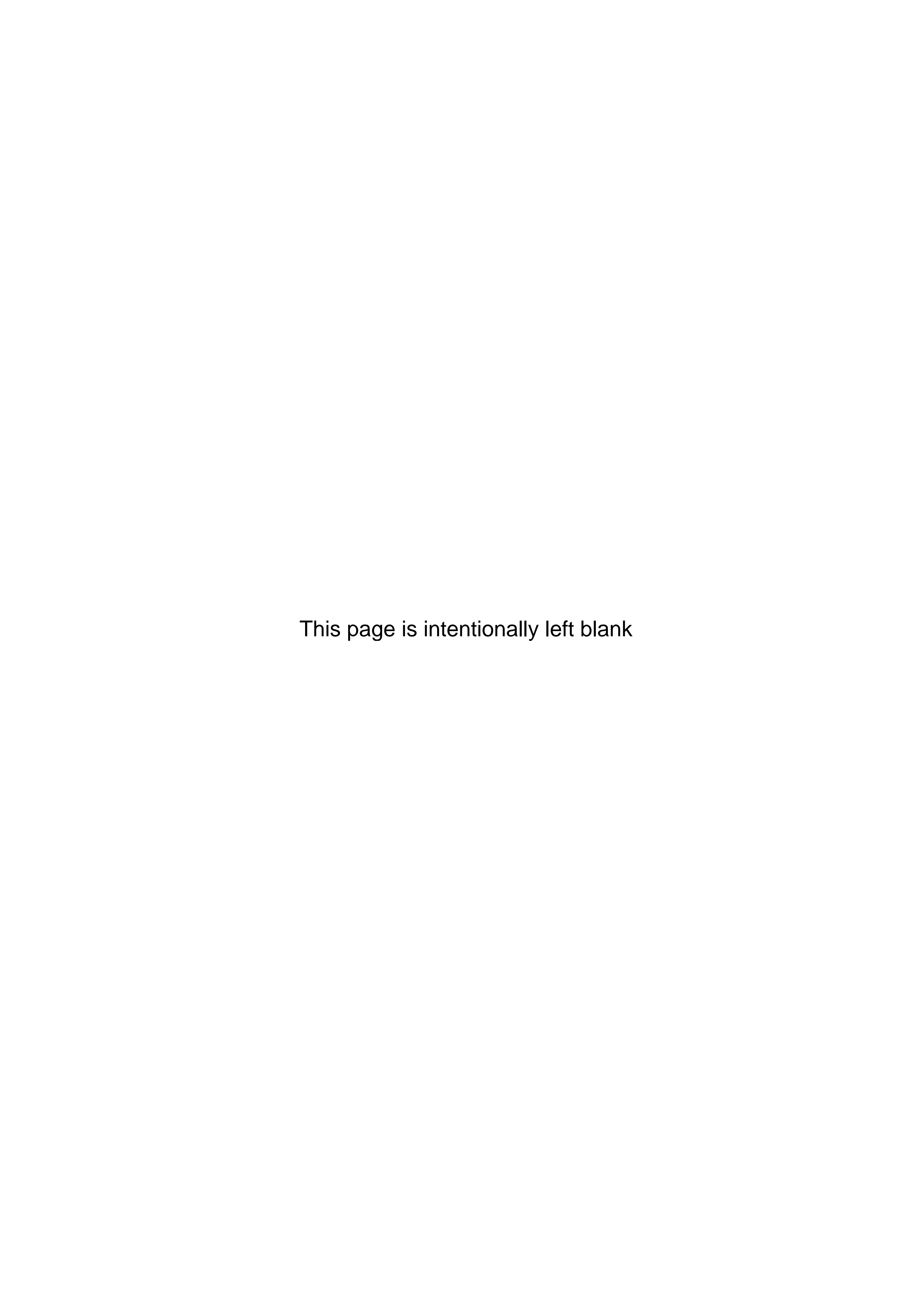
- Would be helpful to see the spend plotted back over time – further back than the 13/14.
- Ideally we should be able to show the spend by sector across both health and social care. The scale of the problem we are facing together is huge. We need to map the different components of spend of each part of the system – if we know what everyone has, where its spent etc.
- Preventative spend – is within the LA budget, although the CCG does commission some services. There's a balancing act to be pulled off – investing in prevention whilst managing the day to day pressures of demand is not an easy balance to achieve. Need to recognise the budgets in LA and NHS are separate – we need to jointly prioritise and make sure we don't pull funding from one agency to another.

Workforce

- We need to make sure the integration of services values the contribution made through domiciliary care. We know that when there are higher skilled people going into people's homes, there are better outcomes. The range of services delivered by domiciliary care workers, is massive and varied – yet career progression opportunities can be limited. We need to create a pathway so people know that coming into domiciliary care has a pathway into social care/ health etc – it needs to be an attractive option for people.
- 18% of the population in Newcastle works in the health and care system; its 14% in Gateshead. That's a massive workforce. Carving out a good and attractive career path is critical.

Depleted communities

- There has been significant reduction in the connectivity people feel with their community. The impact of social isolation needs to be recognised.
- We all need to do some work about people going home to empty houses. '
- Connected communities' event held last year – social prescribing model featured large, as did the approach to community assets.
- We should be looking at all the things the councils does – housing, planning, transport etc…. we need to be radical in the way we are thinking about how we need to work in the future. We need a common and shared vision about what we are doing. Also describe how we are working together to make the difference we all aim to make.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NHS and Local Authority leadership seminar

27 June 2017

INFORMAL notes

The leader of Gateshead Council, Councillor Martin Gannon introduced the second leadership session setting out our collective challenges. Councillor Gannon commended the relationship between the councils of Gateshead and Newcastle and health partners, in seeking to ensure the best possible health outcomes for local people within the resources available.

Dr Mark Dornan from Newcastle Gateshead CCG took colleagues through the attached presentation. There was then a discussion about our collective priorities.

Preventative services.

We are all asking ourselves whether we can do some work together to really make the most of our collective resources?

- How do we direct GP's to have a preventative focus rather than a medical focus on 'treatment' or handing out pills that a councillor had received? Dr Mark Dornan was disappointed to hear of this experience given the work that's been done on 'year of care' – bringing together the patients care and focussing on prevention.
- Is the independent contractor status a weakness in the system as variation continues?
- We need to look very hard at prevention and put money into that. Much of our conversation focussed on substance misuse and alcohol. We recognise this is a significant and shared priority across the system and should focus on it together.
- Secondary prevention through the provision of equipment, maintaining independence and efficiently transacting the equipment provision system is crucial.

Community engagement

Councillors and the council are experts in what's going on in the local community - How can elected members help the NHS engage with communities?

- Council has parks etc. We could collectively exploit those facilities much more to encourage exercise etc. Perhaps the NHS could think about funding wildlife officers etc. to help the local population access what's already on our doorstep.
- Social prescribing is evolving in Newcastle and is testing the effectiveness of broader approaches. Primary care navigators in Gateshead are supporting overall health and wellbeing – especially targeting social isolation/loneliness
- We need to engage more widely too, for example with the voluntary sector (e.g. older people's assembly) provides a range of services aimed at raising the mental health of patients.

The financial challenges

Members asked how we can deal with the NHS's antiquated funding arrangement. We also talked about where we should focus and how we should operate.

- The council's demographic accountability is crucial; councils have taken out significant resources from their budgets. The NHS could learn from that.
- Discharges from hospital are a real problem, with patients not always getting a smooth passage of care.
- There is a disconnect between how the NHS responds to mental and physical health presentations. Some mental health issues and conditions can generate demand for physical health response, but the NHS seems to tackle the physical health symptoms rather than the mental health causes.
- A life course focus is critical. So whilst we can pick off certain groups etc., we need to have an holistic approach and in particular, we need to focus on children together.
- Financial challenges and austerity generally often impact most on those communities and groups that are least resilient and most vulnerable. Consideration should be given to

the establishment of a poverty commission to look at how we can best respond to these challenges with such communities and groups in mind.

Dr Dornan summarised the key themes at the end about us working together to get a preventative approach and use some of our community assets better. Clearly all would support more resources but will work to get the best from what we have.

Dr Dornan agreed to circulate an overview of some of the current tariffs charged for hospital admissions. Note that the tariffs change depending upon complexity and other variables.

Newcastle Gateshead CCG - Example tariff costs 2016/17		
	Indicative Cost per bedday	
Elective Inpatient Admissions	£	1,540
Non Elective Inpatient Admissions	£	423
A&E Attendance	£	80
	Example Cost for Full Hospital Stay	
Stroke - Non Elective	£	5,048
Hip replacement - Elective	£	5,431

Q&A Session

Specific points raised during the Q&A session included the following:

It was queried how the STP addresses the needs of particular groups such as those with learning disabilities.

It was reported that there is a need to address the above average number of people in facilities/institutions by improving the availability of community based care.

It was suggested that the focus of discussions and work should be on finances such as joint budget setting and prioritisation but also the removal of duplication from the system (i.e. through the establishment of multi-disciplinary teams to improve the service to home-based patients who currently receive a number of home visits by different service providers).

It was commented that most spend is on hospital services and this needs to be moved across to other preventative areas to improve outcomes.

It was commented that the national funding system is no longer fit for purpose.

Concerns were raised about the speed of discharging patients from hospital.

It was reported that hospital stays are costly and are often undesired by patients, with many preferring to return home to recover. It was acknowledged that getting our discharge arrangements right is crucial and, as part of this, addressing delayed transfers of care. A long stay in hospital can be counter-productive, e.g. for patients with a weakened immune system.

The costs of a hospital stay were sought after it was commented that the 'hotel operation' of a stay in hospital is what drives up costs.

It was agreed that a breakdown be provided to illustrate the costs associated with hospital stays (provided above).

It was commented that the establishment of cottage hospitals could ease pressures and be an alternative way of providing care within communities.

It was noted that to-date, the use of private sector care homes or the provision of care at the home of the patient has proven successful. It was reported that the establishment of cottage hospitals would be a very costly alternative.

Concerns were reported about the provision of equipment (to assist those recovering at home) taking too long to be provided and then not being collected back in, such as bathing aids and crutches.

The procurement of health products, based solely on price, was raised and the fact that this can be a false economy.

Assurance was given that there are baseline quality levels and a national process for procurement. There are also value based commissioning policies which have established thresholds.

A request was made for GP surgeries to play a more active role within their communities including through the Voluntary and Community Sector.

Details were provided on the Community Care Navigators which have been successful to-date.

It was queried whether GPs have knowledge of the Council's community assets such as nature parks and leisure facilities and whether they prescribe their use to patients to improve physical and mental wellbeing. Further to this, is there scope for health partners to part-fund/subsidise such facilities?

GPs do have local knowledge and this can be enhanced through access to local service directories.

It was stressed that increased spend in preventative treatment measures could improve outcomes and reduce overall costs to all parties.

The funding of treatment for those with drug/alcohol addiction was queried. Assurance was sought that valuable resources are used effectively.

It was reported that substance misuse is often a symptom of a wider health problem, and individuals are often found to be accessing up to 13 other public sector services at a time. Councils can seek to tackle the wider determinants of health such as housing, skills and employment. The greater use of regulatory powers such as licensing can also make a positive contribution.

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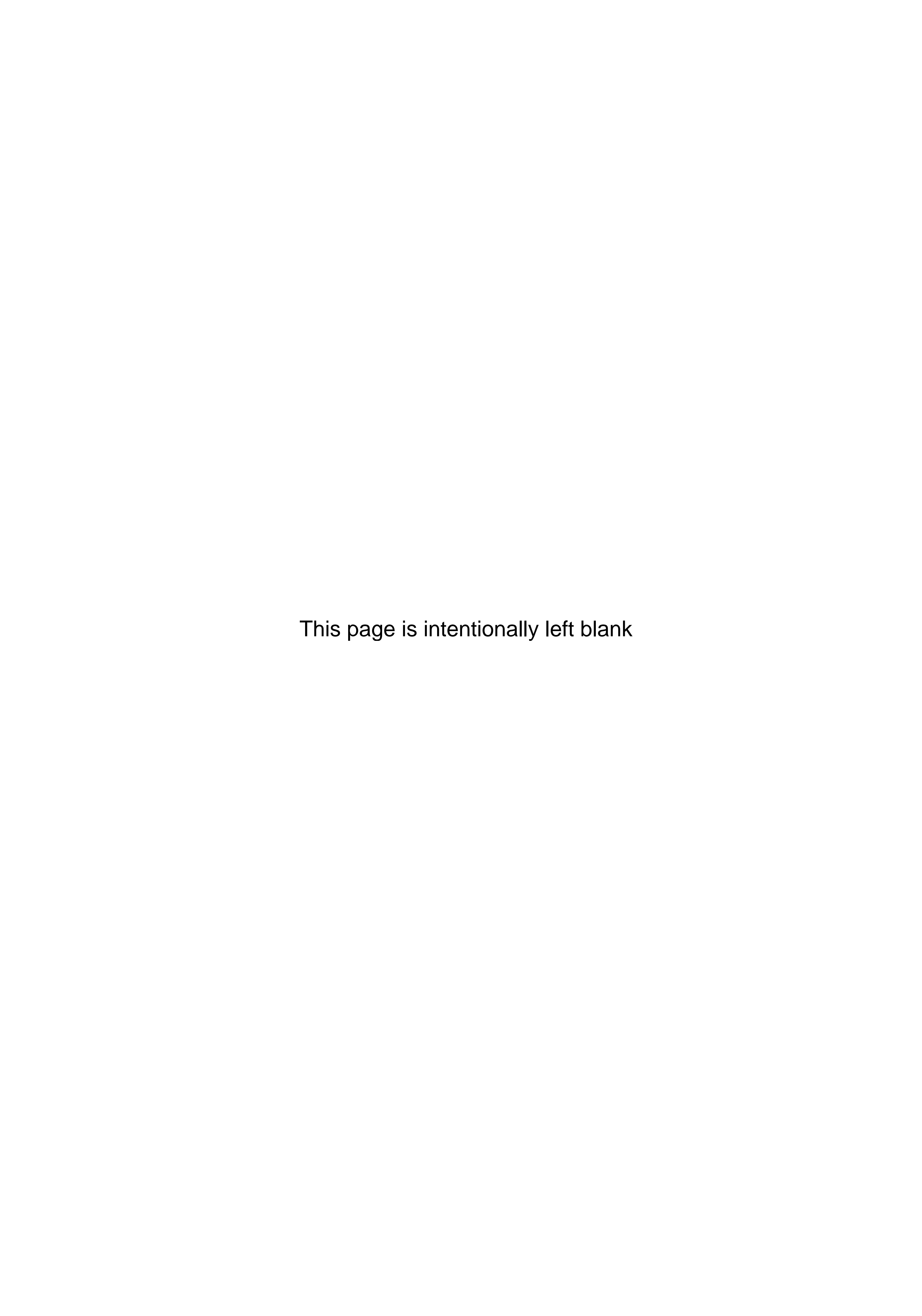
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Item 8

HEALTH AND WELLBEING BOARD
8th September 2017

TITLE OF REPORT: **HealthWatch Gateshead Annual Report 2016/17 and Priorities for 2017/18**

Purpose of the Report

1. To inform the Health & Wellbeing Board about the priorities set for Healthwatch Gateshead in 2017/18 and to update the Board on progress achieved since 1 April 2017.

Background

2. Tell Us North CIC (TUN) is a community interest company which was successful in securing the contract to deliver the Healthwatch Gateshead contract from 1 April 2017. TUN also delivers the contract for Healthwatch Newcastle, and this allows us to work across Gateshead and Newcastle when required, sharing resources, skills and knowledge whilst ensuring that both geographies remain distinct.

3. At the start of this financial year, Healthwatch Gateshead and Healthwatch Newcastle held a joint annual event and conducted additional engagement activities to involve the community and our partners in setting our priorities for 2017/18. A "long list" of possible priorities were considered and based on the comments, concerns and points of view gathered from residents during 2016/17.

4. In June 2017 Healthwatch Gateshead produced our Annual Report (tabled) which describes the work carried out during 2016/17 under the direction of the previous contract management organisation. It also sets out (on page 21) the short-listed priorities which emerged from our engagement and consultation work in April.

Progress made since 1 April 2017

5. A recruitment and selection process has taken place and an 8-strong committee has been appointed to oversee the work at Healthwatch Gateshead. Our committee members have a complimentary range of skills and experience which will of great benefit to our work and the strategic governance of the organisation. We hope that a Chair will emerge from the committee members.

6. The staff team consists of two Project Managers, a Volunteer and Outreach Coordinator, a Finance and Administration Officer and an Operations Manager. Our close working relationship with Healthwatch Newcastle has given us extra capacity and allowed specialist skills to be shared efficiently, as well as the ability to do some joint project work.

7. Members of the Healthwatch Gateshead team have begun working with partners, hosting and attending events and gathering views to help raise awareness of our work

Working on our Healthwatch Priorities

8. NHS Continuing Health Care (CHC)

   NHS continuing health care (CHC) is a package of care provided outside of hospital that is arranged and funded solely by the NHS for individuals aged 18 years and older who have significant ongoing healthcare needs. When someone is assessed as eligible for CHC, the NHS is responsible for funding the whole package of health and social care.

   Access to, and outcome of CHC assessments ranked highly in our engagement processes with residents and partners across both Gateshead and Newcastle and our committees agreed that this subject should become the focus of a project for 2017/18.

   The work is being led by one of our Gateshead Project Managers, and will span both areas. We have begun to gather evidence by talking with stakeholders in the Local Authorities, NHS Newcastle Gateshead Clinical Commissioning Group (NGCCG) and Hospital Trusts across Newcastle and Gateshead. We have been asking partners about their understanding of how the process around CHC should work. We have also referred to national guidance and best practice, including the National Framework for CHC.

   In August, Healthwatch hosted an event under the banner of "One Collective Voice" which enabled us to hear from Voluntary and Community Sector (VCS) organisations who support residents to access services, information or support and guidance around the CHC process. We have received very positive feedback from VCS representatives who attended the event and they were enthusiastic about the concept of "One Collective Voice", and would be keen to engage in this way again on a themes basis.

   The information we are gaining will help us to design a questionnaire for service users and carers to gather their experience of the process, and the information available to help them. Findings will be the subject of a comprehensive report which will be shared with stakeholders and providers for comment before it is published before the end of the financial year.

9. Carers

   This topic was ranked highly in our public / delegate prioritisation exercise and as such has become the focus of our second piece of project work, led by one of our Project Managers. The work will focus on Gateshead residents and will review the service users experience of receiving carers assessments to better understand the barriers to taking-up a carers assessment. It became a statutory duty of local authorities to provide carers assessments (Care Act 2014). However, to date there has been a low update in Gateshead and the numbers are dropping.

   Gateshead Council and NGCCG are reviewing the present carer offer and have carried out some engagement with service users and providers. A tender specification is to be written and presented to cabinet in September 2017. Healthwatch Gateshead is working closely with partners with a view to influencing

the quality and quantity of carers assessments conducted in Gateshead. This project will also feed into the content of the tender specification.

We are currently conducting a survey of carer's which is complimentary to the work completed by the council. The findings will feed in to the consultation process the view expressed by carers on the actual carers assessment process and help identify the barriers to up-take. Healthwatch Gateshead will give residents an independent voice, whilst other reports and surveys have been conducted by stakeholders. The response rate to the survey has been excellent, with around 250 responses having been received to date, over a very short frame of time.

This project is an excellent example of the advantages of flexibility of workforce between Healthwatch Gateshead and Healthwatch Newcastle as we have drawn in additional support from a Newcastle based Project Manager to allow us to meet the timescales required by the tender process.

10 Mental Health

Mental Health ranked highest in the prioritisation exercise following feedback gathered by Healthwatch Gateshead in 2016/17 and was primarily highlighted because of comments from residents about long waiting times. With the CCG about to start moving towards delivery of the 'Deciding Together, Delivering Together' process for adult mental health, the Healthwatch Gateshead Committee decided that further research in this area might be better after this work has been implemented. Healthwatch are taking a very active approach in Deciding Together, Delivering Together by helping to ensure that residents views are heard. Healthwatch Gateshead and Healthwatch Newcastle are holding "fringe events" to complement the CCG-led four, week long, workshops in September and October. Each week will focus on a different aspect of the service:

1. Getting help when you need it
2. Understanding need and planning support
3. Getting support
4. Staying well

The Healthwatch 'fringe' events will allow more members of the public, experts by experience, and voluntary and community sector representatives to make their voices heard and contribute to the new service design. Healthwatch will also be making it possible for people to contribute to the discussion and decision-making process via social media if they can't get along to the events.

Volunteering, Outreach and Engagement

11. Healthwatch Gateshead will be building up our volunteering offer for residents of Gateshead. We currently have seven volunteers who have joined us/stayed with us since April as Healthwatch Champions. Our volunteers are supported by our Volunteer and Outreach Officer. A key priority of our work is the roll out of our "Feedback Centre", which we will be using to gain feedback from Gateshead residents about the health and social care services that they access. The information they provide will be shared with the people who plan and deliver health and social care services.

Our Volunteer and Outreach coordinator is developing an outreach and engagement strategy to meet residents and gather their views, and feedback forms will be distributed to partners. The form can also be completed electronically at www.healthgateshead.co.uk. During 2017/18 we aim to greatly increase awareness of Healthwatch Gateshead and further support resident's voices to be heard.

12. The Healthwatch Gateshead AGM is planned for the morning of 31 October 2017.

Proposal

13. It is proposed that the Board receives this report for information, and receive the Annual Report for 2016/17.

Contact: Steph Edusei Chief Executive of Healthwatch Gateshead Direct: 0191 338 5721 Steph@healthwatchnewcastle.org.uk

Healthwatch Gateshead

Annual report 2016–17

Contents

Message from our interim Chair 2
Message from our Chief Executive 3
Highlights from our year 4
Who we are 5
Our vision 6
Our priorities 6
Your views on health and care 7
Listening to local people's views 8
What we've learnt from visiting services 8
Helping you find the answers 11
How we've helped the community access the care they need 12
Making a difference together 13
How we've worked with our community 16
It starts with you 17
Our plans for next year 20
Our people 23
Decision making 24
How we involve the public and volunteers 24
Our finances 25
Contact us 27

Message from our interim Chair

It gives me great pleasure to introduce the Healthwatch Gateshead annual report. From 1 April 2017, the Healthwatch Gateshead contract has been held by Tell Us North, a community interest company that also runs Healthwatch Newcastle. This is our first report under the new organisation.

It is important for me to stress the fact that, although run by the same organisation, Tell Us North is committed to ensuring that Healthwatch Gateshead has its own independent voice that reflects the views of the residents of Gateshead. We are very aware that there may be occasions when the views of Gateshead residents differ from those of Newcastle residents. We will ensure that those differing views are reflected – there with be no Healthwatch Newcastle/Gateshead! To deliver that promise we are recruiting a Chair and Committee members comprised of people who live in and have knowledge of Gateshead and who will prioritise and oversee the work.

Healthwatch Gateshead has really grown and developed in the past year. This is largely because of the commitment of the staff team and loyal volunteers who have carried out many Enter and View visits to care homes and a medical centre.

During the year, we have developed a 'mystery shopping' approach and trained our volunteers in this work; they carried out their first mystery shop at a GP practice in Gateshead.

However, our main focus has been on reaching out to the many, varied and diverse communities in the borough. Gateshead covers the largest geographical area of the councils in Tyne and Wear, with many small ex-mining villages. The staff team has focussed on contacting and developing conversations with these communities to hear their experience of health and social care services.

As we look forward to the year ahead there will be many challenges facing the residents of Gateshead, with a continued pressure on NHS and council finances. Our role must be to ensure that the NHS and Gateshead Council continue communicating with the public and involving residents in the service changes that they will inevitably have to make. With reduced staff it could be easy for this involvement to slip. But it is my belief that it is only by working with the public, particularly those who have experience of health and social care services, that new and improved forms of service delivery can be developed.

Finally, I want to thank all our volunteers, staff team and the outgoing Healthwatch Gateshead Board for the time and expertise they have given to developing Healthwatch Gateshead into what it is today.

K Israel

Kate Israel
(Interim Chair of Healthwatch Gateshead)

Message from our Chief Executive

Healthwatch Gateshead has had a busy year listening to people's views, finding out more about people's experiences of services and helping to shape the way services are delivered. Our volunteers have been active, undertaking mystery shopping activities as well as completing Enter and View visits to GP practices and care homes. We know that the support of our volunteers allows us to do more and we hope to expand our team in the coming months.

Early in the year we attended the Newcastle Gateshead Clinical Commissioning Group Governing Body meeting where a decision was made on the Deciding Together specialist mental health review. Although this did not result in an inpatient unit in Gateshead, we were pleased to see that people's concerns relating to travelling to Sunderland or Morpeth had been taken into account. We are looking forward to being involved in the groups that will oversee the design of the new community and inpatient services.

Our autumn listening event was very successful and we are planning to share expertise with Healthwatch Newcastle, our sister organisation, to make sure that this year is just as great. We know it is important to make sure that organisations honour the commitments they gave at the event and we are currently following up on any progress that has been made.

Last year we got out and about – visiting groups, communities and events across the borough and plan to do more this year. We know that there are people and communities that we have not heard from so far and will be making them a priority in our engagement strategy and plan.

Healthwatch Gateshead and Healthwatch Newcastle will be working together more often in future but each will remain independent and will focus on the needs of their own area. I am looking forward to welcoming our new Chair and Committee members, who will help us to develop Healthwatch Gateshead and ensure that our work makes a difference for the people of Gateshead.

Steph Edusei
Healthwatch Gateshead Chief Executive

Highlights from our year

We reached 55,185 people on social media

Our volunteers helped us with everything from Enter and View to mystery shopping

We carried out over 50 engagement activities to reach local people and collect their views

Our reports tackled issues ranging from meaningful activities in care homes to Accessible Information Standards

We gathered the views of 75 young people in our survey about health and social care services

We met 1,275 local people at our community events

Who we are

We know that you want services that work for you, your friends and family. That's why we want you to share your experiences of using health and social care services with us - both good and bad. We use your voice to encourage those who run services to act on what matters to you.

We are uniquely placed as a national network, with a local Healthwatch in every local authority area in England.

Healthwatch Gateshead exists to make social care and health services work for the people who use them.

Created under the Health and Social Care Act (2012) we try to make sure that the people who plan and pay for social care and health services (commissioners) and the people that provide those services seek out and listen to the needs, experiences and concerns of people of all ages that use their services.

One of the ways we do this is to listen to local people, look for themes and patterns in what they tell us about services and, where necessary, speak out on their behalf.

Many services that people use in Gateshead are delivered or commissioned by organisations that cover larger areas, so we often work closely with our colleagues in other local Healthwatch as well as with partners in the voluntary and community sector.

Healthwatch Gateshead staff team during 2016–17

- Karen Bunston, freelance Volunteer Coordinator (left March 2017)
- Victoria Clark, Signposting and Information Officer
- Carole Gourdie, Community and Engagement Participation Worker
- Philip Kerr, Manager (left March 2017)
- Kim Newton, Community and Engagement Participation Worker
- Nicola Winship, Administrator

Healthwatch Gateshead Board members during 2016–17

- Douglas Ball
- Janet Gauld
- Michael Glickman
- Kay Parker
- Margaret Rowe (stepped down 2016)
- Kenneth White (stepped down 2016)

Healthwatch Gateshead volunteers during 2016–17

- Ann Atkinson
- Freda Bevan
- Dawn Champion
- Kenneth Daglish
- Syedi Fahmi
- Forough Firouzi
- Grace Fry
- Jan Kassell
- Christina Massey
- Kay Parker

Healthwatch Gateshead recognises the key role that volunteers play in enabling us to reach and involve residents across the borough.

During 2016—17 we continued to invest in a Volunteer Coordinator who was responsible for our volunteer programme, particularly Enter and View. An exciting new 'mystery shopping' role was developed with, and for, volunteers during 2016—17, which broadened the appeal of volunteering.

Our vision

Where every resident of Gateshead has the health and social care services they expect.

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

Our priorities

The Healthwatch Gateshead Board identified the following priorities for 2016—17:

- Participate whenever possible in consultation events run by health and social care commissioners and providers
- Work closely with the Care Quality Commission to assist in its inspections and provide detailed information received from Gateshead residents
- Work with the Commission for Health and Social Care Integration in the North East to try and ensure that any future service design is resident-orientated rather than institution-based
- Work with the Integrated Care Programme Board to develop a sustainable transformation plan that is more patient based than institution-based
- Promote and support Gateshead Council's ten-year tobacco reduction programme

The Board also planned to consider how Healthwatch Gateshead could support:

- The focus on housing and its impact on the health and wellbeing of residents
- Issues around delayed discharges, specific challenges and examples of good practice
- Ensuring that end of life policies in hospitals and care homes respect a patient's dignity

Your views on health and care

Listening to local people's views

We engaged actively and widely in the community over the past twelve months, covering all areas of the borough. We carried out 57 planned engagement activities, reaching out to over 1,275 members of the public, as well attending many events and community festivals where we engaged with hundreds of local people. We reached out to both older and younger members of the community as well as hard to reach groups. Examples of where we have engaged include:

- Age UK – various exercise groups and coffee mornings
- Civic Centre – providing a presence in the foyer engaging with the passing public and council staff
- Queen Elizabeth Hospital
- Gateshead Jewish Family Service
- Sheltered Housing Schemes
- Church groups
- Joint drop-ins with Northumbria Police (Cuppa with a Copper)
- Macmillan Fighting All Cancers Together (FACT)
- GP and practice staff Time Out Events
- Gateshead Carers – Party in the Park
- World Mental Health Day – Gateshead Leisure Centre
- Citizens Advice Bureau
- Gateshead Clubhouse

What we've learnt from visiting services

After the Enter and View visit to Teams Medical Practice on 31 March 2016, we produced a report in May. The purpose was to identify and share good practice examples of how meaningful patient engagement contributes to improving services. The report was shared widely with the Care Quality Commission, commissioners, key stakeholders, partner organisations and publicised through Facebook, Twitter, our e-bulletin and website.

A number of recommendations were made, including increasing awareness of different ways patients could get involved, developing the peer support function and social prescribing role of the Practice Health Champions, using an outcomes approach to report how patients had influenced service delivery, and further developing the use of social media and newsletters as engagement tools. The report was positively received by the practice, which advised us that it had already implemented some of the recommendations and would explore other changes in future.

Enter and View volunteers visited Hawksbury House Residential Care Home in June 2016. The purpose was to talk to residents, family members, staff and managers and find out what opportunities residents were offered during their day to participate in meaningful activity that promotes their health and wellbeing. This links to the National Institute for Health and Clinical Excellence (NICE) Mental wellbeing of older people in care homes – Quality Standard Statement 1: Participation in meaningful activity.

Our report included comments from the provider, confirming that the management would ensure that provision for meaningful social activities would be maximised by using external agencies and care staff on a weekly basis to provide relevant activities to care home residents.

Action has been taken in response to our recommendations, and Healthwatch Gateshead volunteers thanked for carrying out the visit and producing the report. Care home staff present during our visit were complimentary about the way it was carried out.

An Enter and View visit was carried out at Springvale Court Residential Home in October 2016. A team of four trained volunteers and staff members took part. At the time of the visit the care home had been judged as requiring improvement by the Care Quality Commission (CQC). The visit plan was linked to the 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 report was also shared widely through our normal channels, and to the CQC, Healthwatch England, NHS England, the Local Authority, Newcastle Gateshead Clinical Commissioning Group (CCG), and the Health and Wellbeing Board. The CQC advised us that it will be using the information and recommendations as part of the next inspection of the service.

A new mystery shopping approach was developed in September 2016. The first mystery shopping project explored the mechanisms which are in place to support meaningful patient engagement in GP surgeries. A team of volunteers contacted 29 GP practices in Gateshead, acting as a potential new patient to explore patient engagement based on a specific scenario. We circulated our report to all practices and the CCG. Practices were offered specific feedback about their performance if they wished to receive it.

Based on the experiences of our volunteers and information gathered, we identified some low cost/no cost measures that could enhance the patient experience at the first point of contact and encourage patients to become more involved in their practice.

Recommendations included:

- All staff within a practice should know the practice website address and promote it
- Practice staff should be proactive when a patient expresses an interest in becoming more involved
- Rather than putting the onus on the patient to contact Health Champions, Practice Manager, etc., it would be helpful if staff asked the appropriate staff member to contact the patient; this would prevent missed opportunities for patient engagement
- It would be useful for all staff to have a clear understanding of where patients should be signposted should they ask what practice activities, local activities and groups are available to them

- It would be helpful if practices produced a concise 'prospectus' of their services

- Standardised training across all practices for frontline staff to improve understanding of the benefits of patient engagement

The report was favourably received by Newcastle Gateshead Clinical Commissioning Group (CCG) and included some useful recommendations. The CCG advised us that it had discussed the report at the CCG delivery group, which includes practice managers from Newcastle and Gateshead.

A further mystery shopping exercise took place in February 2017. Our volunteers contacted a random sample of NHS GP practices, opticians and dentists to explore the extent to which they are meeting their obligations in relation to the NHS Accessible Information Standard (a legal requirement since 1 August 2016).

The purpose of the mystery shopping exercise was to:

- Test the service user experience of the health and social care services for Gateshead residents using different scenarios and situations

- Find out about the consumer experience of people with disabilities or other specific groups such as young people

- See if contacts and services advertised are up to date and still available

Our mystery shoppers experienced mixed results. Although some NHS providers were very helpful and offered to find out about the support they could offer, there was a considerable number who offered little, inappropriate or no support at all. Some providers put the onus on the patient or their family to make their own arrangements.

Our report was circulated to providers for comment before being published on our website. Recommendations included:

- NHS providers should ensure that staff receive disability awareness training

- NHS providers should ensure that all staff are briefed about the Accessible Information Standard and what this means in practice

- Providers should review their current communication methods in line with the Accessible Information Standard and address and identify any gaps

- Text messaging, social media and email contact mechanisms should routinely be offered to all people with a hearing impairment

- Providers should produce explicit guidelines about the support available to patients with a disability

- NHS providers should offer longer appointments where additional communication support is required

Helping
you find the
answers
healthwatch

How we've helped the community access the care they need

We provide people with advice and information about local services and help them to navigate the health and social care system.

Here are some examples of how we have helped individuals, families and carers to access local services and to take more control of their own health care.

Case study: Medicine management

A man was in considerable pain when he arrived at an A&E department and was given morphine in the department, before being admitted to a ward.

The following day, his wife noticed that he was still in considerable pain. When she asked what pain relief her husband had been given, she was informed it was paracetamol. His wife asked if someone could prescribe stronger pain relief, for example morphine, as this had been prescribed by A&E the previous evening. The doctor was unaware this had been prescribed by A&E, having received no information from the department, and implied that this was normal. The patient's wife felt that this could be very dangerous, as patients could be given an overdose, and thought all information should be put on the computer and transferred with the patient to the ward. She expressed concern over patient safety and prescribing.

We advised her to report her concerns to the Safe Care Team at the hospital in question, and to the Independent Complaints Advocacy (ICA) and the Care Quality Commission (CQC) to lodge a complaint.

Case study: Reducing isolation

An older person rang us to give positive feedback on services received after falling and breaking her arm. During the call we gave her details about various community activities which may help her to gain confidence and reduce isolation, including a Stay Safe Course run by the Older People's Assembly. In this way we were able to add value to her positive experience.

Case study: Providing support

An outpatient lost his support from a psychiatric nurse due to the closure of Dunston Mental Health Services. He had been allocated a social worker at Dunston but felt he needed more support as the social worker was not always available. The caller was also concerned about how this was affecting his wife, as she was his main carer.

We referred him to Pathways Advocacy (provides free and independent advocacy to people who have a mental health need) and gave contact numbers and details for crisis services if needed, including the Initial Response team and Samaritans. We also gave him details of Gateshead Carers Association and Gateshead Adult Social Care for support and assessment.

Making a
difference
together
Have you
What was it like?

What does urgent care mean to me?

Following the publication of Healthwatch Newcastle's 'GP appointments: what do Newcastle patients want?' report in March 2016, Newcastle Gateshead Clinical Commissioning Group (CCG) wanted to better understand how people defined the term 'urgent' and whether they defined it differently in different circumstances. We collaborated with Healthwatch Newcastle to run a short survey with the public in our respective local authority areas during the summer and autumn of 2016. We asked people how quickly they expected to see a healthcare professional when the need was urgent, either for themselves, a child or for a vulnerable relative.

Overall we found that most people, most of the time, would expect to be seen by a health professional within two hours if they had an urgent health problem. If their young child or vulnerable relative had an urgent health problem an even higher proportion of people expected to be seen within two hours.

We found minimal differences when we examined the data by age, gender, ethnicity and postcode. However, there was a difference in the expectations of Gateshead residents when compared with Newcastle residents. In general, a higher percentage of Gateshead residents expected to be seen within two hours irrespective of whether they, their child or their vulnerable relative had an urgent health problem.

When completing the survey face to face we also discovered that there was confusion about what was considered to be an urgent health problem. Our joint report with Healthwatch Newcastle — 'What does urgent care mean to me?' — recommended that the CCG use this information to inform its review of urgent and emergency care pathways and give particular consideration to the differences that have emerged between expectations of Gateshead and Newcastle residents.

The report will make a contribution to the CCG's work on urgent care and extended GP access and has already led to the CCG undertaking further engagement about accessing GP services outside of normal working hours.

"This is a very useful report which we will use to inform our service developments."

Jane Mulholland, Director of Operations and Delivery, Newcastle Gateshead Clinical Commissioning Group

Read the 'What does urgent care mean to me?' report at healthwatchgateshead.co.uk/reports/hwg-reports/

Listening event – October 2016

The themes for this event were based on information and feedback we had received as part of our engagement activities. People told us they would like more information about how to access services, how services are planned and run, and how they can influence decision makers. It was also an opportunity for people to share their experiences.

The key areas raised at the event were:

- Adult Social Care – service delivery and social care pathway
- Healthwatch Gateshead volunteer proposition – what we do and why?
- Health Champions, Newcastle Gateshead CCG – how to get involved
- Newcastle Gateshead CCG Continuing Healthcare – criteria and funding
- Northumberland, Tyne and Wear NHS Foundation Trust – mental health service provision
- North East Ambulance Service NHS Foundation Trust – what can be expected
- Public Health Gateshead – what it does
- Queen Elizabeth Hospital Gateshead – the balancing of patients' priorities

Recommendations were made at the event; we are following these up with the providers and will evaluate responses and communicate these to partners and residents.

Working with other organisations

We work in partnership with both voluntary organisations and statutory bodies to bring about improvements to health and social care services – an approach which reduces duplication of effort and provides greater value for money. Our partners inform us of issues raised by their members or who may have been affected by various consultations.

Strategic partnerships that we provided regular input to during 2016–17, ensuring that the voices and opinions of local people will be considered when decisions are being made about health and social care services, included:

- Health and Wellbeing Board
- Care, Health and Wellbeing Overview and Scrutiny Committee
- Adult Safeguarding Board
- Children's Safeguarding Board
- Local Engagement Board
- Accident and Emergency Delivery Board
- Learning Disability Partnership
- Gateshead Smoke Free Tobacco Alliance
- North East Ambulance Service NHS Foundation Trust
- Transforming Participation Board
- Primary Care Joint Commissioning
- Gateshead Patient User Carer Public Involvement Group (PUCPI)
- Gateshead Care Home Vanguard
- Joint Integrated Care Programme Board/STP
- Achieving More Together
- Gateshead Voluntary Sector Advisory Group
- Northumberland Tyne and Wear NHS Foundation Trust

We also attended:

- World Mental Health Day (October 2016)
- Clinical Commissioning Group (CCG) Engagement Event (November 2016)
- Queen Elizabeth Hospital Strategy Meeting (January 2017)
- Sustainability and Transformation Plan (STP) public event (January 2017)

How we've worked with our community

We have a team of invaluable volunteers whose assistance over the past twelve months has made a significant impact on our work. During 2016—17 our volunteers, supported by staff, carried out three Enter and View visits to:

- Springvale Court Care Home
- Hawksbury House Care Home
- Teams Medical Practice

We visited Springvale Court and Hawksbury House to explore the range, frequency and appropriateness of activities on offer to residents, how they met individual needs and how they promoted health and wellbeing, including for residents with dementia. We visited Teams Medical Practice to talk to patients, carers, clinical and non-clinical staff to identify, and where appropriate share, good practice of meaningful patient engagement and how this can contribute to the improvement of services.

Our volunteers also took part in a mystery shopping exercise so that we could develop further insights into how GP practices across Gateshead carry out meaningful patient engagement and how they share information with their patients. This exercise was directly linked to the Enter and View visit at Teams Medical Practice and our 'GP Access Report December 2015'.

Enter and View and mystery shopping reports can be found on our website at healthwatchgateshead.co.uk/reports/hwg-reports/

Volunteers also hosted a table at our annual event/listening event to showcase their work and to encourage prospective volunteers.

Our work with the Queen Elizabeth Hospital

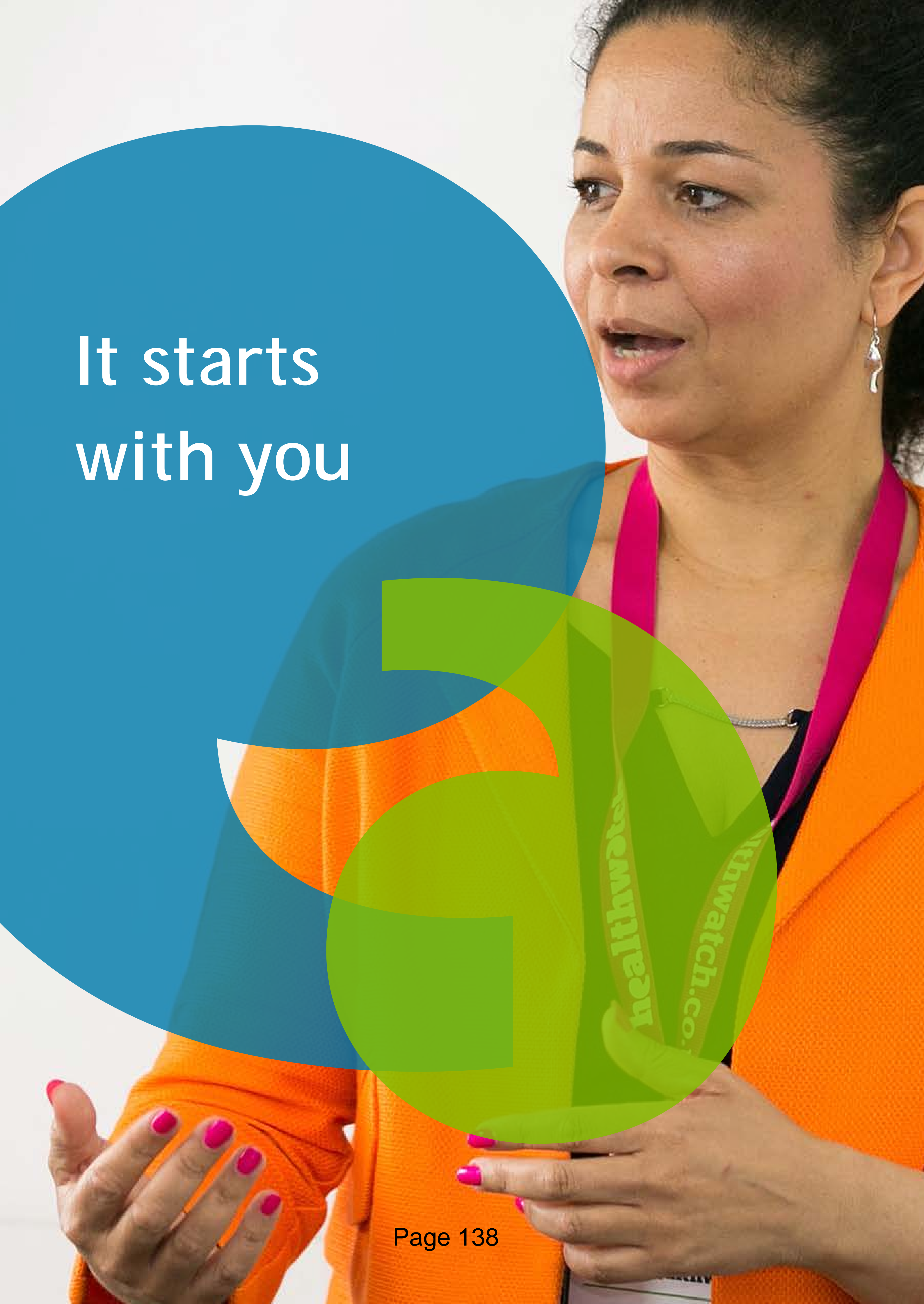
As a result of a discharge survey during 2015—16 across all wards in the Queen Elizabeth Hospital, we put forward recommendations to Gateshead Health NHS Foundation Trust to help bring about improvements to hospital discharge. The recommendations continue to be followed up to monitor ongoing improvements, and our volunteers take part in Patient Led Assessments of the Care Environment (PLACE) visits across wards and clinics throughout the hospital. Two major recommendations were:

Recommendation 1 — Review the way medication is issued to patients during discharge. As a result of this there has been an increase in patients using their own drugs; electronic prescribing has also been implemented across the Trust.

Recommendation 2 — Review communications and information regarding the discharge process provided to staff. This is now part of staff induction and continuous ward based training; literature for relatives and patients has also been reviewed to ensure consistency and relevance.

Involving young people

Work with children and young people is a key area. We have begun to work in partnership with Gateshead College and a wide range of organisations across the borough to establish a picture of young people's experiences of using health and social care services. This is an ongoing piece of work around access to services, diversity, respect and communication, and will allow young people to have their say on services.


It starts
with you

Case study: Home visit provision

An older, housebound man contacted us to say that he needed his ears syringed and had contacted his GP practice, which advised that he would have to attend the surgery for an appointment. We contacted the surgery on his behalf and were given the same information and advised that the district nurses could not do this as a home visit. We then contacted the district nurses directly and an appointment was made for a home visit. We then contacted the surgery to inform staff that home visits are available to housebound patients who require this treatment; and make them aware they could refer patients with similar needs in the future.

Case study: Confidentiality of prescription delivery services

A patient had a concern with prescription delivery from her local pharmacy. If the patient was not home the driver would deliver the medication to a neighbour or someone who knew the patient. However, some of the medication was controlled and on one occasion it had not been delivered.

When the patient queried it with the pharmacy she was told it had been delivered and signed for (which had not happened). It appeared that the driver had delivered to a neighbour who had forgotten to pass the medication on.

The patient felt that her privacy had been violated as people now knew what medication she was taking. We arranged a referral to the Independent Complaints Advocacy (ICA) to consider the complaint and, with the patient's consent, passed her complaint to the General Pharmaceutical Council.

Case study: Improvements to communication and information at a dental practice

A patient contacted us who was upset and confused about the increasing costs of dental treatment for ongoing treatment. We explained the national dental charge tariffs and sent information to the patient by post. As a direct result of the information given, the patient had the confidence to challenge the surgery's actions, decisions and payments.

In response to the patient's challenge, a partner at the dental practice contacted her to explain that there had been a miscommunication, and gave assurances that the practice would remedy the situation and address training needs within their staff team.

The patient was thanked by the partner for bringing her concern to their attention, an apology was received and a full refund offered as a gesture of goodwill.

Case study: Carer experience in social care and housing

During a regular drop-in session at a local library/housing office hub we observed a customer attempting to terminate her mother's tenancy due to a change in social care needs.

The customer was informed that she was unable to do this without an 'AC 13' form from Adult Social Care (ASC), which needed to be received by 12 noon the same day or she would have to pay another two weeks' rent. She was told to go back to ASC to chase up the form. We contacted the Head of Service at Adult Social Care to raise the issue on her behalf, and to highlight the issue of communication between partner organisations.

The service discovered that an error had occurred in the process of submitting the form which had resulted in costs being incurred. The customer was contacted the same day by Adult Social Care to discuss her issues.

Housing agreed to waive a week's rent and ASC agreed to pay for the second week. We were thanked by ASC for getting in touch on behalf of the lady and for highlighting poor customer service experience.

The customer told us that she was grateful to have met us that day as she had felt distressed and that she had been "going around in circles for weeks trying to sort things out". She could now concentrate fully on supporting her mother in her new living arrangements at a care home.

Our plans for next year

Members of the public and delegates at our joint conference with Healthwatch Newcastle (HWN) were presented with a list of eight potential research priorities, which had been selected by the Healthwatch Gateshead Board, and asked to rank them in order of priority. The staff team discussed the results of this prioritisation exercise and made recommendations to the new Healthwatch Gateshead Committee.

The Committee then agreed the following areas as our research priorities for 2017—18.

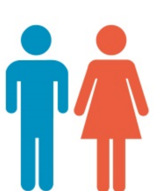
Carers

This was ranked third highest in the public/delegate prioritisation exercise. The Committee agreed that we will prioritise research into people's experiences of accessing care assessments and the follow up support.

NHS continuing health care

The Committee agreed that this will be a joint priority with Healthwatch Newcastle (it was ranked the second highest priority for HWN). It will be an excellent subject to focus on across both areas and will give us the opportunity to combine data collection from Newcastle Gateshead Clinical Commissioning Group (CCG) and acute hospitals with patient and relative feedback.

Young people



This was ranked second in the prioritisation exercise. However, we have not received any service user feedback to indicate what a research focus might be. We propose making young people an engagement priority for this year.

Mental health

Ranked highest in the prioritisation exercise, mental health was primarily on the shortlist because of long waiting times.

Service providers are working with the CCG to improve children and young people's services following engagement done under the 'Expanding Minds, Improving Lives' programme and the CCG is about to start moving towards delivery of the 'Deciding Together' decision for adult mental health. The Committee decided that research in this area might be better after this work has been implemented.

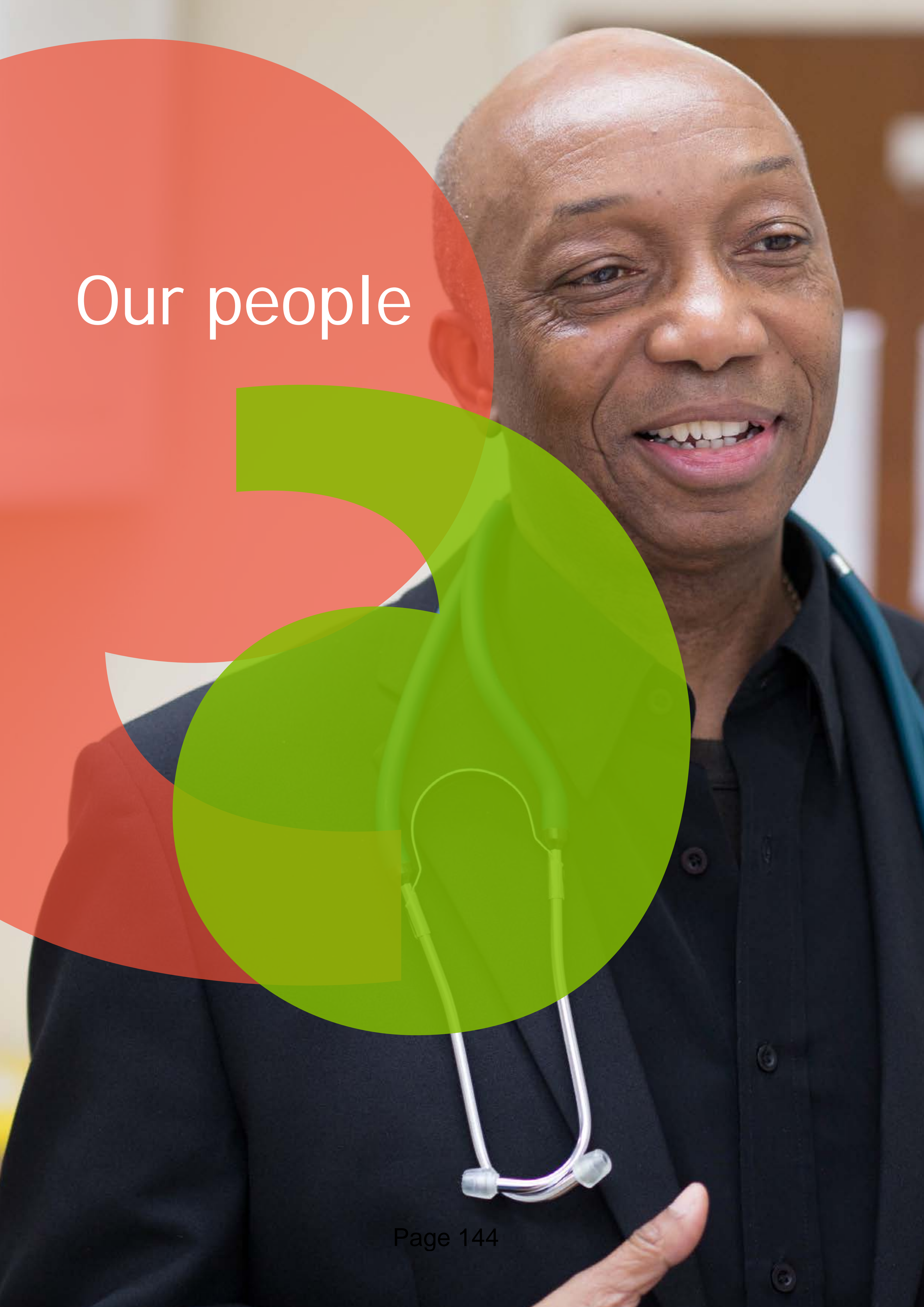
However, one potential area for research would be the physical health of people with mental ill-health. The Committee agreed that, time allowing, we will focus our research on people's experiences of ill-health prevention services (for example, smoking cessation and exercise programmes) and gain an understanding of how these services could be presented to support and encourage mental health service users to benefit from them. This will be a joint priority with Healthwatch Newcastle.

End of life

This was ranked fourth in the prioritisation exercise. The CCG is currently undertaking a review of end of life services and we are involved in this work. So rather than make this the subject of a research project, the Committee agreed that we continue with this involvement.

The other areas on the shortlist for prioritisation were:

- Queen Elizabeth Hospital — we will continue with ongoing engagement work to find out about people's experiences.
- GP services — as we have completed quite a lot of work on GP services in recent years the Committee agreed that this should not be a research priority. However, if further issues arise from CQC inspections, etc. we may reconsider this.
- Black and minority ethnic health needs — we have not heard a great deal from BME communities in Gateshead and therefore the Committee agreed that this should be an engagement priority for this next year.
- Social care — we do not hear a great deal from social care service users and the Committee agreed that this will be an engagement priority for this next year.



Our people

Decision making

The Healthwatch Gateshead Board was responsible for making sure that Healthwatch met its statutory obligations and set strategic objectives during 2016—17. Board meetings were held monthly at our offices in Davidson Building, Swan Street, Gateshead. Two public meetings were held in May and October 2016 to provide an opportunity for residents to talk with Board members and ask questions. Policies and procedures were published on the Healthwatch Gateshead website as they were developed and agreed.

How we involve the public and volunteers

In 2016—17 we introduced two public meetings each year to enable residents to ask questions and to talk to the Board about concerns and issues.

We invited members of the public to contact us with their problems and issues through a range of media. We also made attempts to engage with young people in the borough, through Gateshead College and a range of other organisations, to ensure their voices were heard. We also designed a survey to gather the views of young people on their experience of health care services.

We have links with several representative organisations such as Age UK, Gateshead Carers' Association and the Regional Refugee Forum as a mechanism for disseminating information and collecting views on the various consultations or issues affecting their members.

Our finances

INCOME	£
Funding received from local authority to deliver local Healthwatch statutory activities	150,000
Additional income	
Total income	150,000

EXPENDITURE	
Operational costs	50,307
Staffing costs	104,627
Office costs	17,280
Total expenditure	172,214

Net expenditure	
Balance brought forward 1 April 2016	37,226
Balance carried forward 31 March 2017	15,012

Contact us

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If you require this report in an alternative format please contact us at the Gateshead address above

We make this annual report publicly available by 30 June 2017 by publishing it on our website and circulating it to Healthwatch England; CQC; NHS England; Newcastle Gateshead Clinical Commissioning Group; the Care, Health and Wellbeing Overview and Scrutiny Committee; and our local authority.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

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Item 9

HEALTH AND WELLBEING BOARD
8th September 2017

TITLE OF REPORT: Pharmacy Applications 2017

Purpose of Report

1. The purpose of this report is to present the Health and Wellbeing Board with a summary of new applications July 2017. Applications are received from NHS England in accordance with the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, since the last formal meeting of the Health and Wellbeing Board in November 2013.

Background

2. The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 outline that under regulation 99; 4a NHS England must give notice of the designation (relating to pharmacy applications) to:

   "The Health and Wellbeing Board for the area to which the designation relates, or (as the case may be) for the area in which the premises or descriptions are situated".

3. A process has been agreed whereby any Pharmacy Relocation Applications would first be considered by the Director of Public Health who would make a recommendation to the other Health and Wellbeing Board members as to whether a representation to NHS England was necessary. The application would then be circulated to the Health and Wellbeing Board, along with the Director of Public Health's recommendation.

Pharmacy Applications

4. The Health and Wellbeing Board as an interested party is requested to provide NHS England with any representations in respect of Pharmacy Relocation applications.

5. In July 2017 one application received from AOne Business Centre, Suite 6, 3 Summerhill, Blaydon on Tyne, Tyne & Wear, NE21 4JR in respect of distance selling premises by Pacific Chem Ltd.

6. Representations were made from the Local Pharmaceutical Committee and the Local Medical Council who are of the opinion that there is sufficient pharmaceutical provision within Gateshead and that this contract would undoubtedly destabilize the current service provision. The LMC also felt that GP practices have noted that patients are being approached directly by such (online) pharmacies and asked to give their permission to collect prescriptions and post their medication. This undermines the local relationship with GPs and pharmacists and may lead to requests for repeat prescriptions when not needed.

7. Gateshead Council Public Health also made a representation based on the information that the General Pharmaceutical Council registration for the named pharmacist was unable to be located.

Recommendations

8. It is recommended that the Health and Wellbeing Board:

   - Note the content of this report;
   - Agree the representation made;
   - Receive future reports when new applications are submitted.

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