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HEALTH AND WELLBEING BOARD AGENDA

Friday, 15 January 2016 at 10.00 am at the Whickham Room - Civic Centre

From the Chief Executive, Jane Robinson

Item	Business
1.	**Apologies for Absence**
2.	**Minutes** (Pages 1 - 16) The minutes and action list of the meeting held on 4 December 2015 are attached for approval.
3.	**Declarations of Interest** Members of the Board to declare interests in any agenda item.
	Items for Discussion
4a.	**NHS Planning Guidance 2016/17 to 2020/21** (Pages 17 - 56) To be presented by Mark Dornan, NHS Newcastle Gateshead CCG.
4b.	**Health and Wellbeing Strategy Refresh (Scoping Report)** (Pages 57 - 110) To be presented by John Costello, Gateshead Council.
5.	**Director of Public Health Annual Report 2014/15** (Pages 111 - 120) To be presented by Carole Wood, Director of Public Health.
6.	**Health Protection Update** (Pages 121 - 126) To be presented by Pam Lee, Gateshead Council Public Health Team.
7.	**Role of Housing Providers in Promoting Health and Wellbeing : Housing Conditions** (Pages 127 - 132) To be presented by Lisa Phillliskirk
8.	**Achieving More Together Programme** (Pages 133 - 136) To be presented by Carole Wood.
9.	**Mental Health Employment Trailblazer Pilot: Development of Model** (Pages 137 - 142) To be presented by Alan Jobling.

Continued…..

Contact: Sonia Stewart; email; soniastewart@gateshead.gov.uk, Tel: 0191 433 3045, Date: Thursday, 7 January 2016

Performance Management Items

10. **Performance Report for the Health and Care System** (Pages 143 - 158)

To be presented by David Oates.

Items for Information

11. **Updates from Board Members**

12. **Any Other Business**

GATESHEAD HEALTH AND WELLBEING BOARD

Friday 4 December 2015

Present:	Councillor Lynne Caffrey (Chair)	– Gateshead Council
	Councillor Helen Hughes	– Gateshead Council
	Councillor Michael McNestry	– Gateshead Council
	Councillor Mick Henry	– Gateshead Council
	Dr Mark Dornan	– NHS Newcastle Gateshead CCG
	David Bunce	– Gateshead Council
	Alison Dunn	– GVOC
	Councillor Catherine Donovan	– Gateshead Council
	Carole Wood	– Gateshead Council
	Dr Bill Westwood	– Federation of GP Practices

In attendance:

Caroline Wild	– Northumberland, Tyne & Wear NHS Foundation Trust
Jill McGrath	– Newcastle Gateshead CCG
Phil Argent	– Newcastle Gateshead CCG
Susan Watson	– Gateshead NHS Foundation Trust
Andrew Moore	– Healthwatch Gateshead
Councillor M Hood	– Gateshead Council
John Costello	– Gateshead Council
Chris Piercy	– Newcastle Gateshead CCG
Sonia Stewart	– Gateshead Council

1. APOLOGIES FOR ABSENCE:

Apologies were received from Councillor Malcolm Graham, Councillor Frank Hindle, Ian Renwick, Mike Robson and James Duncan.

2. MINUTES

The minutes of the last meeting held on 23 October were agreed as a correct record.

Matters Arising

There were no matters arising.

Action List

There were 4 new items on the action list which were noted.

3. DECLARATIONS OF INTEREST

No declarations of interest were submitted.

4. MENTAL HEALTH REVIEW DECIDING TOGETHER

Chris Piercy presented to the Board on the current position regarding the review of Mental Health Services and the 'Deciding Together' consultation. The review started in June 2014 and incorporated a long period of time listening to people's views. Different types of events were held to engage with the public. In particular, an event around making the best use of the mental health £ was well attended and produced some excellent ideas, whilst also showing how difficult it was to balance the various challenges that need to be addressed.

The CCG has now embarked upon another period of significant consultation from November this year to February 2016. Currently, 3 public events have been held so far with the most recent taking place on 3 December at which over 30 members of the public attended. What people have said is very important to the review process and the overarching theme is that care needs to be wrapped around the person and, where possible, within the person's local community.

The Board were assured that beds would not be closed until there is total confidence in the community infrastructure in place. It was noted that the services included within the scope of the review are NTW services.

It was noted that the current position in Newcastle Gateshead is that we have a high number of beds compared to the rest of the country. Existing inpatient accommodation does not meet the standards which the CCG and NTW wish to provide. Chris Piercy explained the reasons why service arrangements need to change – firstly, because of a lack of easy access and secondly, the fact that people 'bounce' around the system. There is also a need to ensure that there is both an easy way into services and an easy way out of services.

The proposal is for a new or re-designed or extended community offer. There needs to be joined up services across the piece and a one-stop - shop which would enable easy access. Access points into the service will be aligned to facilitate a more streamlined process. This will be managed in a phased way. The CCG is of the view that we can work in different ways and lessons have been learnt from the experience of Sunderland and South Tyneside.

There are 3 scenarios for change for acute assessment and treatment and rehabilitation services:

Scenario T, which is trust wide, would mean:

- The adult acute assessment and treatment service for Newcastle and Gateshead residents being provided from NTW's hospital at St Georges Park, Morpeth (two additional wards to be provided there) and from NTW's hospital at Hopewood Park, Sunderland (one additional ward to be provided there).
- The rehabilitation service currently at St Nicholas Hopsital, Newcastle being provided from St George's Park. Elm House in Gateshead would be retained at a moving on rehabilitation unit.

Scenario N, which is Newcastle Based, would mean

- The adult acute assessment and treatment service (three wards) for Newcastle and Gateshead residents being provided from St Nicholas Hospital, Newcastle.
- The rehabilitation ward at St Nicholas Hospital Newcastle would provide complex care and Elm House in Gateshead would be retained as a moving on rehabilitation unit.

Scenario G, which is Gateshead based, would mean:

- The adult acute assessment and treatment service (three wards) for Newcastle and Gateshead residents being provided from a location to be identified in Gateshead.
- A complex care rehabilitation ward would also be provided at the same location as above. Elm House in Gateshead would be retained as a moving on rehabilitation unit.

It was noted that the Gateshead based scenario would require new build as the Tranwell Unit building is not considered fit for purpose.

It was also noted that there was a very strong message in the listening exercise that people worry about travelling long distances to visit relatives and friends in hospital including the cost of travel, the time it takes to travel if using public transport, and how service users will keep in touch with their local communities.

There are a number of different factors which will need to be taken into account when deciding on these scenarios including the quality of clinical care, the quality of the accommodation and environment, location and travel for both patients and their families/carers and opportunities to develop new community services (including the balance of investment between community and inpatient care).

Consultation events are taking place now and further events will be taking place in January. There are also some consultation events being planned by the voluntary sector. In developing the consultation document, it was noted that the CCG has worked with the Consultation Institute.

The Board was informed that no decisions have been pre-determined. The outcome will be determined by the CCG Governing Body in the light of the consultation exercise which ends on 12th February 2016. The Case for Change document will be completed having regard to information and feedback from the consultation. A meeting of the CCG's Governing Body will be held in public on 24thMay, when a decision will be made.

Comments

It was felt that the presentation given was really helpful and provided clarity on the process, how things are taking shape, including the thinking around wider community provision. It was queried about the timescales in which wider community services are going to be shaped, which needs to be joined up with the community wellbeing resilience hub concept. Links with adult social care need to be clear with one access point in order to signpost people to the right place - it is important that this thinking is joined up.

It was noted that the transformation of community services is not going to happen overnight; it was felt that getting the infrastructure right could take 2-3 years. Each different inpatient scenario will have a different cost and this will have a direct impact on the amount of funding which can be released to improve community services.

It was reported that the Gateshead VCS are planning to hold 2 focus groups linked to the current consultation. However, the voluntary sector felt that the complexity of the consultation document meant that the holding of such events was quite onerous (particularly for smaller organisations) and a significant amount of input was required. In response, it was noted that this should not be the case and that Chris Piercy or another officer from the CCG would be happy to contact any organisation to offer assistance.

It was noted that a Group has been campaigning regarding the closure of the Tranwell Unit; it was queried whether steps are being taken to engage with this group. It was noted that it is always the case that officers will meet with individuals and groups to give reassurance around the process and listen to any concerns raised.

It was noted that as well as the future options for in-patient services, it is envisaged that a better community infrastructure which will help to prevent admissions in the first place.

It was felt that relevant community services need to be in place and working in the right way before money is pulled out of acute services. It is a real worry that changes are being proposed before community services are developed and working. It was noted that this is a real opportunity to get things right before significant changes are made, making the most of opportunities presented by the 'parity of esteem' agenda for mental health care.

It was noted that local communities need to be made aware of the financial constraints impacting upon future service developments as resources are limited. They also need to be made aware of work that is already ongoing with partner organisations to build clinical capacity and reduce administration.

It was noted that the Board were pleased that the retention of Elm House has been included within the options; however, as the rehabilitation of people with mental health problems can take some time it was queried whether there will be sufficient capacity to meet demand. It was noted that opportunities to secure for more effective discharge into the community will be looked at.

Concern was expressed regarding transport to acute services. It was felt that the travel implications linked to accessing acute services (or to visit service users by family members etc.) from various parts of the Borough would need to be taken into consideration (e.g. where people have to get two or three buses or a metro and a bus). It was noted that an independent travel impact survey has been commissioned to consider the impact of all of the scenarios and it is expected that this will be available in January.

The representative from NTW advised the Board that the Trust has made a commitment to support travel where inpatient services are further away from local communities. The impact of travel on service users, families and carers will be considered and addressed as part of every individual's care plan, including access to taxis and mini bus transport.

RESOLVED - That the comments of the Board be noted in regard to the consultation.

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5.1. GATESHEAD COUNCIL BUDGET CONSULTATION

It was noted that the Council's budgetary position over the last 5 years has meant that it has reduced expenditure by over £100m, which equates to a £300 per person reduction in spend. The Council now has 2,000 fewer employees. A further funding gap of £50.6m approx. will need to be met over the next two years, pending the settlement to be announced in December. Against a backdrop of increasing demands and spending pressures, the Council aims to continue to deliver positive outcomes for local people.

The Council's budget approach for 2016 – 2018 focuses on the shared outcomes of the Council Plan, with two year budget proposals within a five year medium term financial strategy.

There is a focus on four inter-related areas: economic growth and revenue generation, managing demand, increasing collective responsibility and continuing to drive efficiencies through different ways of working.

An overview was provided of the Council's budget proposals with a particular focus on adult social care, children's services and public health.

The consultation on the Council's budget will run until 30th December and comments will be fed into the budget process which will be taken to Council in February.

It was noted that the pace of change is unrelenting and that there is still a long way to go over the next five years. The Council will continue to be open and transparent in its approach and invites partners to work together in seeking to address the challenges which lie ahead.

[Comments made on the budget proposals are set out at the end of section 5.2 below.]

5.2 NHS FUNDING GAP AND FUNDING PRESSURES

The Board heard from Jill McGrath and Phil Argent on the current position regarding funding pressures within the NHS. The NHS Five year forward plan, published in October 2014, estimated that by 2020/21 there would be a £30bn funding gap in the NHS.

One scenario, based on securing productivity improvements of 2 to 3% a year would potentially reduce the funding gap by £22bn to £8bn. Newcastle Gateshead CCG's contribution to the £22bn productivity requirement would be £193m, much of which would need to be met by providers.

It was noted that there are many inter-dependencies between the funding pressures experienced by the CCG and the Local Authority.

The nationally calculated Newcastle Gateshead CCG allocation target of £641m (for 2015/16) means that its actual baseline allocation of £665m is already 3.73% above target. As it is unlikely that the funding formula will change and there is a requirement for CCGs to move towards their target allocations, this will have implications for future funding allocations available to the CCG. The CCG's allocation will be published on 21st December. It is anticipated that there will be a firm allocation for 3 years as well as 2 years indicative funding through to 2020/21.

It was noted that some of the pressures the CCG are facing include:

Prescribing costs - there has been a 12% increase in prescribing costs in the last year.

Changes to Commissioning Responsibilities - it is expected that there will be a change in the definition of specialised services. If some services are passed back to the CCG, this may mean that its share of the national £22bn productivity requirement goes up.

National Tariff Changes – this may give rise to money shifting between the CCG and NHS England. Tariff efficiency and uplifts have resulted in a 1.5% and 1.6% net reduction in 2014/15 and 2015/16 respectively.

Continuing Health Care – there has been an 8% cost growth between 2014/15 and 2015/16.

Acute Pressures - there has been an increase in acute pressures following changes to NICE guidelines e.g. cancer care.

It is hoped that the two Vanguard programmes will help to secure some of the savings required - the Gateshead Care Homes Vanguard and the Regional Urgent Care Vanguard.

It is also hoped that the Better Care Fund and new models of care initiatives will lead to reduced hospital admissions. In terms of integrated care, it was noted that the government is looking to fully integrate health and social care by 2020.

In summary, there will be a requirement to do more with less and to work more closely together.

Comments (on 5.1 and 5.2)

It was suggested that, as local partner organisations, we need to do our thinking together in order to help reduce gaps in services and address budgetary pressures collectively. It was also noted that this links to the previous discussion on the review of mental health services as there may be some services which are no longer available in Gateshead.

It was felt that the proposed Council budgetary cuts would have a significant impact on local people. Linked to this, there is a need to prepare people for the road ahead. This is partly about changing the culture around the provision of services and people's expectations from the Council and NHS. We need to get a message out to local people that things are changing.

The CCG, for its part, will need to take money out of hospital services to use in different ways and it is critical we have intermediate care arrangements in place to minimise hospital admissions.

In terms of prevention, it was noted that many local authorities are not contemplating reducing investment in smoking prevention initiatives so that this key programme of work can continue.

Concern was expressed regarding the proposal to withdraw funding from the Labruit healthy living centre; it was felt that this funding had assisted in securing an increased take-up of immunisations from the Jewish community who are a hard to reach group.

With regard to risks and challenges, it was noted that budgetary decisions being taken across the health and care economy will impact on different years. Also, some of the remodelling work arising from the Vanguard initiative is going to be undertaken further down the track. It needs to be noted by the Board that the 'front-loading' of efficiencies is going to be challenging.

It was noted from a health provider point of view, that provider organisations may lose out more than once e.g. the QE will lose rent from the Tranwell Unit if it closes, as well as funding from the CCG in other areas as plans are implemented to shift resources from the acute sector to fund initiatives further upstream (prevention/early intervention work etc.).

It was noted that there is a lot of change taking place. Good communication with local people and between partners is therefore essential.

The Voluntary and Community Sector (VCS) acknowledged that the present circumstances are very difficult and wish to assist in any way they can. They would like to be included in discussions at the earliest possible opportunity as we respond to the budgetary pressures facing health and care services.

The VCS also expressed the hope that as well as service provision arrangements being reviewed, the needs of users of those services are considered in tandem as there is concern for the most vulnerable groups. Whilst there is currently an advocacy resource, its capacity is limited - in one week a local advocacy service received 5 referrals and if future referrals were to continue at a similar pace, this would not be sustainable. The sector felt that it would be helpful if service reviews are undertaken in a co-ordinated way with relevant advocacy services so that service users can input fully to the process, thereby gaining the most benefit from the reviews.

With regard to Equality Impact Assessments, it was noted that the Carers Association had identified that 16 out of 20 budget proposals will have an impact on carers. Whilst it is understood that there is

already a commitment to undertake impact assessments with reference to the needs of the 'receiver' of the service, it was felt that it would also be beneficial to see impact assessments undertaken with reference to the needs of carers of those receiving services.

It was queried when the CCG will be publishing its commissioning intentions which will provide a better indication of the approach it is taking in response to current challenges facing the system. It was noted that the timing and co-ordination of decisions is vital and, in particular, that it is important that decisions being made do not de-stabilise smaller organisations which play a vital role. The VCS wish to be engaged on this, including inputting to future arrangements for the Better Care Fund and other initiatives.

In response, the CCG acknowledged that it is really important to discuss commissioning intentions as we need to have a clear idea of what we want our health and social care system to look like for the benefit of the people of Gateshead. The CCG is intending to bring a paper to the January board meeting with more details of emerging NHS planning guidance which will drive planning arrangements across the NHS from 2016/17.

It was reported that Heathwatch Gateshead had held a workshop event on 3rd December regarding the Council's budgetary proposals. Comments made will be written up and submitted to the Council to feed into the current consultation taking place. Key themes which emerged from the event included people's concerns regarding the future quality of care and the need to ensure that vulnerable people are safe and not at risk as a result of the proposals.

It was noted that many good suggestions came out of a recent workshop on social prescribing about ways of relieving pressures on health and care budgets. It was noted that these suggestions will need to be fed into the discussions that are ongoing. It was also noted that a paper is being pulled together and will be brought to a future Board meeting.

An overall theme which came through the comments was that we need to work collectively to address the financial challenges facing the Gateshead health and care economy, which also links to the wider devolution agenda. Budgetary decisions taken by one organisation impact upon the whole system (not just the organisation taking those decisions). It was felt that we have a shared responsibility to use our collective resources to best meet the needs of local people. In this connection, it was noted that there is an Integrated Health Programme Board meeting on 17th December which brings together providers and commissioners. A discussion of the issues by system accountable officers has also been requested.

RESOLVED - That the comments in relation to the budget proposals be noted and fed into the budget

process.

6. HEALTH AND WELLBEING STRATEGY REFRESH

It was noted that a scoping report on the refresh of the health and wellbeing strategy was included with the agenda papers for the meeting. However, it was suggested that in the light of time constraints to conclude the meeting, as well as the update provided on emerging NHS planning guidance (as part of the discussion on the previous item), that the report be brought back to the January Board meeting. It will then be considered side by side with a report on NHS guidance for the new planning round.

RESOLVED - That the proposal to discuss at the January Board meeting be agreed, together with a report on new NHS planning guidance.

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7. BCF QUARTER 2 RETURN 2015/16 to NHS ENGLAND

The Better Care Fund Quarter 2 return was presented for the Board for endorsement. The return was submitted to NHS England in line with the prescribed deadlines and was consistent with the performance report presented to the last meeting of the Board. The report also sets out the deadlines for the 3rd and 4th quarterly returns.

RESOLVED - That the Better Care Fund Quarter 2 return be endorsed by the Board.

8. UPDATES FROM BOARD MEMBERS

Gateshead NHS Foundation Trust

With regard to the inspection of the Trust undertaken by the CQC in September, it was reported that formal feedback is expected before Christmas. It is anticipated that this will be positive.

NTW Mental Health Trust

The Trust is going 'smoke-free' for patients from March next year. It was felt that this represents a significant achievement given the high incidence of smoking amongst people with mental health conditions. Staff are being trained to provide support in readiness.

Gateshead Council

The Council has recently undergone an OFSTED inspection of services for children in need of help and protection, looked after children and care leavers. The inspection feedback was extremely

positive and it is anticipated that the final report will reflect the favourable nature of the inspection.

Newcastle Gateshead CCG

Newcastle Gateshead CCG has been assured by the National Team and is one of only five CCGs across the country to have secured such assurance. It was also reported that it has been good to hear positive comments being made at a national level about the Vanguard Project.

9. HEALTH AND WELLBEING BOARD CHAIRS NETWORK

The Health and Wellbeing Board Chairs Network meets 3 times a year. Councillor Caffrey has recently been appointed vice-chair of the network. It was noted that it has been agreed that exchange visits will take place between health and wellbeing boards - in January, the Chair of Stockton's HWB, Councillor Jim Beall, and the Director of Public Health, Peter Kelly will be visiting Gateshead Health and Wellbeing Board. Councillor Caffrey and Carole Wood will be making a reciprocal visit to Stockton in February.

It was also reported that there has been an offer of an academic review of Health and Wellbeing Board strategies to be undertaken. A date in March has been arranged to develop the brief. Alyson Learmonth (former DPH at Gateshead) will be undertaking the work.

11. ANY OTHER BUSINESS

No issues were raised.

12. DATE AND TIME OF NEXT MEETING

Friday 15th January 2016 at 10am.

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GATESHEAD HEALTH AND WELLBEING BOARD
ACTION LIST

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Matters Arising from 4th December 2015 meeting of the HWB			
Partner Updates	Report on NHS Planning Guidance for 2016/17 and beyond, including implications for Gateshead, to be brought to the next meeting of the Board in January.	Mark Dornan	On agenda for 15 January Board meeting
Matters Arising from 23rd October 2015 meeting of the HWB			
North East & Cumbria Fast Track Learning Disability Transformation Plan	Future reports to be brought back to the Board on progress.	Chris Piercy	To feed into the Board's Forward Plan
Child and Adolescent Mental Health Services (CAMHS) Transformation Plan	The Board to receive regular assurance reports.	Chris Piercy	To feed into the Board's Forward Plan
Children & Young People 0 – 19 Framework	The Board to receive a follow-up report when further modelling work is complete.	Carole Wood	To feed into the Board's Forward Plan
Tobacco Control 10 Year Plan	A plan to be brought to the Board within the next 6 months.	Alice Wiseman	To feed into the Board's Forward Plan
Matters Arising from 11th September 2015 meeting of the HWB			
Personal Health Budgets	Personal health budgets to be examined in the context of social prescribing as part of a planned workshop	Alice Wiseman/ Gail Bravant	Workshop completed.

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
	due to take place in November. A further update report on Personal Health budgets to be brought back to the Board in April 2016.	 Julia Young/Gail Bravant	 Included within 2015/16 Forward Plan of HWB
Homeless Health: Deep-dive exercise	NTW also to be involved in this piece of work going forward. The findings of the further research work to be brought back to the Board early in the New Year.	Lisa Philliskirk	Being progressed. Included within 2015/16 Forward Plan of HWB.
Communications Strategy	Communications leads to meet to discuss arrangements for taking forward the strategy and to develop an initial communications plan for the Board for the six month period to 31 March 2016. Bring back the Plan to the board for endorsement.	Lee Hansom	Being progressed.
Substance Misuse Strategy Group Terms of Reference and Workplan for 2015/16	Invite the Local Medical Committee to attend meetings of the Substance Misuse Strategy Group. The Board to receive a draft Substance Misuse Strategy for Gateshead at a future meeting.	Alice Wiseman	To be progressed. Logged for inclusion within the Forward Plan of HWB

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Matters Arising from 17th July 2015 meeting of the HWB			
HWB Forward Plan	Timings to be identified for outstanding items to come to the Board linked to the Forward Plan.	All Partners	Being progressed
Matters Arising from 5th June 2015 meeting of the HWB			
Older Peoples Wellbeing – Addressing Social Isolation	A scoping report setting out work that is already ongoing and identifying gaps to be brought back to a future meeting of the HWB	Alice Wiseman	Included within 2015/16 Forward Plan for HWB
Matters Arising from 24th April 2015 meeting of the HWB			
Place shaping for health and wellbeing	That a Stakeholder workshop be arranged on place shaping for health and wellbeing, led by the Health and Wellbeing Board.	Carole Wood/Paul Dowling	Included within 2015/16 Forward Plan for HWB
Matters Arising from 27th February 2015 meeting of the HWB			
Role of Housing Providers in Promoting Health and Wellbeing	Reports to be brought back to the Board on various aspects of this agenda.	Lisa Phillliskirk	Included within 2015/16 Forward Plan for HWB
Matters Arising from 16th January 2015 meeting of the HWB			
Mental Health Employment Integration Trailblazer Pilot	Follow-up report to come back to the HWB when a model has been worked up (around June) Ensure discussions	Alan Jobling	The start of the Trailblazer Pilot was delayed. Included on the agenda of the

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
	take place with the Voluntary and Community Sector in developing the model.		Board for January 2016

Gateshead Council

Health and Wellbeing Board

15 January 2016

2016/17 NHS England Planning Guidance

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

1. Purpose of the report

1.1 This report provides an update on the key messages of the NHS England Planning Guidance which was published on 22nd December 2015. **Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21** **https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf**

2. Recommendations

2.1 It is recommended that the Health and Wellbeing Board

- Consider and comment on the requirements in the planning guidance, including the connection with the Commission for Health and Social Care Integration report expected by Summer 2016 and the need to develop a clear overall shared vision and plan for our area.

3. Introduction and background

3.1 Each year NHS England produces a framework which CCG commissioners use to work with providers and local authority partners to develop robust and ambitious plans in order to secure high quality services, reduce health inequalities and improve health outcomes for patients and public.

The document sets out a clear list of national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules.

It also reflects the settlement reached with the Government through its new Mandate to NHS England (Annex 2 of the document). For the first time, the Mandate is not solely for the commissioning system, but sets objectives for the NHS as a whole.

NHS organisations are required to produce two separate but connected plans:

- a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
- a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP

In addition we are required to update the Better Care Fund Plan.

4. Key messages

4.1 This is a new, different planning process that supports local change, transcends boundaries and looks beyond one year.

4.2 There are specific asks for 2016/17:

Operational Plans for 2016/17

The 2016/17 Operational Plan should be regarded as year one of the five year STP, and there is an expectation of significant progress on transformation through the 2016/17 Operational Plan.

By April 2016, commissioner and provider plans for 2016/17 will need to be agreed by NHS England and NHS Improvement, based on local contracts that must be signed by March 2016 covering activity, capacity, finance and 2016/17 deliverables from the emerging STP.

All plans will need to demonstrate:
• how they intend to reconcile finance with activity (and where a deficit exists, set out clear plans to return to balance);

- their planned contribution to the efficiency savings;
- their plans to deliver the key must-dos;
- how quality and safety will be maintained and improved for patients;
- how risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan; and
- how they link with and support with local emerging STPs.
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National MUST DO's for 16/17

By March 2017, 25 percent of the population will have access to acute hospital services that comply with four priority clinical standards on every day of the week, and 20 percent of the population will have enhanced access to primary care. There are three distinct challenges under the banner of seven day services:

1. (i) reducing excess deaths by increasing the level of consultant cover and diagnostic services available in hospitals at weekends. During 16/17, a quarter of the country must be offering four of the ten standards, rising to half of the country by 2018 and complete coverage by 2020;
2. (ii) improving access to out of hours care by achieving better integration and redesign of 111, minor injuries units, urgent care centres and GP out of hours services to enhance the patient offer and flows into hospital; and
3. (iii) improving access to primary care at weekends and evenings where patients need it by increasing the capacity and resilience of primary care over the next few years.

Where relevant local systems need to reflect this in their 2016/17 Operational Plans, and all areas will need to set out their ambitions for seven day services.

There are nine ‘must dos’ for 2016/17 for every local system:

1. Develop a high quality and agreed STP, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View.
2. Return the system to aggregate financial balance. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the Right Care programme in every locality.
3. Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues.
4. Get back on track with access standards for A&E and ambulance waits, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.
5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice.
6. Deliver the NHS Constitution 62 day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.
7. Achieve and maintain the two new mental health access standards: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.
8. Deliver actions set out in local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.
9. Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of avoidable mortality rates by individual trusts.

4.3 **The Five Year Local health system Sustainability and Transformation Plan (STP)**

Every health and care system will come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View, this will be called the Sustainability and Transformation Plan (STP).

STPs will cover the period between October 2016 and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016.

In the next six months the NHS is expected to deliver core access, quality and financial standards while planning properly for the next five years.

An important factor to note is that the STP will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards.

Many of these streams of transformation funding form part of the new wider national Sustainability and Transformation Fund (STF). The most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards.

While the STP needs to address the list of national challenges set out in the guidance there is a clear message that the list should not be seen simply as a narrow template for what constitutes a good local plan, the most important initial task is to create a clear overall vision and plan for our area.

Annex 1 of the guidance provides the detailed list of 'national challenges' to help us set out ambitions for our populations – these are about reducing the 3 Gaps below, and are the basis on which we are developing our Plan for 2016/17.

- Health and Wellbeing
- Care and Quality
- Finance and efficiency.

The key national challenges which will need to be considered when discussing the future vision for the STP include our:

- Plan for sustainable general practice and wider primary care?
- Plan to implement enhanced access to primary care in evenings and weekends and using technology?
- Plan to adopt new models of out-of-hospital care, e.g Multi-specialty Community Providers (MCPs) or Primary and Acute Care Systems (PACS)? Why should NHS England prioritise your area for transformation funding?
- Plan for new models of acute care collaboration (accountable clinical networks, specialty franchises, and Foundation Groups)?
- Plan for transforming urgent and emergency care in your area?
- Plan to maintain the elective care referral to treatment standard? productivity?

- Plan to deliver transformation in cancer prevention, diagnosis, treatment and aftercare in line with the cancer taskforce report?
- Plan to improve mental health services, in line with the forthcoming mental health taskforce report, to ensure measureable progress towards parity of esteem for mental health?
- Plan to improve dementia services?
- Plan for delivering the Transforming Care programme, to ensure that people with learning disabilities are, wherever possible, supported at home rather than in hospital? How far are you closing out-moded inpatient beds and reinvesting in continuing learning disability support
- Plan for major expansion of integrated personal health budgets and implementation of choice – particularly in maternity, end-of-life and elective care – be an integral part of your programme to hand power to patients?

Addressing the national challenges is essential in gaining sign off of the plan, and importantly attracting additional national investment.

4.4 **Better Care Fund (BCF plan)**

The CCG and Local Authority need to agree a joint plan to continue to deliver the requirements of the Better Care Fund (BCF) in 2016/17, building on the 2015/16 BCF plan, and taking account of what has worked well in meeting the objectives of the fund, and what has not.

CCGs will be advised of the minimum amount that they are required to pool as part of the notification of their wider allocation. BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care.

Further guidance on the BCF is expected in January but the BCF plan has the same submission deadline as the Operational plan of 8th February 2016.

4.5 **Financial planning guidance**

Full guidance will be issued once the NHS allocations are known but:

- It is likely that contracts will need to be closed off earlier next year
- Plans will clearly need to identify the efficiency gap to meet the planning parameters, with an emphasis on risk assessment and scenario planning.
- Plans will need to contain final planning assumptions including fixed allocations for next three years
- Plans will need to build on triangulation work undertaken in 2015/16 with clear links between activity and finance (including QIPP plans) and commissioners and providers

4.6 **Assurance**

There will be a new, more joined-up approach by arms length bodies to planning, to ensure detailed, credible and robust plans with evidence of them being jointly owned and delivered by commissioners and providers.

This will include organisations being asked to self – assess their readiness for shared planning, identifying issues that will require support, both for its operational plan and the STP.

4.7 **Timelines**

Timetable	Date
Publish planning guidance	22 December 2015
Publish 2016/17 indicative prices	By 22 December 2015
Issue commissioner allocations, and technical annexes to planning guidance	Early January 2016
Launch consultation on standard contract, announce CQUIN and Quality Premium	January 2016
Issue further process guidance on STPs	January 2016
Localities to submit proposals for STP footprints and volunteers for mental health and small DGHs trials	By 29 January 2016
First submission of full draft 16/17 Operational Plans	8 February 2016
National Tariff S118 consultation	January/February 2016
Publish National Tariff	March 2016
Boards of providers and commissioners approve budgets and final plans	By 31 March 2016
National deadline for signing of contracts	31 March 2016
Submission of final 16/17 Operational Plans, aligned with contracts	11 April 2016
Submission of full STPs	End June 2016
Assessment and Review of STPs	End July 2016

5. Reasons for the decision

5.1 Developing the organisation and Sustainability and Transformational Plan within the planning footprint of Newcastle Gateshead will require close working with key partners to deliver the transformation required.

Consideration also needs to be given to Wellbeing for Life Strategy, reconfiguration programmes and devolution. The Health and Wellbeing Board will have a pivotal oversight role in the development of these plans and the production of the Health and Social Care Integration report.

6. Alternative Options

6.1 N/A

7. What happens next

7.1 Work is underway internally in the CCG to develop a framework for the development of the plans.

Accountable Officers meeting

The guidance specifies the need for local system leaders to come together to develop a clear overall shared vision and plan for our area. The Accountable Officers across the Newcastle Gateshead health and social care system are meeting on 12th January in order to discuss how this work can be collectively taken forward.

Agreeing 'transformation footprints'

One of the first milestones is for us to submit our proposed transformation footprint to NHS England by Friday 29 January 2016, for national agreement.

Transformation footprints should be locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver the services, transformation and public health programmes required, and how it best fits with other footprints such as local digital roadmaps and learning disability units of planning

Developing the STP

We need to come together to develop the STP with senior colleagues across the system, mandated by the Accountable Officers to firstly review in more detail the planning guidance, and agree how we drive forward the development of the system sustainability and transformation plan.

A meeting has been arranged for 21st January to begin to progress this work, with membership made up from the current Newcastle and Gateshead Integrated Programme Boards.

8. Background papers

The Planning Guidance is attached as Appendix 1.

9. Contact officers

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Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21

December 2015

Delivering the Forward View: NHS planning guidance

2016/17 – 2020/21

Version number: 1

First published: 22 December 2015

Prepared by: NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), Care Quality Commission (CQC), Health Education England (HEE), National Institute of Health and Care Excellence (NICE), Public Health England (PHE).

This document is for: Commissioners, NHS trusts and NHS foundation trusts.

Publications Gateway Reference: 04437

The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England*
- NHS Improvement (Monitor and the NHS Trust Development Authority)
- Health Education England (HEE)
- The National Institute for Health and Care Excellence (NICE)
- Public Health England (PHE)
- Care Quality Commission (CQC)

*The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Introduction

1. The Spending Review provided the NHS in England with a credible basis on which to accomplish three interdependent and essential tasks: first, to implement the Five Year Forward View; second, to restore and maintain financial balance; and third, to deliver core access and quality standards for patients.

2. It included an £8.4 billion real terms increase by 2020/21, front-loaded. With these resources, we now need to close the health and wellbeing gap, the care and quality gap, and the finance and efficiency gap.

3. In this document, authored by the six national NHS bodies, we set out a clear list of national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules. We reflect the settlement reached with the Government through its new Mandate to NHS England (annex 2). For the first time, the Mandate is not solely for the commissioning system, but sets objectives for the NHS as a whole.

4. We are requiring the NHS to produce two separate but connected plans:

   - a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
   - a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.

5. The scale of what we need to do in future depends on how well we end the current year. The 2016/17 financial challenge for each trust will be contingent upon its end-of-year financial outturn, and the winter period calls for a relentless focus on maintaining standards in emergency care. It is also the case that local NHS systems will only become sustainable if they accelerate their work on prevention and care redesign. We don't have the luxury of waiting until perfect plans are completed. So we ask local systems, early in the New Year, to go faster on transformation in a few priority areas, as a way of building momentum.

Local health system Sustainability and Transformation Plans

6. We are asking every health and care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View. STPs will cover the period between October 2016[1] and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016. We are asking the NHS to spend the next six months delivering core access, quality and financial standards while planning properly for the next five years.

Place-based planning

7. Planning by individual institutions will increasingly be supplemented with planning by place for local populations. For many years now, the NHS has emphasised an organisational separation and autonomy that doesn't make sense to staff or the patients and communities they serve.

8. System leadership is needed. Producing a STP is not just about writing a document, nor is it a job that can be outsourced or delegated. Instead it involves five things: (i) local leaders coming together as a team; (ii) developing a shared vision with the local community, which also involves local government as appropriate; (iii) programming a coherent set of activities to make it happen; (iv) execution against plan; and (v) learning and adapting. Where collaborative and capable leadership can't be found, NHS England and NHS Improvement[2] will need to help secure remedies through more joined-up and effective system oversight.

9. Success also depends on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards.

10. As a truly place-based plan, the STPs must cover all areas of CCG and NHS England commissioned activity including: (i) specialised services, where the planning will be led from the 10 collaborative commissioning hubs; and (ii) primary medical care, and do so from a local CCG perspective, irrespective of delegation arrangements. The STP must also cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.

[1] For the period October 2016 – March 2017, the STP should set out what actions are planned but it does not need to revisit the activity and financial assumptions in the 2016/17 Operational Plan.

[2] NHS Improvement will be the combined provider body, bringing together Monitor and the NHS Trust Development Authority (TDA).

Access to future transformation funding

11. For the first time, the local NHS planning process will have significant central money attached. The STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards. This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives.

12. The Spending Review provided additional dedicated funding streams for transformational change, building up over the next five years. This protected funding is for initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health. Many of these streams of transformation funding form part of the new wider national Sustainability and Transformation Fund (STF). For 2016/17 only, to enable timely allocation, the limited available additional transformation funding will continue to be run through separate processes.

13. The most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards. The process will be iterative. We will consider:

    (i) the quality of plans, particularly the scale of ambition and track record of progress already made. The best plans will have a clear and powerful vision. They will create coherence across different elements, for example a prevention plan; self-care and patient empowerment; workforce; digital; new care models; and finance. They will systematically borrow good practice from other geographies, and adopt national frameworks;

    (ii) the reach and quality of the local process, including community, voluntary sector and local authority engagement;

    (iii) the strength and unity of local system leadership and partnerships, with clear governance structures to deliver them; and

    (iv) how confident we are that a clear sequence of implementation actions will follow as intended, through defined governance and demonstrable capabilities.

Content of STPs

14. The strategic planning process is intended to be developmental and supportive as well as hard-edged. We set out in annex 1 of this document a list of 'national challenges' to help local systems set out their ambitions for their populations. This list of questions includes the objectives set in the Mandate. Do not over-interpret the list as a narrow template for what constitutes a good local plan: the most important initial task is to create a clear overall vision and plan for your area.

15. Local health systems now need to develop their own system wide local financial sustainability plan as part of their STP. Spanning providers and commissioners, these plans will set out the mixture of demand moderation, allocative efficiency, provider productivity, and income generation required for the NHS locally to balance its books.

Agreeing 'transformation footprints'

16. The STP will be the umbrella plan, holding underneath it a number of different specific delivery plans, some of which will necessarily be on different geographical footprints. For example, planning for urgent and emergency care will range across multiple levels: a locality focus for enhanced primary care right through to major trauma centres.

17. The first critical task is for local health and care systems to consider their transformation footprint – the geographic scope of their STP. They must make proposals to us by Friday 29 January 2016, for national agreement. Local authorities should be engaged with these proposals. Taken together, all the transformation footprints must form a complete national map. The scale of the planning task may point to larger rather than smaller footprints.

18. Transformation footprints should be locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver the services, transformation and public health programmes required, and how it best fits with other footprints such as local digital roadmaps and learning disability units of planning. In future years we will be open to simplifying some of these arrangements. Where geographies are already involved in the Success Regime, or devolution bids, we would expect these to determine the transformation footprint. Although it is important to get this right, there is no single right answer. The footprints may well adapt over time. We want people to focus their energies on the content of plans rather than have lengthy debates about boundaries.

19. We will issue further brief guidance on the STP process in January. This will set out the timetable and early phasing of national products and engagement events that are intended to make it much easier to answer the challenges we have posed, and include how local areas can best involve their local communities in creating their STPs, building on the 'six principles' created to support the delivery of the Five Year Forward View. By spring 2016, we intend to develop and make available roadmaps for national transformation initiatives.

20. We would welcome any early reactions, by Friday 29 January 2016, as to what additional material you would find most helpful in developing your STP. Please email england.fiveyearview@nhs.net, with the subject title 'STP feedback'. We would also like to work with a few local systems to develop exemplar, fast-tracked plans, and would welcome expressions of interest to the above inbox.

National 'must dos' for 2016/17

21. Whilst developing long-term plans for 2020/21, the NHS has a clear set of plans and priorities for 2016/17 that reflect the Mandate to the NHS and the next steps on Forward View implementation.

22. Some of our most important jobs for 2016/17 involve partial roll-out rather than full national coverage. Our ambition is that by March 2017, 25 percent of the population will have access to acute hospital services that comply with four priority clinical standards on every day of the week, and 20 percent of the population will have enhanced access to primary care. There are three distinct challenges under the banner of seven day services:

(i) reducing excess deaths by increasing the level of consultant cover and diagnostic services available in hospitals at weekends. During 16/17, a quarter of the country must be offering four of the ten standards, rising to half of the country by 2018 and complete coverage by 2020;

(ii) improving access to out of hours care by achieving better integration and redesign of 111, minor injuries units, urgent care centres and GP out of hours services to enhance the patient offer and flows into hospital; and

(iii) improving access to primary care at weekends and evenings where patients need it by increasing the capacity and resilience of primary care over the next few years.

23. Where relevant, local systems need to reflect this in their 2016/17 Operational Plans, and all areas will need to set out their ambitions for seven day services as part of their STPs.

The nine 'must dos' for 2016/17 for every local system:

1. Develop a high quality and agreed **STP**, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the **Forward View**.

2. Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.

3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.

4. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.

6. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

7. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.

8. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts.

24. We expect the development of new care models will feature prominently within STPs. In addition to existing approaches, in 2016/17 we are interested in trialing two new specific approaches with local volunteers:
    - secondary mental health providers managing care budgets for tertiary mental health services; and
    - the reinvention of the acute medical model in small district general hospitals.

Organisations interested in working with us on either of these approaches should let us know by 29 January 2016 by emailing england.fiveyearview@nhs.net

Operational Plans for 2016/17

25. An early task for local system leaders is to run a shared and open-book operational planning process for 2016/17. This will cover activity, capacity, finance and 2016/17 deliverables from the emerging STP. By April 2016, commissioner and provider plans for 2016/17 will need to be agreed by NHS England and NHS Improvement, based on local contracts that must be signed by March 2016.

26. The detailed requirements for commissioner and provider plans are set out in the technical guidance that will accompany this document. All plans will need to demonstrate:

    - how they intend to reconcile finance with activity (and where a deficit exists, set out clear plans to return to balance);
    - their planned contribution to the efficiency savings;
    - their plans to deliver the key must-dos;
    - how quality and safety will be maintained and improved for patients;
    - how risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan; and
    - how they link with and support with local emerging STPs.

    The 2016/17 Operational Plan should be regarded as year one of the five year STP, and we expect significant progress on transformation through the 2016/17 Operational Plan.

27. Building credible plans for 2016/17 will rely on a clear understanding of demand and capacity, alignment between commissioners and providers, and the skills to plan effectively. A support programme is being developed jointly by national partners to help local health economies in preparing robust activity plans for 2016/17 and beyond.

Allocations

28. NHS England's allocations to commissioners are intended to achieve:

    - greater equity of access through pace of change, both for CCG allocations and on a place-based basis;

    - closer alignment with population need through improved allocation formulae including a new inequalities adjustment for specialised care, more sensitive adjustments for CCGs and primary care, and a new sparsity adjustment for remote areas; and

    - faster progress with our strategic goals through higher funding growth for GP services and mental health, and the introduction of the Sustainability and Transformation Fund.

29. In line with our strategic priorities, overall primary medical care spend will rise by 4-5 percent each year. Specialised services funding will rise by 7 percent in 2016/17, with growth of at least 4.5 percent in each subsequent year. The relatively high level of funding reflects forecast pressures from new NICE legally mandated drugs and treatments.

30. To support long-term planning, NHS England has set firm three year allocations for CCGs, followed by two indicative years. For 2016/17, CCG allocations will rise by an average of 3.4 percent, and we will make good on our commitment that no CCG will be more than 5 percent below its target funding level. To provide CCGs with a total place-based understanding of all commissioned spend, alongside allocations for CCG commissioned activities, we will also publish allocations for primary care and specialized commissioned activity.

    NHS England will in principle support any proposals from groups of CCGs, particularly in areas working towards devolution who wish to implement a more accelerated cross-area pace-of-change policy by mutual agreement.

31. Mirroring the conditionality of providers accessing the Sustainability and Transformation Fund, the real terms element of growth in CCG allocations for 2017/18 onwards will be contingent upon the development and sign off of a robust STP during 2016/17.

Returning the NHS provider sector to balance

32. During 2016/17 the NHS trust and foundation trust sector will, in aggregate, be required to return to financial balance. £1.8 billion of income from the 2016/17 Sustainability and Transformation Fund will replace direct Department of Health (DH) funding. The distribution of this funding will be calculated on a trust by trust basis by NHS Improvement and then agreed with NHS England.

33. NHS England and NHS Improvement are working together to ensure greater alignment between commissioner and provider financial levers. Providers who are eligible for sustainability and transformation funding in 2016/17 will not face a double jeopardy scenario whereby they incur penalties as well as losing access to funding; a single penalty will be imposed.

34. Quarterly release of these Sustainability Funds to trusts and foundation trusts will depend on achieving recovery milestones for (i) deficit reduction; (ii) access standards; and (iii) progress on transformation. The three conditions attached to the transitional NHS provider fund have to be hard-edged. Where trusts default on the conditions access to the fund will be denied and sanctions will be applied.

35. Deficit reduction in providers will require a forensic examination of every pound spent on delivering healthcare and embedding a culture of relentless cost containment. Trusts need to focus on cost reduction not income growth; there needs to be far greater consistency between trusts' financial plans and their workforce plans in 2016/17. Workforce productivity will therefore be a particular priority as just a 1 percent improvement represents £400 million of savings. All providers will be expected to evidence the effective use of e-rostering for nurses, midwives, Health Care Assistants (HCAs) and other clinicians to make sure the right staff are in the right place at the right time to ensure patients get the right hours of care and minimum time is wasted on bureaucracy. This approach will enable providers to reduce their reliance on agency staffing whilst compliance with the agency staffing rules will also reduce the rates paid. In addition, providers will need to adopt tightly controlled procurement practices with compliance incentives and sanctions to drive down price and unwarranted variation. For example, all providers will be expected to report and share data on what they are paying for the top 100 most common non-pay items, and be required to only pay the best price available for the NHS.

36. Capital investments proposed by providers should be consistent with their clinical strategy and clearly demonstrate the delivery of safe, productive services with a business case that describes affordability and value for money. Given the constrained level of capital resource available from 2016/17, there will be very limited levels of financing available and the repayment of existing and new borrowing related to capital investment will need to be funded from within the trust's own internally generated capital resource in all but the most exceptionally pre-agreed cases. Trusts will need to procure capital assets more efficiently, consider alternative methods of securing assets such as managed equipment services, maximize disposals and extend asset lives. In January, the DH will be issuing some revisions to how the PDC dividend will be calculated and a number of other changes to the capital financing regime.

Efficiency assumptions and business rules

37. The consultation on the tariff will propose a 2 percent efficiency deflator and 3.1 percent inflation uplift for 2016/17 (the latter reflecting a step change in pension-related costs). This reflects Monitor and NHS England's assessment of cost inflation including the effect of pension changes. To support system stability, we plan to remain on HRG4 for a further year and there will also be no changes to specialist top- ups in 2016/17; the specialised service risk share is also being suspended for 2016/17. We will work with stakeholders to better understand the impact of the move to HRG4+ and other related changes in 2017/18. For planning purposes, an indicative price list is being made available on the Monitor website. The consultation on the tariff will also include the timetable for implementing new payment approaches for mental health.

38. As notified in Commissioning Intentions 2016/2017 for Prescribed Specialised Services, NHS England is developing a single national purchasing and supply chain arrangement for specialised commissioning high cost tariff excluded devices with effect from April 2016. Transition plans will be put in place prior to this date with each provider to transition from local to national procurement arrangements.

39. The 2 percent efficiency requirement is predicated upon the provider system meeting a forecast deficit of £1.8 billion at the end of 2015/16. Any further deterioration of this position will require the relevant providers to deliver higher efficiency levels to achieve the control totals to be set by NHS Improvement.

40. For 2016/17 the business rules for commissioners will remain similar to those for last year. Commissioners (excluding public health and specialised commissioning) will be required to deliver a cumulative reserve (surplus) of 1 percent. At the very least, commissioners who are unable to meet the cumulative reserve (surplus) requirement must deliver an in-year break-even position. Commissioners with a cumulative deficit will be expected to apply their increase in allocation to improving their bottom line position, other than the amount necessary to fund nationally recognised new policy requirements. Drawdown will be available to commissioners in line with the process for the previous financial year. CCGs should plan to drawdown all cumulative surpluses in excess of 1 percent over the next three years, enabling drawdown to become a more fluid mechanism for managing financial pressures across the year-end boundary.

41. Commissioners are required to plan to spend 1 percent of their allocations non-recurrently, consistent with previous years. In order to provide funds to insulate the health economy from financial risks, the 1 percent non-recurrent expenditure should be uncommitted at the start of the year, to enable progressive release in agreement with NHS England as evidence emerges of risks not arising or being effectively mitigated through other means. Commissioners will also be required to hold an additional contingency of 0.5 percent, again consistent with previous years.

42. CCGs and councils will need to agree a joint plan to deliver the requirements of the Better Care Fund (BCF) in 2016/17. The plan should build on the 2015/16 BCF plan, taking account of what has worked well in meeting the objectives of the fund, and what has not. CCGs will be advised of the minimum amount that they are required to pool as part of the notification of their wider allocation. BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care; further guidance on the BCF will be forthcoming in the New Year.

43. Commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase. Where CCGs collaborate with specialised commissioning to improve service efficiency, they will be eligible for a share of the benefits.

44. NHS England and NHS Improvement continue to be open to new approaches to contracting and business rules, as part of these agreements. For example, we are willing to explore applying a single financial control total across local commissioners and providers with a few local systems.

Measuring progress

45. We will measure progress through a new CCG Assessment Framework. NHS England will consult on this in January 2016, and it will be aligned with this planning guidance. The framework is referred in the Mandate as a CCG scorecard. It is our new version of the CCG assurance framework, and it will apply from 2016/17. Its relevance reaches beyond CCGs, because it's about how local health and care systems and communities can assess their own progress.

Timetable

Timetable	Date
Publish planning guidance	22 December 2015
Publish 2016/17 indicative prices	By 22 December 2015
Issue commissioner allocations, and technical annexes to planning guidance	Early January 2016
Launch consultation on standard contract, announce CQUIN and Quality Premium	January 2016
Issue further process guidance on STPs	January 2016
Localities to submit proposals for STP footprints and volunteers for mental health and small DGHs trials	By 29 January 2016
First submission of full draft 16/17 Operational Plans	8 February 2016
National Tariff S118 consultation	January/February 2016
Publish National Tariff	March 2016
Boards of providers and commissioners approve budgets and final plans	By 31 March 2016
National deadline for signing of contracts	31 March 2016
Submission of final 16/17 Operational Plans, aligned with contracts	11 April 2016
Submission of full STPs	End June 2016
Assessment and Review of STPs	End July 2016

Please note that we will announce the timetable for consultation and issuing of the standard contract separately. A more detailed timetable and milestones is included in the technical guidance that will accompany this document.

Annex 1: Indicative 'national challenges' for STPs

STPs are about the holistic pursuit of the triple aim – better health, transformed quality of care delivery, and sustainable finances. They also need to set out how local systems will play their part in delivering the Mandate (annex 2).

We will publish further guidance early in 2016 to help areas construct the strongest possible process and plan.

We will also make available aids (e.g. exemplar plans) and some hands-on support for areas as they develop their plans.

The questions below give an early sense of what you will need to address to gain sign-off and attract additional national investment.

We are asking local systems first to focus on creating an overall local vision, and the three overarching questions – rather than attempting to answer all of the specifics right from the start. We will be developing a process to offer feedback on these first, prior to development of the first draft of the detailed plans.

A. How will you close the health and wellbeing gap?

This section should include your plans for a 'radical upgrade' in prevention, patient activation, choice and control, and community engagement.

Questions your plan should answer:

1. How will you assess and address your most important and highest cost preventable causes of ill health, to reduce healthcare demand and tackle health inequalities working closely with local government?

    - How rapidly could you achieve full local implementation of the national Diabetes Prevention Programme? Why should Public Health England (PHE) and NHS England prioritise your geographical area (e.g. with national funding to support the programme)?

    - What action will you take to address obesity, including childhood obesity?

    - How will you achieve a step-change in patient activation and self-care? How will this help you moderate demand and achieve financial balance? How will you embed the six principles of engagement and involvement of local patients, carers, and communities developed to help deliver the Five Year Forward View?

2. How will you make real the aspiration to design person-centred coordinated care, including plans to ensure patients have access to named, accountable consultants?

3. How will a major expansion of integrated personal health budgets and implementation of choice – particularly in maternity, end-of-life and elective care – be an integral part of your programme to hand power to patients?

4. How are NHS and other employers in your area going to improve the health of their own workforce – for example by participating in the national roll out the Healthy NHS programme?

B. How will you drive transformation to close the care and quality gap?

This section should include plans for new care model development, improving against clinical priorities, and rollout of digital healthcare.

Questions your plan should answer:

1 What is your plan for sustainable general practice and wider primary care? How will you improve primary care infrastructure, supported in part through access to national primary care transformation funding?

2. How rapidly can you implement enhanced access to primary care in evenings and weekends and using technology? Why should NHS England prioritise your area for additional funding?

3. What are your plans to adopt new models of out-of-hospital care, e.g Multi-specialty Community Providers (MCPs) or Primary and Acute Care Systems (PACS)? Why should NHS England prioritise your area for transformation funding? And when are you planning to adopt forthcoming best practice from the enhanced health in care homes vanguards?

4. How will you adopt new models of acute care collaboration (accountable clinical networks, specialty franchises, and Foundation Groups)? How will you work with organisations outside your area and learn from best practice from abroad, other sectors and industry?

5. What is your plan for transforming urgent and emergency care in your area? How will you simplify the current confusing array of entry points? What's your agreed recovery plan to achieve and maintain A&E and ambulance access standards?

6. What's your plan to maintain the elective care referral to treatment standard? Are you buying sufficient activity, tackling unwarranted variation in demand, proactively offering patient choice of alternatives, and increasing provider productivity?

7. How will you deliver a transformation in cancer prevention, diagnosis, treatment and aftercare in line with the cancer taskforce report?

8. How will you improve mental health services, in line with the forthcoming mental health taskforce report, to ensure measureable progress towards parity of esteem for mental health?

9. What steps will your local area take to improve dementia services?

10. As part of the Transforming Care programme, how will your area ensure that people with learning disabilities are, wherever possible, supported at home rather than in hospital? How far are you closing out-moded inpatient beds and reinvesting in continuing learning disability support

11. How fast are you aspiring to improve the quality of care and safety in your organisations as judged by the Care Quality Commission (CQC)? What is your trajectory for no NHS trust and no GP practice to have an overall inadequate rating from the Care Quality Commission (CQC)?

12. What are you doing to embed an open, learning and safety culture locally that is ambitious enough? What steps are you taking to improving reporting, investigations and supporting patients, their families and carers, as well as staff who have been involved in an incident?

13. What plans do you have in place to reduce antimicrobial resistance and ensure responsible prescribing of antibiotics in all care settings? How are you supporting prescribers to enable them issue the right drugs responsibly? At the same time, how rapidly will you achieve full implementation of good practice in reducing avoidable mortality from sepsis?

14. How will you achieve by 2020 the full-roll out of seven day services for the four priority clinical standards?

15. How will you implement the forthcoming national maternity review, including progress towards new national ambitions for improving safety and increased personalisation and choice?

16. How will you put your Children and Young People Mental Health Plan into practice?

17. How quickly will you implement your local digital roadmap, taking the steps needed to deliver a fully interoperable health and care system by 2020 that is paper-free at the point of care? How will you make sure that every patient has access to digital health records that they can share with their families, carers and clinical teams? How will you increase your online offer to patients beyond repeat prescriptions and GP appointments?

18. What is your plan to develop, retrain and retain a workforce with the right skills, values and behaviours in sufficient numbers and in the right locations to deliver your vision for transformed care? How will you build the multidisciplinary teams to underpin new models of care? How ambitious are your plans to implement new workforce roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice?

19. What is your plan to improve commissioning? How rapidly will the CCGs in your system move to place-based commissioning? If you are a devolution area, how will implementation delivery real improvements for patients?

20. How will your system be at the forefront of science, research and innovation? How are you implementing combinatorial innovation, learning from the forthcoming test bed programme? How will services changes over the next five years embrace breakthroughs in genomics, precision medicine and diagnostics?

C. How will you close the finance and efficiency gap?

This section should describe how you will achieve financial balance across your local health system and improve the efficiency of NHS services.

Questions your plan should answer:

1. How will you deliver the necessary per annum efficiency across the total NHS funding base in your local area by 2020/21?

2. What is your comprehensive and credible plan to moderate demand growth? What are the respective contributions in your local system of: (i) tackling unwarranted variation in care utilisation, e.g. through RightCare; (ii) patient activation and self-care; (iii) new models of care; and (iv) urgent and emergency care reform implementation?

3. How will you reduce costs (as opposed to growing income) and how will you get the most out of your existing workforce? What savings will you make from financial controls on agency, whilst ensuring appropriate staffing levels? What are your plans for improving workforce productivity, e.g. through e-rostering of nurses and HCAs? How are you planning to reduce cost through better purchasing and medicines management? What efficiency improvements are you planning to make across primary care and specialised care delivery?

4. What capital investments do you plan to unlock additional efficiency? How will they be affordable and how will they be financed?

5. What actions will you take as a system to utilise NHS estate better, disposing of unneeded assets or monetising those that could create longer-term income streams? How does this local system estates plan support the plans you're taking to redesign care models in your area?

Annex 2: The Government's mandate to NHS England 2016/17

The table below shows NHS England's objectives with an overall measurable goal for this Parliament and clear priority deliverables for 2016-17. The majority of these goals will be achieved in partnership with the Department of Health (DH), NHS Improvement and other health bodies such as Public Health England (PHE), Health Education England (HEE) and the Care Quality Commission (CQC). It also sets out requirements for NHS England to comply with in paragraph 6.2.

Read the full Mandate to NHS England

1. Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities.	
1.1 CCG performance	**Overall 2020 goals:** • Consistent improvement in performance of CCGs against new CCG assessment framework.
	2016-17 deliverables: • By June, publish results of the CCG assessment framework for 2015-16, which provides CCGs with an aggregated Ofsted style assessment of performance and allows them to benchmark against other CCGs and informs whether NHS England intervention is needed. • Ensure new Ofsted-style CCG framework for 2016-17 includes health economy metrics to measure progress on priorities set out in the mandate and the NHS planning guidance including overall Ofsted-style assessment for each of cancer, dementia, maternity, mental health, learning disabilities and diabetes, as well as metrics on efficiency, core performance, technology and prevention. • By the end of Q1 of 2016-17, publish the first overall assessment for each of the six clinical areas above.

2. To help create the safest, highest quality health and care service.	
2.1 Avoidable deaths and seven-day services	**Overall 2020 goals:** • Roll out of seven-day services in hospital to 100 percent of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards), so that patients receive the same standards of care, seven days a week. • Achieve a significant reduction in avoidable deaths, with all trusts to have seen measurable reduction from their baseline on the basis of annual measurements. • Support NHS Improvement to significantly increase the number of trusts rated outstanding or good, including significantly reducing the length of time trusts remain in special measures. • Measurable progress towards reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries that are caused during or soon after birth by 50 percent by 2030 with a measurable reduction by 2020. • Support the NHS to be the world's largest learning organisation with a new culture of learning from clinical mistakes, including improving the number of staff who feel their organisation acts on concerns raised by clinical staff or patients. • Measurable improvement in antimicrobial prescribing and resistance rates.
	2016-17 deliverables: • Publish avoidable deaths per trust annually and support NHS Improvement to help trusts to implement programme to improve from March 2016 baseline. • Rollout of four clinical priority standards in all relevant specialties to 25 percent of population. • Implement agreed recommendations of the National Maternity Review in relation to safety, and support progress on delivering Sign up to Safety. • Support the Government's goal to establish global and UK baseline and ambition for antimicrobial prescribing and resistance rates.

2.2 Patient experience	**Overall 2020 goals**: • Maintain and increase the number of people recommending services in the Friends and Family Test (FFT) (currently 88-96 percent), and ensure its effectiveness, alongside other sources of feedback to improve services. • 50-100,000 people to have a personal health budget or integrated personal budget (up from current estimate of 4,000). • Significantly improve patient choice, including in maternity, end-of-life care and for people with long-term conditions, including ensuring an increase in the number of people able to die in the place of their choice, including at home.
	2016-17 deliverables: • Produce a plan with specific milestones for improving patient choice by 2020, particularly in maternity, end-of-life care (including to ensure more people are able to achieve their preferred place of care and death), and personal health budgets. • Building on the FFT, develop proposals about how feedback, particularly in maternity services, could be enhanced to drive improvements to services at clinical and ward levels.
2.3 Cancer	**Overall 2020 goals:** • Deliver recommendations of the Independent Cancer Taskforce, including: o significantly improving one-year survival to achieve 75 percent by 2020 for all cancers combined (up from 69 percent currently); and o patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP.
	2016-17 deliverables: • Achieve 62-day cancer waiting time standard. • Support NHS Improvement to achieve measurable progress towards the national diagnostic standard of patients waiting no more than six weeks from referral to test. • Agree trajectory for increases in diagnostic capacity required to 2020 and achieve it for year one. • Invest £340 million in providing cancer treatments not routinely provided on the NHS through the Cancer Drugs Fund, and ensure effective transition to the agreed operating model to improve its effectiveness within its existing budget.

3. To balance the NHS budget and improve efficiency and productivity	
3.1 Balancing the NHS budget	**Overall 2020 goals**: • With NHS Improvement, ensure the NHS balances its budget in each financial year. • With the Department of Health and NHS Improvement, achieve year on year improvements in NHS efficiency and productivity (2-3 percent each year), including from reducing growth in activity and maximising cost recovery.
	2016-17 deliverables: • With NHS Improvement ensure the NHS balances its budget, with commissioners and providers living within their budgets, and support NHS Improvement in: o securing £1.3 billion of efficiency savings through implementing Lord Carter's recommendations and collaborating with local authorities on Continuing Healthcare spending; o delivering year one of trust deficit reduction plans and ensuring a balanced financial position across the trust sector, supported by effective deployment of the Sustainability and Transformation Fund; and o reducing spend on agency staff by at least £0.8 billion on a path to further reductions over the Parliament. • Roll-out of second cohort of RightCare methodology to a further 60 CCGs. • Measurable improvement in primary care productivity, including through supporting community pharmacy reform. • Work with CCGs to support Government's goal to increase NHS cost recovery up to £500 million by 2017-18 from overseas patients. • Ensure CCGs' local estates strategies support the overall goal of releasing £2 billion and land for 26,000 homes by 2020.

4. To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.	
4.1 Obesity and diabetes	**Overall 2020 goals:** • Measurable reduction in child obesity as part of the Government's childhood obesity strategy. • 100,000 people supported to reduce their risk of diabetes through the Diabetes Prevention Programme. • Measurable reduction in variation in management and care for people with diabetes.
	2016-17 deliverables: • Contribute to the agreed child obesity implementation plan, including wider action to achieve year on year improvement trajectory for the percentage of children who are overweight or obese. • 10,000 people referred to the Diabetes Prevention Programme.
4.2 Dementia	**Overall 2020 goals:** • Measurable improvement on all areas of Prime Minister's challenge on dementia 2020, including: o maintain a diagnosis rate of at least two thirds; o increase the numbers of people receiving a dementia diagnosis within six weeks of a GP referral; and o improve quality of post-diagnosis treatment and support for people with dementia and their carers.
	2016-17 deliverables: • Maintain a minimum of two thirds diagnosis rates for people with dementia. • Work with National Institute for Health Research on location of Dementia Institute. • Agree an affordable implementation plan for the Prime Minister's challenge on dementia 2020, including to improve the quality of post-diagnosis treatment and support.

5. To maintain and improve performance against core standards	
5.1 A&E, ambulances and Referral to Treatment (RTT)	**Overall 2020 goals:** • 95 percent of people attending A&E seen within four hours; Urgent and Emergency Care Networks rolled out to 100 percent of the population. • 75 percent of Category A ambulance calls responded to within 8 minutes. • 92 percent receive first treatment within 18 weeks of referral; no-one waits more than 52 weeks.
	2016-17 deliverables: • With NHS Improvement, agree improvement trajectory and deliver the plan for year one for A&E. • Implement Urgent and Emergency Care Networks in 20 percent of the country designated as transformation areas, including clear steps towards a single point of contact. • With NHS Improvement, agree improvement trajectory and deliver the plan for year one for ambulance responses; complete Red 2 pilots and decide on full roll-out. • With NHS Improvement, meet the 18-week referral-to-treatment standard, including implementing patient choice in line with the NHS Constitution; and reduce unwarranted variation between CCG referral rates to better manage demand.
6. To improve out-of-hospital care.	
6.1 New models of care and general practice	**Overall 2020 goals:** • 100 percent of population has access to weekend/evening routine GP appointments. • Measurable reduction in age standardised emergency admission rates and emergency inpatient bed-day rates; more significant reductions through the New Care Model programme covering at least 50 percent of population. • Significant measurable progress in health and social care integration, urgent and emergency care (including ensuring a single point of contact), and electronic health record sharing, in areas covered by the New Care Model programme. • 5,000 extra doctors in general practice.

	2016-17 deliverables: • New models of care covering the 20 percent of the population designated as being in a transformation area to: o provide access to enhanced GP services, including evening and weekend access and same-day GP appointments for all over 75s who need them; and o make progress on integration of health and social care, integrated urgent and emergency care, and electronic record sharing. • Publish practice-level metrics on quality of and access to GP services and, with the Health and Social Care Information Centre, provide GPs with benchmarking information for named patient lists. • Develop new voluntary contract for GPs (Multidisciplinary Community Provider contract) ready for implementation in 2017-18.
6.2 Health and social care integration	**Overall 2020 goals:** • Achieve better integration of health and social care in every area of the country, with significant improvements in performance against integration metrics within the new CCG assessment framework. Areas will graduate from the Better Care Fund programme management once they can demonstrate they have moved beyond its requirements, meeting the government's key criteria for devolution. • Ensure the NHS plays its part in significantly reducing delayed transfers of care, including through developing and applying new incentives.
	2016-17 deliverables: • Implement the Better Care Fund (BCF) in line with the BCF Policy Framework for 2016-17. • Every area to have an agreed plan by March 2017 for better integrating health and social care. • Working with partners, achieve accelerated implementation of health and social care integration in the 20 percent of the country designated as transformation areas, by sharing electronic health records and making measurable progress towards integrated assessment and provision. • Work with the Department of Health, other national partners and local areas to agree and support implementation of local devolution deals. • Agree a system-wide plan for reducing delayed transfers of care with overall goal and trajectory for improvement, and with local government and NHS partners implement year one of this plan.

	2016-17 requirements: • NHS England is required to: o ring-fence £3.519 billion within its allocation to CCGs to establish the Better Care Fund, to be used for the purposes of integrated care; o consult the Department of Health and the Department for Communities and Local Government before approving spending plans drawn up by each local area; and o consult the Department of Health and the Department for Communities and Local Government before exercising its powers in relation to failure to meet specified conditions attached to the Better Care Fund as set out in the BCF Policy Framework.
6.3 Mental health, learning disabilities and autism	**Overall 2020 goal:** • To close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole (defined ambitions to be agreed based on report by Mental Health Taskforce). • Access and waiting time standards for mental health services embedded, including: o 50 percent of people experiencing first episode of psychosis to access treatment within two weeks; and o 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks.
	2016-17 deliverables: • 50 percent of people experiencing first episode of psychosis to access treatment within two weeks. • 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks. • Increase in people with learning disabilities/autism being cared for by community not inpatient services, including implementing the 2016-17 actions for Transforming Care. • Agree and implement a plan to improve crisis care for all ages, including investing in places of safety. • Oversee the implementation of locally led transformation plans for children and young people's mental health, which improve prevention and early intervention activity, and be on track to deliver national coverage of the children and young people's Improving Access to Psychological Therapies (IAPT) programme by 2018. • Implement agreed actions from the Mental Health Taskforce.

7. To support research, innovation and growth.	
7.1 Research and growth	**Overall 2020 goals:** • Support the Department of Health and the Health Research Authority in their ambition to improve the UK's international ranking for health research. • Implement research proposals and initiatives in the NHS England research plan. • Measurable improvement in NHS uptake of affordable and cost-effective new innovations. • To assure and monitor NHS Genomic Medicine Centre performance to deliver the 100,000 genomes commitment.
	2016-17 deliverables: • Implement the agreed recommendations of the Accelerated Access Review including developing ambition and trajectory on NHS uptake of affordable and cost-effective new innovations.
7.2 Technology	**Overall 2020 goals:** • Support delivery of the National Information Board Framework 'Personalised Health and Care 2020' including local digital roadmaps, leading to measurable improvement on the new digital maturity index and achievement of an NHS which is paper-free at the point of care. • 95 percent of GP patients to be offered e-consultation and other digital services; and 95 percent of tests to be digitally transferred between organisations.
	2016-17 deliverables: • Minimum of 10 percent of patients actively accessing primary care services online or through apps, and set trajectory and plan for achieving a significant increase by 2020. • Ensure high quality appointment booking app with access to full medical record and agreed data sharing opt-out available from April 2016. • Robust data security standards in place and being enforced for patient confidential data. • Make progress in delivering new consent-based data services to enable effective data sharing for commissioning and other purposes for the benefit of health and care. • Significant increase in patient access to and use of the electronic health record.

7.3 Health and work	**Overall 2020 goal:** • Contribute to reducing the disability employment gap. • Contribute to the Government's goal of increasing the use of Fit for Work.
	2016-17 deliverables: • Continue to deliver and evaluate NHS England's plan to improve the health and wellbeing of the NHS workforce. • Work with Government to develop proposals to expand and trial promising interventions to support people with long-term health conditions and disabilities back into employment.

#FutureNHS

Gateshead Council

HEALTH AND WELLBEING BOARD
15 January 2016

TITLE OF REPORT: Health & Wellbeing Strategy Refresh – Scoping Report

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Purpose of the Report

1. To seek the views of the Health & Wellbeing Board on the scope of the refresh of Gateshead's Health & Wellbeing Strategy.

Background

2. Health & Wellbeing Boards were established as statutory boards from 1st April 2013 as part of a range of health reforms introduced at that time. They were identified by the Department of Health as having a key role to play to modernise the NHS to:
   - ensure stronger democratic legitimacy and involvement
   - strengthen working relationships between health and social care, and
   - encourage the development of more integrated commissioning of services

3. HWBs were required to develop local Health and Wellbeing Strategies to address the health and wellbeing needs of local people and to steer the work of the Board. Gateshead developed its strategy 'Active, Healthy & Well Gateshead' for the period 2013/14 to 2015/16 which was agreed by the Board on 8 February 2013 (attached at Appendix 2).

4. The Gateshead Health & Wellbeing Strategy sought to build upon the foundations of partnership working already in place and identified a small number of key system improvement priorities and thematic priorities linked to our health and wellbeing agenda:

   System Improvement Priorities:
   - Secure joined-up, person centred services across health and social care – address 'service fragmentation'.
   - Make the most of available resources to secure better, higher quality services – shift more investment from expensive hospital care towards prevention, early intervention and community provision.
   - Strengthen engagement and build capacity within communities, especially those with the poorest health. Make the most of community assets.

- Make the most of new working opportunities, including those across new geographies.
- Make the most of 'place shaping' opportunities to promote active and healthy lifestyles.

Thematic Priorities:

- Ensure children have the best start in life and lead active, happy and healthy lives.
- Tackle the major causes of ill health and early death, ensuring a focus on prevention and high quality treatment.
- Promote choice and empower local people to have more control over their health and social care and remain independent for as long as possible.
- Improve mental health and wellbeing for all members of our community.

5. In addressing these priorities, the Board recognised that it would need to consider how it can best steer and join up existing and future work underpinned by a robust assessment of needs. An annual Forward Plan was developed to help shape the work of the Board and, more recently, a performance management section to the Board's agenda in order to regularly consider progress against key health and wellbeing indicators.

Refresh of our Health & Wellbeing Strategy

6. At the December Board meeting, it was agreed to defer consideration of the refresh of the health and wellbeing strategy pending publication of NHS Planning Guidance for 2016/17 and beyond (Item 4.1 refers). In particular, it was felt that consideration needed to be given to how the strategy would sit with the anticipated requirement for local health economies to produce a five year Sustainability and Transformation Plan (STP) for their area. In this connection, it needs to be borne in mind that whilst the Board's existing health and wellbeing strategy covers the Gateshead area, it is anticipated that the Sustainability and Transformation Plan will cover the wider Newcastle Gateshead planning footprint.

7. The NHS Planning Guidance published on 22nd December includes a requirement for STPs to reflect local agreed health and wellbeing strategies.

8. Other considerations include the fact that whilst the key health and wellbeing challenges which underpinned our existing strategy are still relevant today, the context in which we address those challenges has changed – organisational changes, changes to functional responsibilities, national policy context – as well as continuing financial pressures facing the local health and care economy as a whole.

9. The attached scoping report identifies points that will need to be considered in shaping our approach to the refresh of our health and wellbeing strategy.

Proposals and Next Steps

10. The Board is asked to consider the points raised under paragraphs 6 to 8 above and the scope of the strategy refresh set out in appendix 1 attached.

11. The next step would be to undertake further work to translate the scoping paper into a framework document and to identify a draft timeline for its development.

Recommendations

12. The Health and Wellbeing Board is asked to:

    (i) consider the issues raised within this report regarding the refresh of Gateshead's Health & Wellbeing Strategy.

Contact: John Costello (4332065)

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Appendix 1

Gateshead Health & Wellbeing Strategy Refresh – Scope

Overarching Issues

Overarching points to confirm/take a view on include the following:

- How should the Strategy sit with the five year Sustainability and Transformation Plan (STP) to be produced for Newcastle Gateshead by June 2016?
- The Strategy should continue to have a dual aim of improving the health and wellbeing of local residents and to reduce the health inequality gap across Gateshead.
- The Strategy should continue to have a dual focus on System Priorities linked to the health and wellbeing transformation agenda and Thematic Priorities linked to health and wellbeing needs. Clearly, System and Thematic Priorities are linked, support one another and underpin integrated working.
- Strategy priorities should reflect the health needs of Gateshead people based on hard and soft intelligence from the JSNA and other needs assessments.
- The JSNA refresh indicates that the key health and wellbeing challenges for Gateshead have not changed significantly and therefore they still need to be the cornerstone of the strategy's Thematic Priorities.
- Do we incorporate a Health Inequalities Framework within the strategy refresh or develop in parallel but keep separate?
- How should the place shaping agenda and wider determinants of health be reflected within the strategy?
- How should the 'achieving more together' agenda to increase community resilience and capacity within communities be reflected within the strategy?
- The extent of engagement required in refreshing the strategy, having regard to engagement activity already undertaken in relation to the JSNA, Vision 2030 refresh, Council Plan etc. and further engagement to be undertaken in developing a Sustainability and Transformation Plan for Newcastle Gateshead.
- Confirm arrangements for stakeholder engagement - how do partner organisations wish to input to the refresh of the strategy?
- Agree key milestones to steer the refresh of the Strategy,

Gateshead Profile

Gateshead profile information to be updated, reflecting latest population projections, health profile data, life expectancy gap etc.

Vision

Confirm the Vision, with reference to the refreshed Vision 2030 Big Idea (Active & Healthy Gateshead), revised Council Plan 2015-2020, updated CCG and other

partner vision statements. Clearly, the strategy vision would also need to be consistent with the vision that will underpin the Sustainability and Transformation Plan for Newcastle Gateshead.

Vision 2030 Refresh – Active & Healthy Big Idea:
Although Vision 2030 has been refreshed, the core vision remains the same - 'Local people realising their full potential, enjoying the best quality of life in a healthy, equal, safe, prosperous and sustainable Gateshead'

The Active and Healthy Gateshead big idea wants to 'Create healthy communities by providing the support to encourage people to improve their health and lifestyle.'

Council Plan 2015-2020
The revised Council Plan has identified a number of 'shared outcomes' that will shape the focus of its work over the next 5 years to have the most impact and address inequalities. They include:

- A place where children have the best start in life
- A place where older people are independent and are able to make a valuable contribution to the community
- A place where people choose to lead healthy lifestyles, with more and more people across Gateshead living longer and without life-limiting illnesses
- A place where those who need help have access to appropriate joined up services that make a difference to the quality of their life

Newcastle Gateshead Sustainability and Transformation Plan 2016/17 – 2020/21 CCG 5 Year Strategic Plan:
The latest NHS Planning Guidance (2016/17 to 2020/21) includes a requirement for local health economies to produce a five year Sustainability and Transformation Plan (STP) for their area by the end of June 2016. Plans will need to be developed working with local authorities and Health & Wellbeing Boards. The STP will need to be underpinned by a shared vision for 2021 regarding care both inside and outside hospitals, whilst also covering better integration with local authority services, including prevention and social care. The STP will also need to reflect local agreed health and wellbeing strategies.

Changing Context

A section is needed on the changing context of our health and wellbeing agenda – this will provide an opportunity to highlight/signal new issues that will need to be picked up as part of the refresh (or issues to be strengthened/given greater focus) as well as recognising continuing trends – e.g. financial pressures on the system etc.

Refer to:

- organisational developments since the Strategy was approved by the HWB in February 2013 – transfer and integration of public health within the Council and current re-modelling work within care, wellbeing and learning; Newcastle Gateshead CCG merger and joint commissioning responsibility for primary care (GP Services), NHS England local boundary changes, Healthwatch Gateshead development, VCS landscape etc.

- changing policy context - national and local (NHS Forward View and latest NHS Planning Guidance 2016/17 to 2020/21, Care Act 2014, Better Care Fund, Vanguard, PM's Challenge etc.).
- local service developments – Livewell Gateshead, Mental Health 'Deciding Together', Community Services Review, Urgent Care, Primary Care etc.
- NECA devolution agenda including the proposed health and social care commission for integration.
- changes to HWB membership which have been introduced to include provider representation on the Board.

Needs Analysis

The existing Strategy pulled out intelligence from the JSNA under the sections on individual strategic priorities. These references will need to be updated.

It may also be useful to include a stand-alone section on Needs Analysis/JSNA after the Gateshead profile section that draws out the key health and wellbeing needs of local people. This section could also reference work being undertaken to develop the intelligence encompassed by the JSNA and to develop JSNA working arrangements/engagement (inc. the JSNA website to make it more user friendly).

System Improvement Priorities (Working Better Together)

Confirm the continued relevance of the 4 existing system improvement priorities:

- Secure joined-up, person centred services across health and social care – address 'service fragmentation'.
- Make the most of available resources to secure better, higher quality services – shift more investment from expensive hospital care towards prevention, early intervention and community provision.
- Strengthen engagement and build capacity within communities, especially those with the poorest health. Make the most of community assets.
- Make the most of new working opportunities, including those across new geographies.
- Make the most of 'place shaping' opportunities to promote active and healthy lifestyles.

Consider adjustments to the focus of our system improvement priorities and the next steps e.g.

'Secure joined-up, person centred services across health and social care – address 'service fragmentation'.

- Consider how the next steps around integrated commissioning of health and social care and whole-system working should be reflected within the strategy.

'Make the most of available resources to secure better, higher quality services – shift more investment from expensive hospital care towards prevention, early intervention and community provision'.

- The next steps to be identified having regard to such initiatives as the BCF, Vanguard and new ways of working.

'Strengthen engagement and build capacity within communities, especially those with the poorest health. Make the most of community assets.'

- This is currently being addressed through the 'achieving more together' agenda to increase resilience within communities and people's capacity to 'self-help' and will need to be reflected here.

'Make the most of new working opportunities, including those across new geographies'.

- This can be developed further in the context of the North East Combined Authority agenda on the one hand and the scope for closer working on more local footprints on the other e.g. Gateshead Newcastle.

'Make the most of 'place shaping' opportunities to promote active and healthy lifestyles'.

This could be extended to more fully reflect the wider determinants of health and the cumulative impact of an integrated approach to place shaping. This also links to the NECA devolution agenda.

Thematic Priorities

Confirm the continued relevance of the 4 existing thematic priorities:

- Ensure children have the best start in life and lead active, happy and healthy lives.
- Tackle the major causes of ill health and early death, ensuring a focus on prevention and high quality treatment.
- Promote choice and empower local people to have more control over their health and social care and remain independent for as long as possible.
- Improve mental health and wellbeing for all members of our community.

Consider adjustments to the focus of the thematic priorities and the next steps e.g.

'Ensure children have the best start in life and lead active, happy and healthy lives'.

- This will need to reflect such developments as the transfer of public health commissioning responsibilities to the Council for children 0 to 5, the next steps in taking this work forward and in developing our 0 to 19 framework.

'Tackle the major causes of ill health and early death, ensuring a focus on prevention and high quality treatment'.

- As the key challenges in tackling the major causes of ill health and early death remain, including associated health inequalities within Gateshead, they will continue to be a key focus of the strategy. Links with a proposed Health Inequalities Framework will also need to be incorporated.
- The homeless health agenda has been considered by the HWB during the current year and work in ongoing to add to existing intelligence regarding the

health and wellbeing needs of homeless people. This will need to be reflected more explicitly within the refreshed strategy document.

'Promote choice and empower local people to have more control over their health and social care and remain independent for as long as possible'.

- The opportunity can be taken to expand/strengthen this thematic priority around the self-help and self-care agenda. This links to the financial pressures experienced across the local health and care economy and the need to support local people to self-care where appropriate. It also links to the system improvement priority around building capacity within communities, especially those with the poorest health.

'Improve mental health and wellbeing for all members of our community'

- The cumulative impact of the financial climate in recent years, welfare reforms introduced etc. continues to impact upon the wellbeing of local people, linking to the wider determinants of health. At the same time the mental health review 'Deciding Together' will shape the mental health service offer for Gateshead residents and how services are accessed. Considerations such as these will need to feed through to the refreshed strategy.

Action Plan

To be updated and revised to reflect the strategy's priorities. Any gaps to be identified and addressed.

Monitoring Arrangements

Consider the arrangements for monitoring progress against the strategy and, in particular, against a basket of key outcome measures. This will need to be aligned with the reporting arrangements for strategic indicators included in performance management updates to the HWB.

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Appendix 2

‘Active, Healthy and Well Gateshead’

A Health & Wellbeing Strategy for Gateshead

(2013/14 to 2015/16)

Contents

Foreword

I'm pleased to introduce you to our Health and Wellbeing Strategy: 'Active, Healthy and Well Gateshead', which sets out our aspirations and priorities to improve the health and wellbeing of all communities across Gateshead.

We are in a period of much change, both nationally and locally. We're seeing significant changes in the way services are organised and delivered. At the same time, we need to ensure we get the most from our limited resources in a context of new and increasing financial pressures.

Against this background, we need to redouble our efforts to address new and existing health and wellbeing challenges. We also need to reduce the unacceptable gap in healthy life expectancy within our own communities and between Gateshead and the rest of the country. Only in this way can we deliver our vision for Gateshead, set out in 'Vision2030'.

Our priorities have been shaped by what the evidence is telling us about the health challenges we face in Gateshead. We're having an ongoing conversation with local groups and communities about how we can take these priorities forward so that we can work together to improve the health and wellbeing of local people.

We know that the agenda we've set ourselves is not an easy one, but it's an agenda we must address head-on if we are to make the step-changes needed to achieve our health and wellbeing aspirations.

We also know that there is much more we can do to 'work better together' so that local people get the right package of advice, support and services they need, when they need them, delivered in a joined-up way. We also need to help people to help themselves, to improve their own health and wellbeing and remain independent for as long as possible.

I have no doubt that we can build upon the fine tradition of working in partnership in Gateshead, to take on the agenda for change set out in our strategy document. I look forward to working with you, and colleagues on our Health and Wellbeing Board, to achieve our health and wellbeing aspirations for the people of Gateshead.

Councillor Mick Henry

Chair of Gateshead's Health & Wellbeing Board and Leader of Gateshead Council

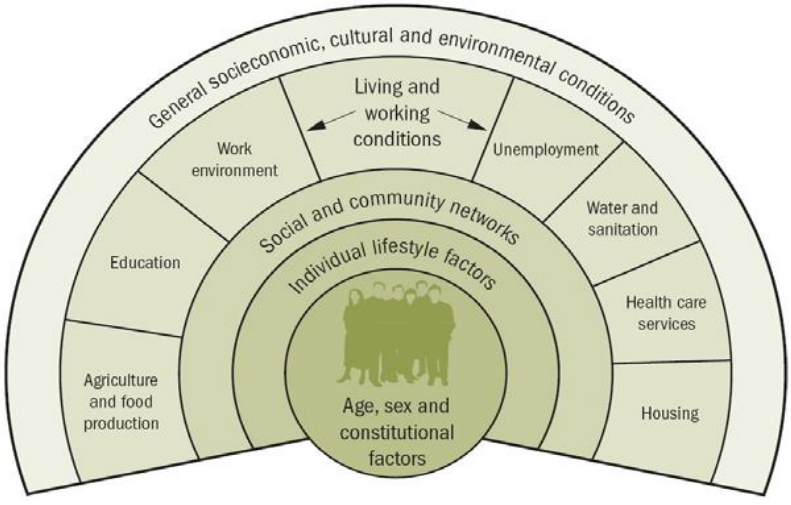
Health and Wellbeing – What is it and why does it matter?

We all have heard the old saying “Your health is your wealth”, which remains as true today as it ever did.

The word **"health"** comes from the old English word *hale*, meaning "wholeness, a being whole, sound or well." Although it has been defined and redefined many times over the years, it is clear that health is more than the ‘physical’ aspects of health - good body health from regular physical activity, good nutrition and lifestyle etc. Health is as much about our ‘emotional wellbeing’ - realising one’s potential, coping with the normal stresses of life, working productively and making a contribution to one’s community.

Together, ‘physical’ and ‘emotional health’ combine to provide a rounded view of health, as was intended by the original meaning of the word. It follows that health and wellbeing underpins every aspect of our lives, as individuals and in our relationships with one another.

Our health and wellbeing strategy *‘Active, Healthy and Well’* recognises this diversity of health and wellbeing and the factors which influence and underpin it. The following diagram illustrates the range of factors which determine good health, starting with the individual and moving outwards to include the wider influences of society – from people’s age and hereditary factors, to their social networks and position within society such as their income, employment, education and skills level, social class; their local environment such as housing conditions, crime levels, access to services; and their ability to have control over their life and to lead a life they value (i.e. the social or wider determinants of health).



Dahlgren G and Whitehead M 1992 Policies and Strategies to Promote Equity in Health

Health and Wellbeing in Gateshead – A Snapshot

Gateshead has a population of 200,300 which is forecast to increase by around 5% over the next 20 years. We have a higher proportion of older people in comparison with England as a whole. It is also predicted that the number of people aged 85 years and over will nearly double over the next 20 years.

While there have been improvements, far more people in Gateshead continue to suffer illness and early death than the national average. The life expectancy gap between England and Gateshead for men is 1.9 years and 1.7 years for women, although the trend over recent years is for life expectancy to be improving faster than the national average.

There are also big differences between different areas within Gateshead. Life expectancy is 8.9 years lower for men and 9.4 years lower for women in the poorest areas of Gateshead, compared to the most affluent areas. People who live in the more affluent areas of the borough can also expect to live much longer without getting a limiting, long term illness or disability than people from more deprived areas. In Gateshead, the difference in 'disability free life expectancy' for men is 14.8 years and for women it is 11.5 years. Worklessness, family poverty and deprivation play a major part in creating these inequalities in health outcomes, across the whole lifecourse from 'early life' to 'end of life'.

In Gateshead, people feel that they have poorer health and wellbeing than the rest of England, and are admitted to hospital more often. The major causes of premature deaths are cardiovascular disease and cancer, and these avoidable deaths are linked with lifestyle issues such as smoking, alcohol and obesity.

Gateshead has also seen significant increases in the number of older people most at risk of needing care and support e.g. people with dementia, people living alone, and those with long term illnesses. In recent years, the demand for social care services has increased which has placed extra demands on adult social care.

Gateshead has higher than England average proportions of families in low-rise social housing with high levels of benefit need.

In terms of overall deprivation, Gateshead is ranked 43rd out of 326 local authorities (where 1 is most deprived). It is particularly disadvantaged in relation to employment and also disadvantaged in relation to income and education, skills and training. Higher than average proportions of children are living in poverty or in low income families.

The current economic climate and welfare reforms have the potential to result in worsening health for our population. It is all the more important therefore that we

have clear aspirations for the health and wellbeing of local people and how we are going to deliver them by working with local communities and our partners. For more information on Gateshead's health profile, use the following link:

http://www.apho.org.uk/default.aspx?QN=HP_METADATA&AreaID=50316

Our Vision for Health and Wellbeing

Gateshead's Vision 2030 sets out an ambitious and aspirational vision, that:

"Local people will realise their full potential and enjoy the best quality of life in a healthy, equal, safe, prosperous and sustainable Gateshead."

Much of the success of the council and local partners in recent years has been rooted in a clear sense of the importance of people and place to regenerate the borough, to attract investment and to ensure local people and local businesses are well placed to make the most of those opportunities.

Our vision is underpinned by our aspirations for an active and healthy Gateshead:

- Gateshead residents are amongst those with the longest, happiest and healthiest lives in England
- Gateshead is recognised as a healthy and happy community in which to live
- All people across Gateshead have the opportunity to make positive lifestyle choices to improve their physical and mental health and wellbeing
- All residents have a positive attitude to physical activity and incorporate it into their daily lives
- Vulnerable and older residents lead fulfilling lives with support of their choice
- The unacceptable health and inequality gaps across the Borough and with England have been eradicated, particularly in relation to life expectancy

Our Health and Wellbeing Strategy - *'Active, Healthy and Well Gateshead'*

Our Health and Wellbeing Strategy 'Active, Healthy and Well Gateshead' sets out a route map on how we can work towards our ambitious vision for health and wellbeing based on evidence of local needs and evidence of what works.

Our Strategy has been informed by a wide range of information on local needs brought together by the Gateshead Strategic Needs Assessment (which incorporates our Joint Strategic Needs Assessment). This information was also used as a basis for engagement with partners and local communities on our emerging priorities.

Our Strategy sets out our response to the key health and wellbeing challenges facing present and future generations and what success would look like - where we need to be in 2, 5 and 10 years time in addressing these challenges.

Our Strategy recognises the financial constraints faced by the public sector as a whole as well as the potential impact of the Government's welfare reform measures on peoples' health and wellbeing. Against this backdrop, it sets out our priorities to transform the way we work together and allocate available resources to achieve our goals.

Our Strategy recognises the importance of the 'wider determinants' of health, both in securing the sustained health improvement of local people and addressing health inequality gaps within and between Gateshead communities. It recognises that there is a strong association between worklessness and poor health – leading to higher mortality rates, poorer general health and mental health. This means looking at how we live, how we can build active and healthy lifestyles into our lives, how we can make the most of peoples skills, community assets and diversity, and how we can help people to improve their life chances by learning new skills and securing employment to ensure a prosperous, attractive, healthy and safe Gateshead for all to enjoy.

Our Health and Wellbeing Board for Gateshead

The NHS is changing significantly from 1st April 2013 as GPs take on a bigger role in deciding how health services are provided locally. Gateshead Council will also have a bigger role to play through its new public health responsibilities. Healthwatch Gateshead, the new local consumer champion for health and social care, will have a key role to play in ensuring the views of local people are heard and inform decision making.

Each of these organisations will also have a joint leadership role to drive forward the health and wellbeing agenda through their membership of the Gateshead Health and Wellbeing Board. As part of the Government's health reforms, local areas are required to establish Health and Wellbeing Boards to lead on the health and wellbeing agenda locally. Gateshead was an 'early implementer' and established a shadow Health and Wellbeing Board in October 2011, building upon its successful track record of partnership working with local NHS and partner organisations. From the 1st April, 2013, the Board formally became a committee of the Council.

A Health and Wellbeing Board for Gateshead provides an important new opportunity to consider public health, health care and social care services in the

round (i.e. as a ‘whole system’) and how they link to the wider determinants of health.

The Board will work collectively to:

- Transform health, social care and wellbeing outcomes for the better;
- Significantly reduce health inequalities;
- Enable people and communities to improve their own health and wellbeing and to influence the delivery of services;
- Provide greater accountability to local people.

A ’Who’s Who’ on Gateshead’s Health & Wellbeing Board is included with the supporting information section at the end of this document.

Our Health and Wellbeing Priorities – Overview

In working towards our ambitious aspirations for the health and wellbeing of local people in Gateshead, the Health and Wellbeing Board has developed:

- a set of ‘**working better together**’ **(system improvement) priorities** that focus on changing the way we work together, the way we organise and deliver various activities and services that will support better health and wellbeing.

- a set of **‘thematic priorities’** to help focus action on particular health and wellbeing topics, which our evidence base tells us will secure the biggest health improvements for the people of Gateshead and reduce health inequalities. As the factors which influence health are very much interrelated, our key themes are cross-cutting and span the life course of the individual, from early life to end of life.

Working Better Together – Our 'System Improvement' Priorities

The Gateshead health and social care system is undergoing significant change arising from the health reforms and the overall policy direction of Government. This presents both challenges and opportunities. We need to recognise these so that we are well placed to respond to the challenges and make the most of opportunities to tailor the new system to help us achieve our health and wellbeing priorities for local people.

We also need to recognise the external pressures on the 'system' as a whole, not least the financial constraints on health and social care which will impact on how we do business, how we make the most of available resources (whether financial, human or technological) and ultimately, how we can work together to enhance the health and wellbeing of our communities.

The NHS Institute for Innovation and Improvement worked with our shadow Health & Wellbeing Board to help us identify the key issues to be addressed across Gateshead. The key system improvement priorities which have been identified are:

- **Secure joined-up, person centred services across health and social care – address 'service fragmentation'.**

- **Make the most of available resources to secure better, higher quality services – shift more investment from expensive hospital care towards prevention, early intervention and community provision.**

- **Strengthen engagement and build capacity within communities, especially those with the poorest health. Make the most of community assets.**

- **Make the most of new working opportunities, including those across new geographies.**

- **Make the most of 'place shaping' opportunities to promote active and healthy lifestyles.**

Working Better Together:

Secure joined-up, person centred services across health and social care – address 'service fragmentation'.

Why is this a priority?

We want the focus of services to be on the individual across the life course (from 'early life' to 'end of life') so that peoples needs can be met in a joined-up and seamless way throughout their lives i.e. care that is not restricted by either organisational or professional boundaries. This will require local agencies and professionals working together ever more closely.

The health reforms will see significant changes in the way services are commissioned and delivered. We need to ensure that we use opportunities presented by the changes to address service fragmentation across health and social care and avoid duplication. Fragmented services do not make the most of clinical and professional resources and can lead to unscheduled care instead of proactive planned care. This, in turn, impacts on the quality and value of care provided and ultimately, on patient outcomes and experience.

Working towards integrated commissioning and integrated provision of services will be the focal point of our approach. We will align service delivery arrangements into an integrated model that provides excellence across the whole system, especially at the interfaces between services and the transition of care. A culture shift is also required to embed an ethos of collaborative working across organisations and workforces.

Focus for action (2013 – 16):

- Develop a route map for integrated commissioning of health and social care - from alignment of commissioning intentions to working towards a single integrated commissioning plan.
- Work towards an integrated commissioning model across health and social care (adults and children). Share learning from the integrated commissioning pilots around services to children (0 to 5) and older people with long term conditions.
- Address fragmentation around the way services are delivered across agencies so that they respond to the needs of the individual in a holistic way – secure integrated provision of services shaped by our commissioning intentions/plans.

- As part of this, develop a locality model for the delivery of services – identify appropriate population level(s) to deliver services and match with service provision arrangements.

- Secure the necessary culture shift required to support and embed collaborative working and service re-design.

- Ensure continuity of existing services as new working arrangements are implemented.

Working Better Together:

Make the most of available resources to secure better, higher quality services – shift more investment from expensive hospital care towards prevention, early intervention and community provision

Why is this a priority?

Currently, there are significant resource constraints upon health and social care, pressures that will continue in the future. We will need to work in new ways to get the most from available resources, while maintaining and improving service quality. It is not just our financial resources that need to be maximised, but our staffing, technological and other resources as well.

This will mean working together to reduce our reliance on acute services (hospital admissions and readmissions) and investing more in prevention, early intervention and community provision. In doing so, we will need to ensure that we sustain the viability of key local services and that local people have easy access to quality primary care and other services.

We will need a particular focus on urgent care where much of our hospital spend is focused on. We need to help services to work more effectively and efficiently in this setting and to link better with intermediate care, including reablement.

We also need to reduce unwarranted variations in the way services are delivered across primary and secondary care, whilst enabling individuals and communities to shape and tailor services to best meet their needs.

We need to lead by example and help employers in Gateshead to maintain and improve the health and wellbeing of their employees and become 'health improving' organisations. A happier, healthier workforce will also be more productive, more efficient and cost effective.

Ultimately, we need to change hearts and minds about how we use our resources. At a time when resources are limited, we need to focus on key common goals, in areas that will make the biggest difference - targeting our most vulnerable groups and specific areas of our community. This approach is central to tackling health inequalities, to closing the gap between our most advantaged and most disadvantaged communities.

We need to mitigate the impact of the current economic climate on those who are most disadvantaged and vulnerable. In particular, we need to mitigate the impact of the welfare reforms on these groups.

Focus for action (2013 – 16):

- Secure a greater shift in investment from acute services towards prevention, early intervention and community provision where appropriate.
- Ensure local people have easy access to quality primary care services.
- Review urgent care and links with intermediate care and reablement to secure better, higher quality services.
- Tackle unwarranted variations in service delivery (clinical and other variations) and seek to 'bring the worst up to the level of the best'.
- Ensure commissioning is evidence based and clinically led as appropriate.
- Develop 'health improving' organisations across Gateshead, including the Council itself, making the most of our human and financial resources and promoting a health improving culture amongst employees.
- Minimise the impact of social care and health funding pressures, as well as the current economic climate generally, on the health and wellbeing of our most vulnerable communities. As part of this, address the impact of the government's welfare reforms on these communities.

Working Better Together:

Strengthen engagement and build capacity within communities, especially those with the poorest health. Make the most of community assets.

Why is this a priority?

Gateshead has a strong sense of community where local people have a clear sense of belonging to their neighbourhood and want to live in a community with a sense of pride. We want our communities to be sustainable and cohesive – places where people share values and aspirations for the future and work together to achieve them, making the most of community assets.

In May 2012, Gateshead Strategic Partnership agreed the Gateshead Communities Together Strategy which sets out how partners will work together to ensure that local communities are engaged and empowered to be involved in decisions that affect their lives, where everyone feels valued and understood and share a sense of belonging.

The strategy identifies five key priority areas, each of which will shape how we work with local communities in taking forward our joint health and wellbeing agenda:

- *Community engagement and participation* – promoting positive and effective relationships, identifying issues that concern our diverse communities and responding appropriately, and ensuring hard to reach and other groups are not disadvantaged.

- *Community capacity building and making the most of community assets* – supporting the development of new skills within communities and the development of new and existing voluntary and community sector groups and social enterprises to help build community assets. Also, building community resilience to withstand the current economic climate, helping communities to make the most of their assets and to harness local resources and expertise to help themselves in an emergency (in ways which complement council and emergency service responses).

  This will also support the 'co-production' of solutions (for example, design of services) by people who may use them alongside those who have traditionally provided or arranged them.

- *Information and communication* – ensure that local people have access to up-to-date information in suitable formats on activities, planned developments and support available within their communities.

- *Involving children, young people and schools* – encouraging the development of children's and youth forums that provide a platform for all young people in Gateshead; promoting community cohesion, equality and diversity and citizenship in schools, out of school activities, youth and sports clubs and uniformed organisations.

- *Supporting positive community relationships* – supporting people within communities to live, work and learn together and to respect the diversity of communities within Gateshead.

Gateshead Council's Volunteers Plan will support this work and, in particular, will link to community capacity building and making the most of peoples skills. It encompasses all volunteering activity across the borough and will provide strategic direction for work to build on current volunteering activity within areas and neighbourhoods, making the most of new opportunities. It will also focus on areas where volunteer activity is currently low and support work with communities to improve their health and wellbeing.

Gateshead Healthwatch will be the new consumer champion for both publicly funded health and social care. It will gather people's views on, and experiences of, health and social care which will be used to influence those who commission and provide services for local people. This will enable commissioners to be more responsive to what matters to service users and the public, and to design services around their needs.

Through its membership of our health and wellbeing board, Gateshead Healthwatch will contribute to the preparation of our Joint Strategic Needs Assessment and Health and Wellbeing Strategy action plans on which local commissioning decisions will be based. This will help to hardwire public engagement into the strategic planning of health and care services.

Gateshead Healthwatch will also support individuals by providing information and advice about access to services (e.g. signposting) and promoting choice. This will help to empower and enable people to take more control of their own health, treatment and care, and understand and use the increased choices available to them.

Focus for action (2013 – 16):

- Continue to identify the issues that concern local people, particularly those with the poorest health, through an on-going conversation with local communities.

- Work in a collaborative and supportive way with local people and groups to develop ideas and solutions to address their health and wellbeing needs.

- Ensure local people have access to up-to-date information on activities and support available within their communities, including advocacy support.

- Build community resilience to withstand the current economic climate and help communities to make the most of their assets, resources and skills to help themselves.

- Through the Volunteers Plan, make the most of new opportunities to build on volunteering activity within areas and neighbourhoods across Gateshead and support communities in improving their health and wellbeing.

- Develop a communications and engagement plan for the Health & Wellbeing Board to help secure a more joined-up and cohesive approach to communications and engagement around our health and wellbeing agenda.

Working Better Together:

Make the most of new working opportunities, including those across new geographies

Why is this a priority?

The health reforms will see significant changes in the way health services are commissioned and organised. Clinical Commissioning Groups will become the main commissioners of health care, local authorities will take on new public health responsibilities and a new footprint will emerge for the Gateshead health system. We need to be well placed to make the most of opportunities arising from these changes to work across new geographies where appropriate to achieve our health and wellbeing priorities for local communities.

Social care is also seeing significant changes in the way services are commissioned and delivered through the impact of 'personalisation' (enabling people to tailor and to be more in control of the services they receive). There is also scope for a broader range of services to be delivered by a greater variety of organisations. We need to make sure that we build upon what works locally, develop and make the most of new relationships and new ways of working for the benefit of local people.

Focus for action (2013 – 16):

- Examine the scope for collaboration on a footprint beyond Gateshead (both north and south of the river) to deliver our priorities. Also, make the most of opportunities to collaborate at a regional level where appropriate e.g. to address health inequalities across the north east.
- Make the most of collaborative working opportunities to secure economies of scale and value for money e.g. around the support infrastructure to Gateshead's health and social care system (*this is linked to the priority on making the most of available resources*).
- Ensure peoples' needs can be met through a diversity of quality provision.
- Ensure maximum available choice for Gateshead residents when accessing health and social care, having regard to patient/service user flows and a move towards greater personalisation.

Working Better Together:

Make the most of 'Place Shaping' opportunities to promote active and healthy lifestyles

Why is this a priority?

'Place shaping' describes the ways in which local authorities and local partners can collectively use their influence, powers and creativity to create attractive, prosperous, healthy and safe communities – places where people want to live, work, enjoy leisure activities and do business.

Place shaping brings together a number of components that are central to sustainable and healthy communities:

- active, inclusive and safe – fair, tolerant, cohesive
- well run – effective and inclusive participation
- environmentally sensitive – caring for environment and resources
- well designed and built – quality environment
- well connected – good services, access and links
- thriving – flourishing and diverse economy and jobs
- well served – good public, private and voluntary services
- fair for everyone – just and equitable

It is clear that place shaping is central to delivering our vision and aspirations for Gateshead in the long term, in promoting active and healthy lifestyles, improving peoples life chances (including developing skills and employment opportunities) and securing sustainable health and wellbeing. It also lies at the heart of the approach we are taking to regenerate and develop our borough for the long term benefit of local people.

Our investment in place shaping aligns very closely with investment in prevention, as a key aspect of our approach is the creation of the necessary conditions to facilitate community wellbeing.

We need to make the most of opportunities to connect our place shaping and health and wellbeing agendas in everything we do. We need to join up the social elements of wellbeing (such as self esteem, social networks, mental health etc.) with the physical elements that promote active lifestyles and wellbeing (such as health enabling environments, sustainable transport, housing, employment and local amenities etc.).

Gateshead's Local Economic Assessment states that there is a need to tackle worklessness, improve skills levels of local people:

- There is a need to provide innovative approaches to help unemployed young people aged 18-24 to find suitable work and training opportunities.

- Promoting financial inclusion will improve economic wellbeing and will enhance life chances. Reducing illegal money lending, improving financial education and addressing issues such as child poverty will help create sustainable communities.
- Welfare reforms impact on people in work and out of work, affecting over half of Gateshead's households. This will reduce spend in the economy and impact widely on businesses.

Housing is a basic human need and good quality homes are essential to ensuring that local residents have good physical and mental health. The security of a warm, dry home, free from hazards and harrassment and with sufficient space is a positive contributor to health and wellbeing.

Our cultural and countryside offer to Gateshead residents also presents significant opportunities to join-up the social and physical infrastructure that supports health and wellbeing.

Focus for action (2013 – 16):

- Use the community leadership role of the Council and Health and Wellbeing Board to champion our 'place shaping for better health and wellbeing' agenda.

- Take forward opportunities arising from the Joint Gateshead and Newcastle 'One Core Strategy' and other planning and development initiatives to secure health enabling environments (*this also links to the priority on making the most of collaborative working opportunities*).

- Join-up work across partners which address the wider determinants of health, such as education and skills development, employment, economy, housing, transport, environment and amenities etc.

- Develop Gateshead's cultural and countryside offer and other assets in ways which support our health and wellbeing aspirations for local people.

- Develop our approach to Health Impact Assessment as a tool to inform our local planning framework and decision making.

Our Thematic Priorities – Securing the Biggest Health and Wellbeing Improvements for the People of Gateshead and Reducing Health Inequalities

In order to give focus to our work to address the key health and wellbeing needs of local people across the life course (from early life to end of life), we have identified the following thematic priorities:

- **Ensure children have the best start in life and lead active, happy and healthy lives.**
- **Tackle the major causes of ill health and early death, ensuring a focus on prevention and high quality treatment.**
- **Promote choice and empower local people to have more control over their health and social care and remain independent for as long as possible.**
- **Improve mental health and wellbeing for all members of our community.**

We believe they will secure the greatest health and wellbeing improvements for the people of Gateshead.

For each thematic priority, we have described why it is a priority, drawing on evidence of peoples needs. We have then set out the key outcomes we are seeking to achieve and how we will measures progress. Finally, we have identified the main focus of action for the period 2013-16.

Overarching Outcomes

There are two overarching outcomes which underpin our 'Active, Healthy and Well Gateshead' strategy as they cut across all our priority areas and draw on our vision for Gateshead. They are:

1. Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life. (Public Health Outcomes Framework 0.1)
2. Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities). (PHOF 0.2)

Priority - Ensure children have the best start in life and lead active, happy and healthy lives

Why is this a priority?

The Marmot Review into health inequalities ('*Fair Society, Healthy Lives*') identified 'Giving every child the best start in life' as its most important recommendation.

Gateshead Children's Trust has as its aspiration "all children and young people are empowered and supported to develop to their full potential and have the life skills and opportunities to play an active part in society." This aspiration is supported by strategic objectives around safeguarding children and young people, supporting families and vulnerable children and young people, tackling poverty, starting and staying healthy and safe, and giving all children and young people the best chance of success, as outlined within our 'Children Gateshead Plan'.

What our children experience during their early years lays down a foundation for the whole of their lives. A child's physical, social, and cognitive development during their early years strongly influences their school-readiness and educational attainment, economic participation, lifestyle and health. Development begins before birth when the health of a baby is crucially affected by the health and wellbeing of their mother. Low birth weight in particular, is associated with poorer long-term health and educational outcomes (Marmot 2011).

The development of good speech, language and communication skills in early years is crucial to improving long term outcomes for children and young people. Research has shown that children who have normal non-verbal skills but a poor vocabulary at age five are one-and-a-half times more likely to have literacy difficulties or mental health problems later in life. This same group was more than twice as likely to be unemployed as those who had normally developing language at age five. Vocabulary levels at age five has been found to be a very strong predictor of the qualifications achieved at school leaving age and beyond.

Similarly, lifestyle choices at an early age are a good predictor of lifestyle choices later in life. It is all the more important therefore that young children are encouraged and supported to lead active lifestyles, built into their daily lives, and that this continues across the lifecourse. The needs of our most vulnerable children and young people warrant particular attention.

Each year, around 2,300 babies are born in Gateshead, offering an opportunity for every child to be supported to have the best health outcomes possible and to realise their full potential. Additional support is needed for children who are more vulnerable so that all children are born healthy, develop healthily and stay healthy.

In order to do the best for every child in Gateshead, we will ensure we have integrated commissioning arrangements in place and that roles are clear and focus on the needs of children and families.

We will ensure that we have universal children and family services in place that can identify vulnerable children early and assess their needs quickly. This will include:

- a family focused approach which builds on strengths as well as needs;
- high quality early education which is flexible and run by well trained staff and includes high levels of parent participation and an ethos of partnership with families
- sharing of information on assessment, including the 2 to 2.5 year check

We will ensure that we have effective targeted interventions to help children and their families. These will include:

- home visiting services coordinated by health visitors and midwives and the family nurse partnership as an intensive service
- access to additional family support services such as parenting support
- agreed integrated working between health and early years practitioners
- special educational needs (SEN) support in early years settings

We will also ensure that we have effective and clear routes into more specialist services for those children and families with multiple needs. These will include the new education, heath and care plans for 0-25 for children with complex special educational needs and disabilities (SEND).

Issues from Gateshead Strategic Needs Assessment (includes JSNA) –

- 53% of children in Gateshead achieve a good level of development at age 5, which is lower than the England average.
- The proportion of women smoking during pregnancy is higher than the England average.
- Teenage conceptions in Gateshead are higher than the England Average.
- There are 190 low birth weight births in Gateshead each year (below 2,500g) - this represents 7.8% of all births.
- Breast feeding rates are increasing but remain significantly lower than the England average.
- Over 20% of 10 and 11 year olds in Gateshead are obese.

Issues from Gateshead Strategic Needs Assessment (includes JSNA) –

- The proportion of children undertaking 3 hours of PE and out of school sport each week (2009/10) is only 47%, which is much lower than the England average.
- Gateshead had 365 Looked after Children in 2011 - the rate per 10,000 children is significantly higher than the England average.
- Rates of immunisation for first dose against measles, mumps and rubella are higher than the England average. However, the percentage of children receiving their second dose of MMR immunisation is lower than the England average.
- Admisions to hospital due to injury, self harm and alcohol are high for children and young people

The Children's Trust Board has a major role to play to ensure children have the best start in life and lead active and healthy lives. It will work with the Health and Wellbeing Board to deliver priority actions to improve health and wellbeing outcomes for all children and, in particular, those who are most vulnerable through an integrated commissioning model.

The outcome measures and indicators to track progress (below) should be seen alongside the Children's Trust Board outcomes. So, for example, educational attainment and those related to safeguarding and child protection are covered there. Monitoring of immunisation and screening will also be done separately, working with Public Health England and the NHS England. There are some areas, recently flagged up in the Government's Children and Young People's Health Outcomes report, which we hope to be able to measure in future including wellbeing, physical activity and diet, and better measures of risk taking behaviour relating to drugs, alcohol, tobacco and sexually transmitted infections.

Headline Outcome Measure

1. Children in Poverty (PHOF 1.01).

Indicators

- Smoking status at time of delivery (PHOF 2.03)
- Low birth weight of term babies (PHOF 2.01)
- Breastfeeding initiation (PHOF 2.02i)
- School readiness (PHOF 1.2 *placeholder*)
- Excess weight in 4-5 year olds and 10-11 year olds (PHOF 2.06i 2.06ii)
- Risk taking behaviour: first time entrants to the youth justice system (PHOF 1.04i)
- Risk taking behaviour: smoking at age 15 (PHOF 2.9 *placeholder*)

- Hospital admissions as a result of self harm (PHOF 2.10 *under 18s when available*)
- Under 18 conceptions (PHOF 2.04)
- 16-18 years olds not in education, employment or training (PHOF 1.05)

Focus for action (2013 – 16):

- Ensure high quality maternity care across the antenatal and postnatal period and reduce risk taking behaviours during pregnancy.
- Promote breastfeeding, good nutrition and play.
- Provide parenting and family support proportionate to family needs, recognising the particular needs of looked after children and other vulnerable children.
- Ensure effective and clear routes into specialist services are in place for those children and families with multiple and complex needs.
- Continue to improve immunisation uptake rates.
- Encourage and enable children to lead active lives, building physical activity into their daily lives.
- Raise aspirations and improve attainment levels of all children.
- Reduce risk taking behaviours amongst children and young people e.g. smoking, drug and alcohol misuse, preventing hospital admissions and improving outcomes and life chances.
- Ensure children stay healthy and safe e.g. promoting a healthy weight, sexual health and emotional health and wellbeing *(this links to the priorities on tackling the major causes of ill health and early death, and improving emotional health and wellbeing).*
- Tackle child poverty, focusing upon the needs of the family as a whole.
- Ensure sufficient focus on transition from childhood to adulthood.

Priority - Tackle the major causes of ill health and early death, ensuring a focus on prevention and high quality treatment

Why is this a priority?

The health of the people of Gateshead is generally worse than the England average. Life expectancy is 76.7 in men (compared to an England average of 78.6 and England best of 85.1) and 80.9 in women (compared to an England average of 82.6 and England best of 89.8). As well as dying earlier, people have fewer years without health problems and overall wellbeing is worse than the national average.

There are also marked inequalities. Life expectancy is 8.9 years lower for men and 9.4 years lower for women in the most deprived areas of Gateshead than in the least deprived areas.

Overall, health is improving in Gateshead although the gap with England has not changed significantly.

Cancers and circulatory disease both have complex and multiple causes. Some of these cannot be changed: age, sex and family history for example. Others can, particularly if related to lifestyle.

The most important causes of cancer that can be changed are: smoking tobacco, excess alcohol, being overweight, physical inactivity and poor diet (including low consumption of fruit, vegetables and fibre rich foods and high intake of red meat and salt).

The causes of circulatory disease include: smoking tobacco, excess alcohol, being overweight and poor diet (particularly high salt intake).

In Gateshead, we have particularly high rates of obesity, many people have a poor diet with low levels of physical activity and consume too much alcohol. We have had very high rates of smoking, although these are now down to below the national average. While this is still too high (about 1 adult in 5 smokes), it shows that lifestyle factors which affect peoples health can be improved.

A significant proportion of health and social care resources are devoted to these conditions: in prevention, diagnosis, treatment and care. Many people will have these conditions for many years and need long term support and care. Commissioners of services aim to get the best outcomes for the people of Gateshead in all these areas within the resources available.

There is an important role for services to detect conditions early (e.g. screening for cancers) so that they can be treated earlier and to prevent progression of the condition once it is recognised (‘secondary prevention’). This is particularly so for

circulatory disease where the management of high blood pressure, high cholesterol, and diabetes are a key part of reducing the burden of disease.

Issues from Gateshead Strategic Needs Assessment (includes JSNA) -

- Two groups of conditions account for half of the life expectancy gap: cancers and circulatory disease (sometimes known as cardiovascular disease - CVD).
- The death rate for Lung Cancer in Gateshead is 60% higher than for England. Smoking is a key risk factor for lung cancer and wide disparities in rates of smoking across Gateshead will contribute to the high lung cancer mortality rate in some communities.
- For men, 30% of the life expectancy gap with England is due to cancer (notably lung cancer) and 20% to circulatory disease. For women, 25% is due to cancers (lung cancer again predominating) and 27% to circulatory disease.
- Every year around 2,000 people die in Gateshead: of these about 670 deaths are from circulatory diseases, 600 from Cancer, 300 from respiratory diseases and 430 from all other causes.
- The most recent Health Profiles suggest that 22% of Gateshead residents are drinking at increasing or higher risk and 31% are obese. Moreover only 8% are taking sufficiently physical activity and 20% have a healthy diet. With the exception of alcohol consumption, these are all much worse than the average for England. Alcohol misuse, nevertheless, remains a key public health issue for Gateshead.
- The rate of diagnosis of genital herpes in Gateshead is slightly higher than both the England and regional average. The rate of gonorrhoea is higher than the regional average, but slightly lower than the national average. STI's are rising in new groups in the population, notably those over the age of 55 years. An estimated 169 people in Gateshead are HIV infected, this is a rising trend.

Headline Outcome Measures

1. Potential Years of Life lost from causes amenable to healthcare (NHS Outcomes Framework 1a)
2. Life expectancy at 75 (NHSOF 1b)

Indicators

- Smoking prevalence (Public Health Outcomes Framework 2.14)
- Alcohol related hospital admissions (PHOF 2.18)
- Proportion of physically active adults (PHOF 2.13)
- Excess weight in adults (PHOF 2.12)

- Cancer screening coverage (PHOF 2.20)
- Take up of NHS health check programme (PHOF 2.22)
- Emergency admissions for acute conditions that should not usually require hospital admission (NHSOF 3a)
- Emergency readmissions within 30 days of discharge from hospital (NHSOF 3b and PHOF 4.11)
- Reducing time spent in hospital by people with long-term conditions (NHSOF 2.3)
- Gateshead CCG Quality Premium indicators

Focus for action (2013 – 16):

Prevention:

- Maintain momentum on actions to reduce smoking prevalence.
- Address the harm caused by substance misuse and promote sensible drinking.
- Promote healthy eating, build exercise into peoples' daily lives (especially walking and cycling) and ensure people have access to leisure opportunities that help them remain active and healthy.
- Promote positive sexual health messages across the life course and support individuals to access high quality services.

Early identification, treatment and condition management:

- Better awareness of early signs and symptoms of cancer.
- Promote the uptake of Health Checks, cancer and other screening programmes.
- Ensure high quality clinical management of long term conditions.
- Promote self care and support individuals to manage their long term conditions.

Priority – Promote choice and empower local people to have more control over their health and social care and remain independent for as long as possible.

Why is this a priority?

The numbers of older people in the population will increase significantly over the next 20 years. In particular, there will be large increases in the numbers of people aged 80 and over. This is the age group that needs most support e.g. people with dementia, people living alone and those with a limiting long term illness. A key part of our commissioning plans will be to invest in services that aim to reduce people's needs for care and support whilst also delivering better outcomes.

We are also reviewing provision to the most vulnerable older adults so that services in care homes and to those who are housebound better meet their needs.

People's expectations are changing, they want more say in how they are supported through 'personalisation'. We need to support and empower people to have as much choice and control over their care and support as possible, whether they have short term needs or long term conditions. This is consistent with our vision for social care.

A key theme of our Housing Strategy is the provision of support to residents to find and maintain a home of their own which enables them to live independently and which promotes their wellbeing.

Living a life that is free from harm and abuse is a fundamental right of every person. We need to ensure that people at risk from abuse or neglect are effectively safeguarded, with the person at risk staying as much in control of decision making as possible.

Carers are the first line of prevention. Their support often stops problems from escalating to the point where more intensive packages of support become necessary. We need to provide the right support to carers so that they can fulfil their caring roles whilst also feeling fulfilled and valued themselves. Similarly, we need to maximise the contribution of housing packages and solutions to our preventative work.

Under the Equality Act 2010, public bodies are required to eliminate unlawful discrimination, harassment and victimisation and promote equality of opportunity. We will champion equality of opportunity in all aspects of health and social care and, in particular, our work to promote choice and to empower local people to have more control over their care and to remain independent for as long as possible.

Issues from Gateshead Strategic Needs Assessment (includes JSNA) -

- The proportion of over 65s is projected to rise by 25% between 2008 and 2025 (to 42,000 people). Even more dramatic is the expected rise in population aged 85+, increasing to 4,600 by 2015, then to 6,600 by 2025 (74% increase from 2008).
- Isolation and loneliness in older people may lead to malnutrition and health problems, including depression and dementia. Contact with health and social care systems can be delayed until a crisis is reached.
- There are over 1,100 admissions a year to hospital due to falls among people aged 65 and over (significantly higher rate than that of England).
- There are around 90 Excess Winter Deaths in Gateshead each year (i.e. extra deaths from all causes that occur in the winter months), most of which are considered preventable.
- 62% of terminally ill patients died in hospital, rather than at home in Gateshead during 2009-10, above the national average.
- Approximately 1.2% of children in Gateshead are severely disabled and an estimated 0.5% of children have a severe learning disability. As many as 7% of all children may have some form of disability. This has particular implications for transition from child to adult services e.g. identifying the needs of young people returning to Gateshead from out of borough placements.
- It is estimated that 12,000 people aged 18 – 64 in Gateshead (10.2% of the population) have a moderate or severe physical disability. This will grow as a result of overall population growth. Whilst the number of younger people with a disability is set to remain constant, the number of all people with a sensory impairment will increase significantly as a consequence of an aging population.
- It is estimated that 2,874 people aged 18 – 64 in Gateshead (2.4% of the population) have a learning disability. People with learning disabilities are living longer and the number of older people with a disability will increase significantly.
- 6.1% of Gateshead's adults with learning disabilities were in employment at their latest review, which is higher than the regional average.
- Carers who are unable to take advantage of educational or job opportunities suffer poorer health associated with low incomes.

Headline Outcome Measures

1. Social care related quality of life (Adult Social Care Outcomes Framework 1A)
2. Health related quality of life for people with long term conditions (NHSOF 2)

Indicators

- Proportion of people who use services who have control over their daily life (ASCOF 1B)
- Proportion of people using social care who receive self-directed support, and those receiving direct payments (ASCOF 1C)
- Proportion of adults with a learning disability who live in their own home or with their family (ASCOF 1G and PHOF 1.6)
- Proportion of adults in contact with secondary mental health services living independently (ASCOF 1H and PHOF 1.6)
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcomes Framework 2.3 i)
- Proportion of older people who were still at home 91 days after discharge from hospital (ASCOF 2B and NHSOF 3.6)
- Falls and injuries in the over 65s (Public Health Outcomes Framework 2.24)
- Proportion of people who use services who feel safe (ASCOF 4A)
- Patient experience of primary care (NHSOF 4a), secondary care (NHSOF4b) and satisfaction of service users with care and support (ASCOF 3A)
- Carer-reported quality of life (ASCOF 1D)

Focus for action (2013 – 16):

- Ensure individuals are supported and empowered to maintain and regain their health and independence e.g. through reablement, housing solutions.
- Invest in services that prevent or delay people reaching the point where they need health and/or social care e.g. falls prevention, telecare etc.
- Support people to have as much choice and control as possible through personalisation.
- Ensure seamless transition from child to adult services where care and support is tailored to meet individual needs. Ensure individuals, their families and carers have a positive experience of care and support.
- Ensure people are protected from abuse and avoidable harm and that their wellbeing is safeguarded, in particular those who are most vulnerable.
- Support people and their carers to take part in their communities, to have opportunities for work and leisure and to feel fulfilled and valued. As part of this, ensure people with physical and/or learning disabilities have the same rights and opportunities as everyone else.

Priority - Improve mental health and wellbeing for all members of our community

Why is this a priority?

Good mental health and wellbeing are essential prerequisites for an individual's ability to live to their full potential. While the terms mental health, mental wellbeing, and emotional wellbeing are often used interchangeably, mental health refers to a positive state, not just an absence of mental disease or illness. Mental health is described by the World Health Organization as:

"... a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."

Work is underway locally and nationally to more accurately capture local information on peoples' mental health and wellbeing. Mental illnesses such as anxiety and depression are very common and can exacerbate long term conditions experienced by people. Nationally, among people under 65, nearly half of all ill health is mental illness. There are inequalities in the incidence of mental illness, with higher levels of mental illness in particular sections of the community, including socioeconomically disadvantaged communities, the unemployed and people with poor educational achievement.

Mental illness often increases the scale of physical illness. It can make existing physical illness worse, with complex relationships between mental health problems, smoking, obesity and physical activity. Good mental health therefore underpins any attempt to improve population health and reduce health inequalities – 'no health without mental health'.

The Welfare Reform Act came into force in March 2012, the main aims being to move more people off benefits and into employment, to simplify the benefits system and to tackle administrative complexity. The Act will have a significant impact on local people, with many having to deal with changes that they are ill equipped to deal with. GP practices are already seeing an increase in the numbers of patients experiencing stress and anxiety associated with financial difficulties, impacting on family wellbeing. There could also be an increase in levels of homelessness. The Council and partner organisations will need to work together and provide advice and support to those affected.

Issues from Gateshead Strategic Needs Assessment (includes JSNA) –

- There are around 90 emergency hospital admissions each year due to self-harm among children and young people under 19 years of age in Gateshead, significantly higher than the rate across England.
- In Gateshead, 31,000 adults – nearly 19% of the adult population – have been diagnosed with depression (significantly different from England's 11%).
- As at February 2012, there were about 4,700 people claiming benefits due to mental and behavioural problems in Gateshead (a rate of 38 per 1,000 working population, higher than the England rate of 27 per 1,000).
- Between 2007 and 2011, the number of people diagnosed with dementia in Gateshead has risen from 1,000 to 1,200. Gateshead's prevalence of dementia, 0.60%, is significantly higher than that of England (0.48%). Increasing life expectancy will mean that the number of people with dementia living in Gateshead will rise.
- Initial analysis of data from a local survey shows that in adults, mental wellbeing dips between the ages of 35 to 54. It rallies between the ages of 55 to 74, then decreases again for those aged 75 and over.

Headline Outcome Measure

Self reported wellbeing (Public Health Outcomes Framework 2.23)

Indicators

- Suicide (PHOF 4.10)
- Employment of people with mental illness (Adult Social Care Outcomes Framework 1F, NHS Outcomes Framework 2.5, PHOF 1.8)
- Enhancing quality of life for people with dementia (NHSOF 2.6)
- Social connectedness (PHOF 1.18)
- Statutory homelessness (PHOF 1.15)
- Patient experience of community mental health services (NHSOF 4.7)
- Percentage of the population affected by noise (PHOF 1.14)
- Utilisation of green space for exercise/ health (PHOF 1.16)
- Air pollution (PHOF 3.1)
- Excess winter deaths (PHOF 4.15)

Focus for action (2013 – 16):

- Raise the aspirations of local people to achieve their full potential.
- Improve provision for children and adults with anxiety and/or depression by developing the range of services available.
- In implementing the Dementia Strategy for Gateshead, ensure emphasis on enablement and intermediate care access, accommodation solutions, end of life support and health and social care workforce development.
- Improve outcomes for patients by ensuring that all mental health treatment and care services sign post and refer patients to the full range of advice, advocacy and support services (e.g. debt counselling, employment services, housing, physical health improvement).
- Address the impact of the welfare reforms on local communities, particularly those who are most vulnerable.
- Support action to tackle loneliness, reduce social isolation and homelessness.
- Support the development of vibrant, safe and cohesive neighbourhoods e.g. through multi-agency safer neighbourhoods arrangements.
- Wider actions to tackle social and economic wellbeing.

‘Active, Healthy and Well Gateshead’ - How we will Deliver

Our health and wellbeing strategy **‘Active, Healthy and Well Gateshead’** sets out challenging aspirations for the health and wellbeing of local people, in line with ‘Vision 2030', our vision for Gateshead.

We will work to deliver these aspirations through the priority areas and actions set out in this document.

Our strategy sets out a number of headline outcomes measures to track progress in working towards these aspirations. Trajectories will be set for these measures so that we can see where we are now, where we want to be in the future to achieve our health and wellbeing aspirations and the progress that will be need to be made along the way to get there.

These measures will be supported by indicators to track progress on particular aspects of our health and wellbeing agenda.

During our engagement work with partnerships, local groups and communities, a number of big ideas were suggested to take forward our health and wellbeing agenda. These fell under the following themes:

- ‘Do the best for every child born in Gateshead / Make a commitment to every child’
- ‘Think ‘families’ in everything we do’
- ‘Get every child ready for school’
- ‘Make the most of intergenerational work to support health and wellbeing’
- ‘Make sure health is everyone's business’
- ‘Get the most from our natural assets and use to promote active lifestyles’
- ‘Introduce car free areas ‘(e.g. a car-free central Gateshead on Sundays) to bring streets back into community use, to promote cycling, walking, family and community interaction/activities’
- ‘Lead by example to send out clear messages e.g. around alcohol’
- ‘Restrict hot food take-aways e.g. around schools’
- ‘A local food economy for Gateshead’
- ‘Gateshead communities coming together / Bring health close to communities’
- ‘Increase community access to local facilities and amenities’
- ‘Focus on hard to reach and vulnerable groups’

Through our ongoing conversation with local communities, we will consider how we can take these ideas forward as part of our health and wellbeing agenda. In particular, we will work to ensure that we do the very best for every child in Gateshead in order to give them the best start in life.

We will also work with local commissioners, local providers and the voluntary and community sector to turn our health and wellbeing aspirations into reality and secure an active, healthy and well Gateshead.

Supporting Information

- **'Who's Who' on Gateshead Health & Wellbeing Board**
- **Our Joint Statement on Commissioning for Health and Wellbeing**
- **Explanation of Terms Used**

‘Who’s Who’ on Gateshead’s Health & Wellbeing Board

The membership of Gateshead’s Health & Wellbeing Board from 1 April 2013 is:

Cllr Mick Henry (Leader of Gateshead Council),

Cllr Martin Gannon (Deputy Leader of Gateshead Council),

Cllr Mary Foy (Cabinet Member for Healthier Communities),

Cllr Michael McNestry (Cabinet Member for Adult Social Care),

Cllr Gary Haley,

Cllr Frank Hindle,

David Bunce (Group Director, Community Based Services),

Margaret Whellans (Group Director, Learning & Children),

Carole Wood (Director of Public Health),

Dr. Mark Dornan, (Chair of NHS Gateshead Clinical Commissioning Group),

Mark Adams or Jane Mulholland (NHS Gateshead Clinical Commissioning Group),

Alison Slater, (Director of Operations & Delivery, Cumbria, Northumberland, Tyne & Wear Area Team, NHS England)

Robert Buckley (Healthwatch Gateshead representative),

Gev Pringle (Chief Executive, GVOC) and

Additional representatives of partner organisations can be invited to take part in Board discussions on particular issues. These may include:

- Clinical leads on particular issues
- Gateshead NHS Foundation Trust, Northumbria, Tyne & Wear Mental Health Trust and other Providers
- NHS England
- Public Health England
- The Gateshead Housing Company
- Northumbria Police
- Northumbria Probation Service
- Tyne & Wear Fire and Rescue Service
- Gateshead College
- Nexus
- Business sector
- Gateshead Community Network

- Other Council Members & Officers

The Board will also work with the Children's Trust Board and other thematic partnerships of Gateshead Strategic Partnership, the Local Safeguarding Children's Board and Safeguarding Adults Partnership Board in taking forward its health and wellbeing agenda.

Our Joint Statement on Commissioning for Health and Wellbeing

Gateshead Health and Wellbeing Board has a duty to promote and encourage integrated commissioning of services for the health and wellbeing benefit of local people across the lifecourse (including health care, public health and social care).

A Strategic Commissioning Group has been established to provide strategic leadership and to support the Health and Wellbeing Board to fulfil this responsibility. It will also have a reporting relationship to the Children's Trust Board and other partnership boards as required.

Areas of Focus

- Provide strategic leadership on developing integrated commissioning arrangements to enhance the health and wellbeing of Gateshead residents across the lifecourse (from prenatal care to end of life care).
- Develop our understanding of the total level of resources available across the system i.e. the resource base as a whole and how this can best be matched and targeted to meet identified needs (to maximise returns from resources, secure value for money etc.).
- Scope out existing arrangements for the commissioning of services and where opportunities exist to work towards greater alignment /integration of commissioning arrangements.
- For those service areas, identify where they currently lie on a continuum from 'working towards alignment' to 'working towards full integration' of commissioning plans/intentions.
- Consider what the pace of change/timescales should be in moving towards a more integrated commissioning approach i.e. acknowledging that:
    - some service areas may be better placed to move along the continuum at a faster pace than others and/or
    - the progression of key priorities of our Health & Wellbeing Strategy (HWB) will likely require more integrated commissioning arrangements to be in place for particular service areas.
- Oversee the integrated commissioning pilots for older people with long term conditions and services for children (0 to 5), sharing learning to inform further pilot work across Gateshead.
- Look at new and innovative ways to deliver the priorities of Gateshead's HWB strategy through integrated commissioning arrangements.
- Oversee the integrated commissioning cycle and look to align the commissioning cycles of key partner organisations – in particular, needs assessment, development of commissioning intentions, engagement with providers and performance review.
- Develop and link with existing joint working arrangements in place e.g. the Joint Commissioning Business Group.

- Liaise with NHS England and Public Health England to support integrated commissioning arrangements.
- Link our commissioning arrangements with the wider determinants of health.
- Lay the foundations for the alignment and integration of service delivery arrangements, especially at the interfaces between services and the transition of care.

Relationship with Provider Organisations/Forums

The Strategic Commissioning Group will utilise and build upon existing provider forums to facilitate engagement with providers on Gateshead's health and wellbeing agenda. This will include moving towards integrated commissioning arrangements and enabling provider organisations to input to this work.

Explanation of Terms Used

Capacity Building – the ability of communities to perform functions, solve problems and set and achieve objectives in a sustainable manner. It is about increasing the skills, infrastructure and resources of individuals, communities and organisations.

Clinical Commissioning Group (CCG) – Under the health reforms, CCGs will be the main commissioners of NHS services from 1st April 2013. This means that Gateshead CCG will become the main commissioner of NHS hospital, community and mental health services for the local population of Gateshead.

Commissioner – a manager in the NHS or a council who oversees the day-to-day process of ***commissioning*** services.

Commissioning – the process of ensuring that health and care services are provided so that they meet the needs of the population; it includes a number of stages including assessing population needs, prioritising outcomes, procuring products and services, and overseeing service providers.

Community Resilience – the ability of a community to withstand and recover from adversity.

Co-production – production of solutions (for example, design of services) by the people who may use them alongside those who have traditionally provided or arranged them. The concept of co-production assumes that people have assets to contribute rather than simply needs which must be met.

Health and Wellbeing Board (HWB) – from 1st April 2013, a statutory committee of a local authority which will lead and advise on work to improve health and reduce health inequalities among the local population. Members will include councillors, GPs, health and social care officers and representatives of patients and the public, including local HealthWatch.

Health and Wellbeing Strategy – ***Health and Wellbeing Boards*** will be required to produce a Health & Wellbeing Strategy for the local area, based on the needs identified by the ***JSNA***

Health Improving Organisation – An organisation which seeks to have health improvement as a core element and which, in turn, influences all aspects of the organisation's activity.

Health Inequalities – differences in the health (and increasingly wellbeing) experienced by different groups in a community which are avoidable and therefore considered to be unacceptable.

HealthWatch – effective from April 2013, local HealthWatch will be patient and public engagement bodies, taking over from Local Involvement Networks (LINks). They will be supported by a national organisation, HealthWatch England.

Integration – bringing together the work of partners so that their efforts can be combined. Most commonly applied to the NHS and the social care part of the local authority and now including public health, integration offers a joined-up experience to service users, and can be both more effective and efficient in its use of limited resources. Integration can be applied at different points – for example, in needs assessment, commissioning, or in service provision.

Joint Strategic Needs Assessment (JSNA) – the process and document(s) through which local authorities, the NHS, service users and the community and voluntary sector research and agree a comprehensive local picture of health and wellbeing needs. The development of JSNAs will be the responsibility of ***Health and Wellbeing Boards***. ***CCGs*** and ***NHS England*** will be required to "have regard to" JSNAs when developing their commissioning plans.

Lifecourse – a lifecourse approach to health emphasises the accumulated effects of an individual's experience across their life span in understanding peoples' health and the prevention of illness. Poor economic and social conditions in the very early years of life have been shown to affect adversely individuals' growth and development, their risk of disease and ill health in later life and their life expectancy. Professor ***Marmot's 2010 review of health inequalities***, '*Fair Society, Healthy Lives'*, strongly advocates a lifecourse approach to population health, health improvement and tackling health inequalities, with the first five years of life being the highest priority.

Marmot Review of Health Inequalities – a review of the causes and the "causes of the causes" (i.e. the social and economic determinants) of ***health inequalities*** in England, carried out by Professor Sir Michael Marmot in 2010. It identifies a number of key areas for action to reduce health inequalities, the most important of which is "giving every child the best start in life". The review, *Fair Society, Healthy Lives*, can be accessed through the following link: http://www.marmotreview.org/english-review-of-hi/key-messages.aspx

Mental Health – is described by the World Health Organisation as "... a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."

Needs Assessment – reviewing the characteristics of a population (for example their health status, the number with long-term conditions, numbers in different age groups) and their needs, leading to agreed priorities and resource allocation decisions to improve health and wellbeing and reduce inequalities. A ***Joint Strategic Needs Assessment*** is a statutory requirement for each area.

NHS England – a national body created by the Health and Social Care Act 2012, whose role includes supporting, developing and holding to account the ***clinical commissioning groups***, as well as being directly responsible for some specialist commissioning. There are 27 Area Teams across the country, including the Cumbria, Northumberland, Tyne & Wear Area Team.

Outcomes Framework – a national framework which sets out the outcomes and corresponding indicators against which achievements in health and social care will be measured. There are three outcome frameworks – for the NHS, for adult social care and for public health.

Personalisation – the principle behind the current transformation of adult social care services, and also relates to health services. It is about providing individualised, flexible care intended to promote the independence of those who need care.

Place Shaping – describes the ways in which local authorities and local partners can collectively use their influence, powers and creativity to create attractive, prosperous, healthy and safe communities – places where people want to live, work, enjoy leisure activities and do business.

Public Health – "The science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society." (UK Faculty of Public Health, 2010). The three domains of public health are: health improvement; health protection; and health services. Under the Health and Social Care Act 2012, responsibility for public health is transferring from the NHS to local government. A national public health service, Public Health England is also being established.

Reablement – is a range of services focused on helping a person maximise their independence by learning or re-learning the skills necessary for daily living.

Social (or Wider) determinants of health – the social and economic conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for ***health inequalities***.

Wellbeing – used by the World Health Organisation (1946) in its definition of health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". More recently the concept was described as "feeling good and functioning well" (New Economics Foundation, 2008).

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Gateshead Council

REPORT TO HEALTH AND WELLBEING BOARD
15 January 2016

TITLE OF REPORT: **Gateshead Director of Public Health Annual Report 2014/15**

REPORT OF: **Carole Wood, Director of Public Health**

Purpose of the Report

1. The purpose of this paper is to present the Director of Public Health Annual Report 2014/15 to the Gateshead Health and Wellbeing Board.

Background

2. The production of this report is in line with the Director of Public Health's statutory duties under the Health and Social Care Act 2012. The council has a duty to publish the report. Under Faculty of Public Health Guidance, the Director of Public Health Annual Report presents an independent professional view, based on sound epidemiological evidence. The report is the vehicle by which Directors of Public Health can identify key issues, flag up problems, report progress and thereby serve the interest of their local populations. It is also a key resource to inform local multiagency action.

3. The focus of this year's report is health inequalities and the wider determinants of health, health in childhood and in particular the role of services and schools in child health improvement.

   A full version of the 2014/15 Gateshead Director of Public Health Annual Report is available online at www.gateshead.gov.uk/DPHReport2015.

4. The executive summary and recommendations are attached at Appendix 1.

5. The report's main theme, childhood health, was chosen to highlight the significance that achieving the best start in life has in reducing health inequalities in subsequent years. The topic of health and children is especially timely in a year when the commissioning responsibility for public health services for those aged from birth to five years old transferred from the NHS to local government. The council is now responsible for commissioning public health services for children 0-19 years of age, currently in the form of the health visitor service, the Family Nurse Partnership and school nursing services.

6. Children born into poverty have a greater likelihood of poor health outcomes both as children and later as the adults they become. This combined with a likelihood of also achieving poorer outcomes in other domains (ie. educational attainment, employment, income) acts to make health inequalities and deprivation persist

between generations. The poor health of people in Gateshead then impacts upon sustainable economic growth, producing a vicious circle.

7. Some of the key points reflected in the report are:

- The health of people in Gateshead is improving but at a slower rate than that of those who live in less socio-economically deprived circumstances. The report details the ways in which ensuring that children's experience of the best start in life has the potential to reduce health inequalities and argues for universally available services and interventions that are able to deliver higher levels of support according to need ("proportionate universalism").

- Socio-economic inequalities are reflected in inequalities in children's health in Gateshead. These inequalities, both between Gateshead and less deprived local authority areas and between different communities within Gateshead, are unfair and preventable. Outcomes which show marked variation linked to areas of deprivation include dental health of children at five years of age and child obesity. Effective working with children and families draws upon the notions of "risk" and "resilience". All children are exposed to "risks" (i.e. factors with the potential to cause harm) to some degree. "Resilient" children have developed positive adaptations that mitigate the impact of the risk or risks. Children and families can be supported to encourage resilience and recognise and reduce the likelihood of risks.

- Services and interventions in the national Healthy Child Programme can mitigate against health inequalities. The council is now responsible for commissioning key public health services for children and young people aged 0-19 years. Working with NHS commissioners, the council will ensure that services are joined-up and deliver support according to need. The future direction for remodelling children and family 0-19 services is also discussed within the context of collaborative working across the NHS and the council.

- Schools present a unique opportunity for interventions that improve the health of children, parents and staff. Gateshead has already recognised this in its continued support for the National Health Schools Programme. The Programme has been remodelled for local delivery as the "Health in Schools" support programme.

8. The foreword of the report acknowledges the realities of the challenging financial context which requires the council to make difficult decisions about resources. The report focusses on the importance of continuing work to tackle health inequalities in line with the principles established by the Marmot Review (2010) on health inequalities which are reflected in the Council Plan, and which require full engagement across all organisations and communities in Gateshead.

9. Recommendations in the Director of Public Health Annual Report are summarised as:

- Gateshead Council uses all opportunities to tackle poverty and inequality, and works with Newcastle/ Gateshead Clinical Commissioning Group (CCG) to develop a joint strategy for tackling health inequalities, balancing a "whole population" universal offer with scalable support to individuals according to

need. This strategy should build upon existing approaches that make the best use of community assets to enable people to prevent and/or manage their own health conditions and health risk behaviours.

- Gateshead Council should continue to commit to the priority of 'giving children the best start in life', strengthening systems for early intervention with vulnerable families, and continues its work with Newcastle/Gateshead CCG to ensure that services for children 0-19 are delivered in an integrated way that is equitable and commensurate with need. Priorities should include a consistent approach to promoting infant and maternal mental health and encouraging good oral hygiene and take-up of regular dental care.

- Schools are encouraged to build on existing work to improve children's health and continue to participate in the Healthy Schools Programme (noting that this will be delivered under a new arrangement from September 2016, where Gateshead Council will offer the programme to schools at a modest charge).

- Gateshead Council and the Health and Wellbeing Board are requested to note that the information in this report provides assurance that the Health Protection System operated effectively in 2014/15, and that clear mechanisms are in place to support the DPH to ensure appropriate responses to health protection issues.

10. The report also includes a chapter on health protection issues and arrangements over the previous twelve months in line with the council's health protection assurance role. This has previously been presented to the Health and Wellbeing Board as a separate report.

Previous DPH Annual Report Recommendations and Progress Update

11. This section of the report provides details of action taken in response to the previous Director of Public Health Annual Report 2014/2015 which focused on alcohol.

Proposal

12. The Director of Public Health Annual Report is presented to the Health and Wellbeing Board to consider and support its recommendations.

Recommendations

13. It is recommended that the health and Wellbeing Board:

(i) Notes and comments on the Director of Public Health Annual Report
(ii) Agrees to support its recommendations.

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APPENDIX 1

Director of Public Health Gateshead Annual Report 2014/15

Executive Summary and Recommendations

Overview

The report presents an overview of health and health inequalities in Gateshead and details some of the key changes and developments that have taken place in 2014/15.

The focus of this year's report is the significance of various factors in childhood which contribute to health throughout life. It looks at the role of services and schools in particular in reducing health inequalities by supporting children and families in greater need than others. This is particularly relevant in a year that has seen responsibility for commissioning public health services for children aged from 0 to 19 move from the NHS to local government during a time of unprecedented reductions to budgets for public services, including public health services.

Health protection issues are included in this Annual Report, in line with the Director of Public Health's assurance remit within the council.

Opening sections and Chapter 1 - Key issues for 2014/15

More people in Gateshead continue to live longer and healthier lives than ever before. However, gaps in many health outcomes remain between the people of Gateshead and the average national population. These are at their starkest when looking at life expectancy. Men and women living in Gateshead have a shorter life expectancy and healthy life expectancy than the national average. Currently, for men in Gateshead, this is 77.4 years, against 79.4 years nationally. For women in Gateshead, the current average life expectancy stands at 81.2 years, whereas nationally, it stands at 83.1 years.

These inequalities, shared across many communities in the North of England, can also be seen between communities in Gateshead. Therefore, while the health of our residents improves, it improves more slowly than that of the national average population. Healthy life expectancy in Gateshead has not improved significantly since 2009/11.

The reasons for these differences are complex, but arise from the circumstances under which one is born, grows and lives. At a population level, poorer health outcomes are intrinsically linked with that population's relative social and economic circumstances. This means that people living in poorer areas are more likely to develop illnesses and disabilities and die at a younger age than those from more affluent areas. The report details some of the ways in which Gateshead's communities are changing, some of the health challenges we face, and the significant impact of the "wider determinants" of health in reducing inequalities.

The report in 2010, *Fair Society, Healthy Lives (The Marmot Review, 2010),* recommended a number of actions to reduce health inequalities, including improving living and working conditions, giving every child the best start in life, enabling people to maximise their capabilities and have control over their lives, and strengthening the role of preventive health services. It also introduced the approach of "Proportionate

Universalism", through which services or interventions are made available to all populations universally, but offered in increasing levels of intensity to those in the most disadvantaged or complex circumstances according to need. A subsequent report, *Due North, Independent Inquiry on Health Equity for the North, 2014*, is referenced, which examined in detail the increasing North-South health divide and likely causes, with recommendations stressing the importance of reducing economic inequalities experienced by the population living in the North of England and the promotion of healthy development in the early years of life.

In the current public sector funding climate these principles can inform how we allocate diminishing resources to achieve the greatest impact.

Main Theme - Children

Children's health is important in its own right. A child's early experience impacts on their health and development throughout life and influences life chances. Growing up in poverty may have a long-term adverse impact upon many aspects of quality of life both as a child and later as an adult. In Gateshead, the 43rd most deprived area out of the 326 English authorities, 22.1% (7,555) of children under 16 live in poverty, significantly above the national average of 19.2%. Focussing upon the factors which equip a child to have the best start in life has the potential to improve not only their own life, but the lives of future generations.

Chapter 2 - Children's health in Gateshead

Children and young people comprise over one fifth of the Gateshead population. Their health and wellbeing is generally poorer than that of the England average, however some indicators such as childhood immunisation rates, show very good performance.

Outcomes where significant improvement is needed include:

- Children achieving a good level of development at age 5
- Children in poverty (under 16 years)
- Under 18 conceptions
- Hospital admissions due to alcohol specific conditions and substance misuse
- Smoking in pregnancy
- Breastfeeding initiation and continued breastfeeding (6 to 8 weeks)
- A&E attendances (0 to 4 years) / Hospital admissions caused by injuries in children and young people
- Hospital admissions as a result of self-harm
- Childhood obesity

One area of particular concern is childhood obesity. Overweight and obese children are more likely to stay obese into adulthood and to develop diseases such as diabetes and cardiovascular diseases (heart disease and stroke) at a younger age.

Obesity is defined as having a body mass index (BMI) greater than the 95th percentile. Overweight is defined as having a body mass index greater than or equal to the 85th percentile but less than the 95th percentile.

In 2013/14 in Gateshead:

- Over one in ten (10.5%) children in Reception year (aged 4 to 5 years) were obese
- Over one in five (20.7%) of children in Year 6 (aged 10 to 11 years) were obese

The number of obese children therefore doubles between Reception Year and Year 6. Also, the number of reception age pupils who are obese has increased since 2012/13.

Children's dental health in Gateshead is generally good, in no small part thanks to the supply of fluoridated water throughout the borough. There are variations within communities in Gateshead, with children from the most deprived communities having the highest levels of decay. For example, 9% of children aged five years in Whickham South and Sunniside ward have tooth decay, compared to 47% of children in Felling.

Tooth decay is one of the most common reasons for hospital admissions for children aged 5 to 9 years old. A number of different programmes work with children directly through schools and indirectly by training other professionals in contact with children to raise awareness of children's dental care needs and to promote oral health directly.

Chapter 3 – Interventions and services that contribute to the best start in life for children living in Gateshead

As stated in *Fair Society Healthy Lives (The Marmot Review, 2010),* disadvantages impact upon a child's development before birth and accumulates throughout life. This is why giving every child the best start in life, in particular from conception to age two, is critical to reducing health inequalities.

The Healthy Child Programme (HCP) is the main nationally defined universal health service for improving the health and wellbeing of children from pregnancy to adulthood. It is delivered through:

- health and development reviews
- health promotion
- parenting support
- screening and immunisation programmes

The principle of the programme is to provide universal support to all, with more support for families from the right service (i.e. GPs, health visitors, midwives, nursing staff, social care workers) available when needed ("progressive universalism").

Since October 2015, local authorities and Directors of Public Health have assumed responsibility for commissioning children's public health services for those from birth to nineteen years old. These services are health visiting and the Family Nurse Partnership (for the 0-5 population) and school nursing services (for ages 5-19). NHS England will continue to commission immunisation/vaccination and screening programmes and the Clinical Commissioning Group will commission midwifery services.

"Children Gateshead", the plan for children, young people and families in Gateshead, sets out a firm commitment to early intervention in the "Gateshead Prevention and Early Intervention Strategy, 2013-2016". It is consistent with "Active, Healthy and Well Gateshead, our Health and Wellbeing Strategy" - shifting more investment towards prevention, early intervention and community provision.

The report details the role of several key services/interventions that support the “best start in life” including:

- Health visitors
- Family Nurse Partnership Programme
- Gateshead Children’s Centre
- School nursing
- Breastfeeding support
- Support to stop smoking during pregnancy
- Accident prevention
- Readiness for school
- Teenage pregnancy
- Maternal mental health
- Specialist services (i.e. maternity services, paediatrics, therapists)
- Safeguarding arrangements

Services working with children and families draw upon the notions of “risk” and “resilience”. All children are exposed to risks (i.e. factors with the potential to cause harm) to some degree. Resilient children are those who have developed positive adaptations that mitigate the impact of the risk or risks. The work of these services is to promote those circumstances that encourage resilience and recognise and reduce the likelihood of risks.

In particular, there six high impact areas that have the biggest impact on a child’s life:

- Transition to parenthood and the early weeks
- Maternal mental health (including postnatal depression)
- Breastfeeding (initiation and duration)
- Healthy weight, healthy nutrition (including physical activity)
- Managing minor illness and reducing accidents
- Health, wellbeing and development of the child aged two – two year old review and support to be “ready for school”

The division of commissioning responsibilities between different organisations arising from the reorganisation of the NHS in 2013 presented the risk of “fragmented” services. Gateshead responded to this by working with all relevant commissioners to produce effective, efficient services.

As the Gateshead Public Health Team becomes the responsible commissioner for 0-19 services, further opportunities for the integration of evidence based interventions that focus on achieving positive outcomes for children can be adopted.

Chapter 4 - Health in school settings

Schools are a key setting to promote the health of children and young people, as well as their parents, teachers and the wider community.

Gateshead is fortunate that our schools have always been very enthusiastic and engaged around health. In December 2009, Gateshead was the first local authority to see 100% of its schools achieving National Healthy Schools status. The National Healthy Schools Programme no longer runs at a national level but Gateshead has continued this programme locally.

A new Gateshead Health in Schools programme launched in 2015. Based on an evidence review and the evaluation of the Gateshead Healthy Schools Programme, the new programme will focus on promoting healthy weight, physical activity, social and emotional wellbeing, and promoting resilience to adversity. The Gateshead Health in Schools Core Offer will be made available to all schools and academies in Gateshead in 2016/17 for a small charge.

Schools also provide an ideal opportunity to gather health data on children and young people. Examples include the National Child Measurement Programme (NCMP) and the Health Related Behaviour Questionnaire undertaken by Exeter University. Data from these sources is robust and reliable and is analysed when looking at health needs of children and young people. It can also be drawn upon in support of other health improvement programmes. For example, data from the NCMP was used to inform work with planning to limit the proliferation of hot food takeaways.

Chapter 5 - Health protection

This section of the report covers health protection issues in Gateshead during 2014/15, included as part of the DPH assurance remit.

A range of issues are covered, including infectious diseases trends, immunisation and screening programme uptake, and the quality of screening programmes. Specific reference is made to how the system responded to the outbreak of Ebola in West Africa. The local health protection arrangements are assessed as effective and operate to provide assurance to Gateshead Council and the Health and Wellbeing Board.

Achievements and update on recommendations from DPH Report for 2013/14

The report concludes with a summary of last year's recommendations and progress made over the past 12 months. Good progress is reported in a number of areas, including the development and signing of the Local Government Declaration on Alcohol, improved system for identification and brief intervention, development of new treatment services, and the strengthening of licencing policy which is resulting in the increased use of licencing reviews to restrict underage sales.

Further achievements are noted such as the launch of the revised Joint Strategic Needs Assessment, the Gateshead Year of Walking Campaign, the strong performance of the NHS Health Checks programme in Gateshead, the introduction of new planning regulations to limit the proliferation of Hot Food Takeaways and continued work with health and voluntary sector partners on cancer prevention.

Recommendations arising from this report

1. Gateshead Council should continue to commit to the priority of 'giving children the best start in life', recognising the need to strengthen systems for early intervention with vulnerable families to reduce the numbers of children in need and going into care (this is already stated in the Gateshead Council Plan 2015 - 2020).

2. Gateshead Council, in its community leadership role, uses all available opportunities to tackle poverty and inequality, recognising the need to advance longer term objectives of improved education attainment, quality housing, good jobs and economic growth. The proposed devolution deal for the North East Combined

Authorities, to which the council is a party, presents a key opportunity to work in partnership with other local authorities, private and public sector partners to build a stronger economy and generate more and better jobs.

3. Gateshead Council and Newcastle/Gateshead Clinical Commissioning Group (CCG) develop a clear joint strategy for tackling health inequalities, based on the principles of proportionate universalism, which balances “whole population” universal approaches with provision of support to individuals and families, scaled according to need.

4. Gateshead Public Health team and Newcastle/Gateshead CCG continue to develop an approach which supports people in managing their own health conditions and health risk behaviours. This approach should build on the evaluation of the current Live Well Programme, and be supported by an asset-based approach which recognises and harnesses assets in local communities (volunteers, skills, social networks and voluntary groups).

5. Gateshead Council continues its commissioning work programme in partnership with the Newcastle/Gateshead CCG to ensure redesign of services for children 0-19 (including PH services) are delivered in an integrated way, delivering effective identification of risk, early help and intervention. There should be a particular emphasis on developing a robust pathway from the antenatal stage until a child is age two.

6. A consistent approach to promoting infant and maternal mental health for key professionals, with clear pathways and referral routes. A strong focus on training and development of key staff including health visitors, in relation to mental and infant mental health and a clear understanding how agencies can work together to deliver the most appropriate services.

7. Gateshead Council, in collaboration with partners, communities and families, should continue to proactively promote healthy lifestyles to tackle obesity, smoking and alcohol misuse.

8. Gateshead Council should work with partners, schools and communities to encourage the young adult and population of Gateshead to access dental care in higher numbers, and investigate and tackle the high rates of admissions for General Anaesthetics for extraction of teeth in 0-19 year olds.

9. Schools are urged to build on existing work to improve children’s health and continue to participate in the Healthy Schools Programme (noting that this will be delivered under a new arrangement from September 2016, where Gateshead Council will coordinate the programme and schools will be offered the programme with a modest charge to support delivery).

10. Gateshead Council and the Health and Wellbeing Board should note that the information provided in this report should be received as provision of assurance that the Health Protection System operated effectively in 2014/15. It should be noted that clear mechanisms are in place to support the DPH in monitoring and ensuring appropriate response to health protection issues as they arise.

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Gateshead Council

HEALTH AND WELLBEING BOARD
15 January 2016

TITLE OF REPORT: **Health Protection Update**

Purpose of the Report

1. To raise awareness of the Health & Wellbeing Board of some recent important health protection issues of interest in Gateshead.

Background

2. In November 2015, the Health and Well-being Board received the Director of Public Health's Health Protection Assurance report 2014/15. This report has been incorporated into the Director of Public Health Annual Report 2014/15 (Chapter 5), which is presented as a separate item on the agenda. This paper provides an update about major issues from April 2015 to date, to keep the Health and Well-Being Board informed about significant health protection issues.

2.1 Since April 2015, there have been three major data releases of interest to the Health and Well-being Board: uptake of cancer screening programmes, excess winter deaths and uptake of flu vaccinations. This paper provides an update re each of these issues and other areas of interest: sexual health and tuberculosis.

2.2 Uptake of Cancer Screening Programmes

There are three cancer screening programmes for which the DPH has an assurance role: breast, cervical and bowel. The 2014 end of year data is attached at appendix 1.

Key messages are:

a) Breast cancer screening: 78.5% of eligible women were screened (17316 women), up 0.9% compared to 77.6% in 2014. This is higher than the North East (77.1%) and England (75.4%)
b) Cervical cancer screening: 75.8% of eligible women were adequately screened (38526 women), down 0.9% compared to 2014. This is similar to North East (75.7%) and higher than England (73.5%)
c) Bowel cancer screening: 60% of eligible people were screened, higher than North East (59.4%) and England (57.1%). NB this is the first time the data has been published at LA, regional and national levels.

Members of the Health and Well-being Board received a cancer update earlier in the year which reported that Macmillan had funded a post to increase cancer screening uptake. The post holder is employed by GVOC to work in the community for three years. The data referred to in this report is too early to reflect any impact of the post.

2.3 Excess Winter Deaths

Excess winter mortality is calculated as winter deaths (deaths occurring in December to March) minus the average of non-winter deaths (April to July of the current year and August to November of the previous year).

2.3.1 England has seen an increase in excess winter deaths from 11.3% in 13/14 to 27.45 in 14/15, an increase of 142%

2.3.2 The north east has seen an increase in excess winter deaths from 9.5% in 13/14 to 28.3% in 14/15, an increase of 198%

2.3.3 Data has not been published for local authorities, however, based on the increasing trends shown across all the other published English regions it is likely Gateshead will be following this trend.

2.3.4 At the time of writing, there is no explanation for this large increase. However, excess winter deaths are associated with: 'flu (last year's flu was not particularly severe), falls, cold homes, malnutrition etc.

2.3.4i Each year, over 1,000 Gateshead residents aged 65 and over are admitted to hospital following a fall. Falls often have long term physical, mental and emotional effects. Falls can destroy confidence, increase isolation and reduce independence and are very costly to health and social services.

2.3.4ii The Gateshead vision for falls prevention is "that the health and wellbeing of older people is maintained and improved every year, to enable them to live full and active lives",

2.3.4iii Data show that the number of people aged 65 or over who are injured in Gateshead by a fall is higher than the North East average and significantly higher than the England average. As previously reported to the Board, a falls prevention strategy is in place to reduce the number of falls, and the following actions are being taken:

- **Falls pathway** - develop and implement a falls prevention pathway adhering to NICE guidelines.
- **Falls Training** - deliver training for all front line staff and community groups who deal with older people, to increase knowledge and awareness of falls prevention evidence
- **Routine screening** - explore the use of routine screening across different settings, including home risk assessments, and case identification in primary care.
- **Falls in the home** - continue to develop the Falls Prevention Scheme and share evidence with commissioners
- **Co-ordination and promotion of falls prevention** - continue to develop links with other strategic plans and to gain commitment to implementation of the action plan from key partner organisations, and have clear accountability structures.

2.4 Uptake of Flu Vaccinations

Through the National Flu programme, there are four specified target groups for 'flu vaccinations:

- population aged 65+,

- population < 65 at risk,
- pregnant women and
- front line health care staff.

This data is provided by GP practices and at the time of writing 28/31 GP practices in Gateshead had submitted data.

2.4.1 Population aged 65+. At the time of writing, 60% of this target group had received a 'flu vaccination (21239 people) down 2.6% on this time in 2014. However, the number of vaccinations increased by 5637 due to an increase in the population 65 and over. This is below the 75% target for this population, although above the England coverage of 58.1%

2.4.2 Population < 65 at risk. At the time of writing, 37.6% of eligible patients had received a 'flu vaccination (8279 patients), down 10.3% compared to 2014(an increase of 1879 vaccinations)

2.4.3 Pregnant women. At the time of writing 32.2% of pregnant women registered with their GP had received a flu vaccination (486 people) down 6.4% on this time in 2014, but an increase of 94 vaccinations. This is better than the Cumbria, Northumberland Tyne & Wear value (31.9%) and the England value (31.8%)

2.4.4 Front line health care staff. This data includes NHS trusts, GP practice staff and independent health sector staff; it does not include social care workers. At the time of writing, 53.6% of health care workers in Gateshead NHS Foundation Trust and GP practices in Gateshead had been vaccinated (1613 vaccinations), an increase of 17.5% compared to last year and higher than Cumbria, Northumberland Tyne & Wear (40.3%) and England (32.4%). It is worth noting that Gateshead NHS Foundation Trust has achieved 64.7% of staff vaccinated this year.

2.5 Tuberculosis (TB)

2.5.1 TB is caused by a bacterium (Mycobacterium tuberculosis) that is spread through the air when infected people cough or sneeze. The disease most often affects the lungs but it can infect any part of the body, including the bones and the nervous system.

Of those exposed to TB who do not develop symptoms immediately there is a 1:10 to a 1:20 chance of developing TB at a later point in life. Until disease develops people are described as having inactive or latent TB if infection is identified. Latent TB is not infectious.

Most people who are exposed to TB never develop symptoms, since the bacteria can live in an inactive form in the body, but if the immune system weakens, such as in malnourished people, people with HIV or the elderly, TB bacteria can become active. Other high risk groups include: homeless people, prisoners and drug and alcohol users.

Sometimes there is no adequate explanation as to why some individuals go on to develop active TB disease. Amongst infected migrants from high prevalence TB countries the disease is most likely to develop seven years after arriving in the UK and of these patients there is a higher prevalence of non-infectious non

pulmonary TB than amongst white British patients who are more likely to develop infectious pulmonary TB.

There is a latent TB case finding programme in place for newly arrived migrants from high risk TB countries and for TB contacts. Contact tracing is carried out for both infectious and non-infectious TB cases. Screening is completed in adult and paediatric TB screening clinics at the QE Hospital by the Specialist HV for TB and Migrant Health in conjunction with Respiratory Medicine and Paediatrics. Follow up home visits are important to ensure compliance. There is usually an average of between 10-15 individuals on prophylactic treatment at any one time. Prophylaxis reduces the risk of TB disease developing in these individuals in future but it is essential compliance is good to prevent drug resistance as the same drugs are used that are also used to treat active TB disease

2.5.2 Gateshead is a low prevalence area for TB. Cases are shown in the table below.

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

Improved notification systems and better data collection may have contributed to the increased cases

2.5.3 Gateshead Public Health Team is working with Public Health England and the Specialist Health Visitor (TB and Migrant Health) to improve training amongst staff working with the most vulnerable groups. The team will also work with Newcastle Gateshead CCG to ensure robust commissioning arrangements are in place to support the TB pathway

2.6 Sexual Health

Gateshead Council is responsible for commissioning comprehensive, open access sexual health services. The Public Health Team leads a strategic Sexual Health partnership focussing on chlamydia detection rates, increasing HIV testing with an, emphasis on early testing to avoid late diagnosis and unintended pregnancies, including under 18 and under 16 conception rates.

A new model Integrated Sexual Health Service was commissioned by the Council from 1st April 2015. This is supplemented with Primary Care contraception contracts which the Council holds with General Practices and Community Pharmacists across Gateshead.

Headline figures (2014):

- Overall 1534 new sexually transmitted infections (STIs) were diagnosed in residents of Gateshead, a rate of 767.0 per 100,000 residents (compared to 797.2 per 100,000 in England).
- Gateshead is ranked 94 (out of 326 local authorities in England; first in the rank has highest rates) for rates of new STIs excluding chlamydia diagnoses in 15-24 year olds; with a rate of 772.8 per 100,000 residents (compared to 828.7 per 100,000 in England).

- 56% of diagnoses of new STIs in Gateshead were in young people aged 15-24 years (compared to 46% in England). This includes those tested in genitourinary medicine clinics (GUM) only.
- There were 6 new HIV diagnoses in Gateshead and the diagnosed HIV prevalence was 1.5 per 1,000 population aged 15-59 years (compared to 2.1 per 1,000 in England).
- In 2013, the under 18 conception rate per 1,000 females aged 15 to 17 years in Gateshead was 29.3, while in England the rate was 24.3.

Future challenges:

- Monitoring performance; continued refinement of KPI data from service providers
- Managing demand and costs of a tariff based service; implementing financial impact assessment project to establish best value funding structure for the service.
- Engaging partners; commissioners and providers working together to support joined up patient pathways.

Proposal

3. It is proposed to update the Health and Well-being Board at regular intervals on an exception basis to ensure the Board is kept informed

Recommendations

4. The Health and Wellbeing Board is asked to consider the issues reported

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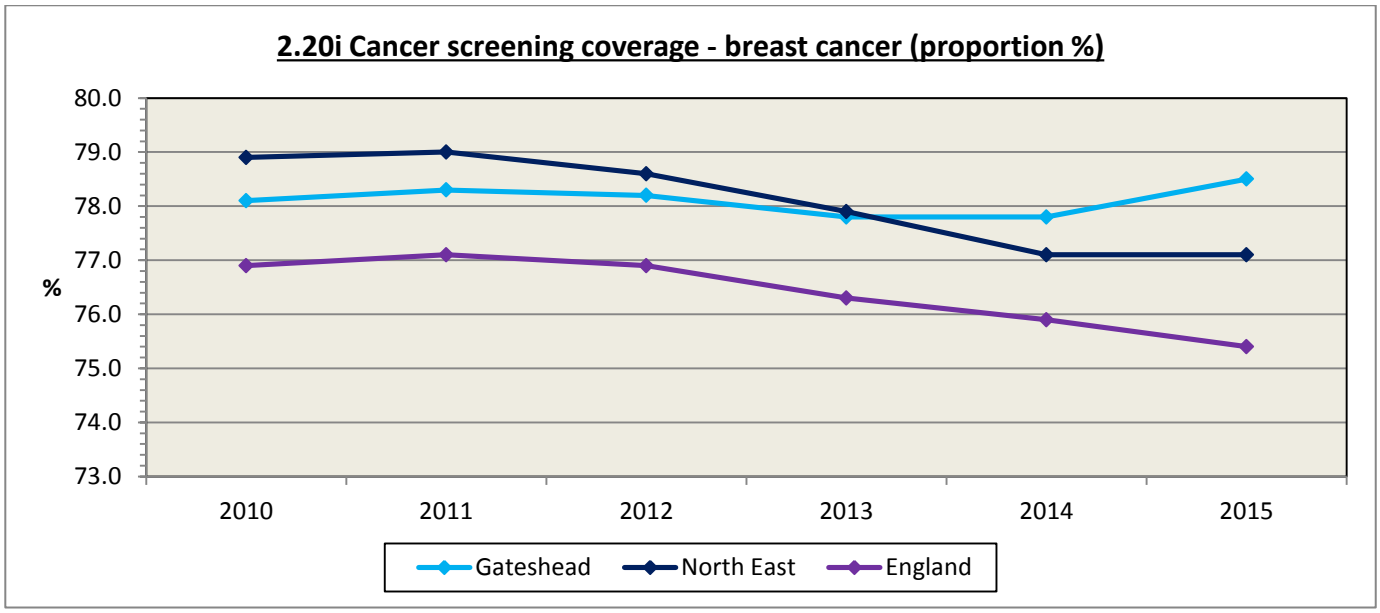
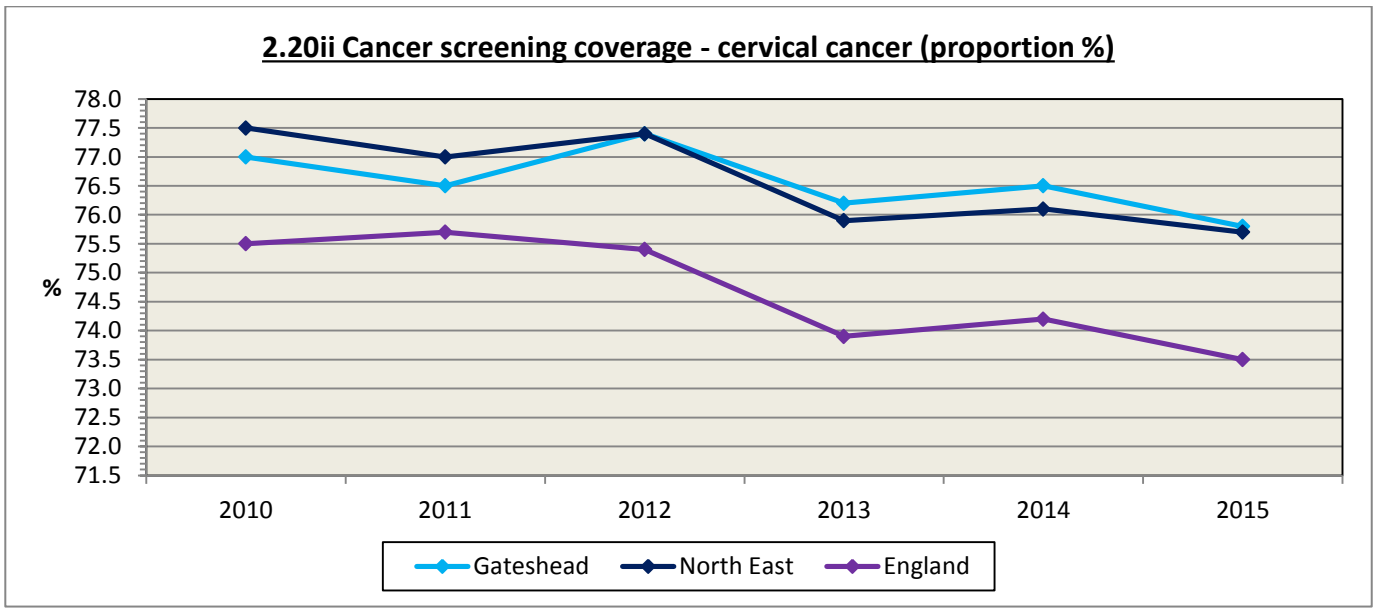
Contact: Carole Wood, Director of Public Health: 4333066


2.20i Cancer screening coverage - breast cancer (proportion %)
80.0
79.0
78.0
77.0
76.0
75.0
74.0
73.0
%
2010
2011
2012
2013
2014
2015
Gateshead
North East
England


2.20ii Cancer screening coverage - cervical cancer (proportion %)
78.0
77.5
77.0
76.5
76.0
75.5
75.0
74.5
74.0
73.5
73.0
72.5
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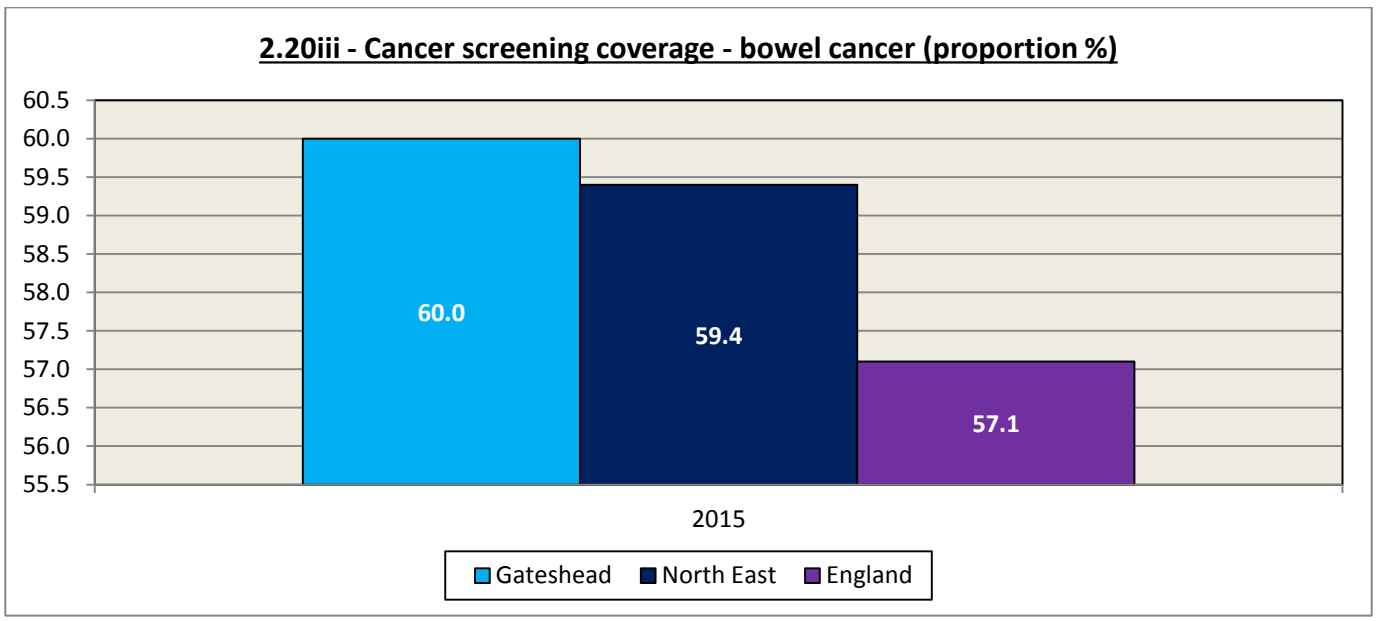
Gateshead
North East
England


2.20iii - Cancer screening coverage - bowel cancer (proportion %)
60.5
60.0
59.5
59.0
58.5
58.0
57.5
57.0
56.5
56.0
55.5
60.0
59.4
57.1
2015
Gateshead
North East
England

Gateshead Council

HEALTH AND WELLBEING BOARD
15 January 2016

TITLE OF REPORT: Impact of Housing Conditions on Promoting Health and Wellbeing

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Purpose of Report

1. In 2015 The Health and Wellbeing Board received a report relating to the impact of housing on health and wellbeing. The report provided a broad range of accommodation linked issues and included some key information on the impact of physical housing conditions. The Board subsequently requested more detailed information relating to this subject.

2. This report provides intelligence to give an in depth understanding of housing conditions and key challenges faced. It outlines current objectives and describes Gateshead's approach and the outcomes that are being achieved.

Housing provision in Gateshead

3. The make-up of housing stock in Gateshead, and the prevalence of certain 'hazards' to occupier's health and wellbeing was documented in a report produced for the Council by the Building Research Establishment (BRE) Stock Condition Projection Model for Gateshead in 2013:

	Total Dwellings	Cat 1 Hazards	Disrepair	Fuel Poverty
Owner occupied	52,885	5,314 (10%)	2,374 (4%)	11,189 (21%)
Private rented	13,109	1,464 (11%)	1,052 (8%)	3,920 (30%)
TGHC	18,999	(7%)	(7%)	(29%)
RSL	2,175			

4. The concept of 'Category 1 Hazards' were introduced by the Housing Act 2004, their existence in a property means that the standard of the property falls below the legal minimum standard for housing. Hazards that increase the risk of illness include damp, mould, and cold. Nationally cold housing is thought to be the main reason for up to 40,000 additional (excess winter) deaths reported each year between December and March. Cold homes are linked to increased risk of cardio-vascular, respiratory and rheumatoid diseases, as well as hypothermia and poor mental health. Excess winter deaths become significant for those in the 45+ age group, with a marked increase in risk for those over the age of 85. Very young children and those with a disability or long-term illnesses (households who spend longer in their home) are also disproportionately affected. It is estimated that the cost of not improving poor housing to the average SAP rating (Government measurement of energy efficiency) to the NHS is £145 million.

5. Being able to afford to keep a warm home, particularly a home that is difficult to heat, is a key factor in the health of older people and workless households. The risk of fuel poverty is higher in rural areas, whilst two-thirds of fuel poor households are owner occupiers. Fuel poverty is expected to increase as energy costs rise. The risk to health from homes that are hard to heat is considered to be much greater than those recorded by excess winter deaths, as households choose to save energy which increases the risk of accidents, poor air quality and damp.

6. Structural defects increase the risk of an accident (such as poor lighting, or lack of stair handrails); 45% of accidents occur in the home and accidents are in the top 10 causes of death for all ages. The majority of injuries to people aged 75 and older occur at home. Unintentional injury is a leading cause of death among children and young people aged 1–14, with one million visits to accident and emergency departments by children every year arising from the injuries in the home. The annual cost to the UK government from falls in those aged 60+ is £1 billion with the average cost of a single hip fracture estimated at £30,000; this is five times the average cost of a major housing adaptation and 100 times the cost of fitting hand and grab rails.

7. In 2010, the BRE calculated that poor housing cost the NHS at least £600 million per year in England, based on data from the English House Condition Survey, with the total cost to society each year estimated to be greater than £1.5 billion.

8. The private rented sector contains the highest proportion of non-decent homes. Lack of investment in homes now may result in increased costs in the future - 80% of current housing will still be in use in 2050.

Current objectives and approach

9. Gateshead's Housing Strategy has long recognised the impact of housing quality, condition and management on health and wellbeing, with a key objective being "To improve the quality, condition and management of housing so that all residents benefit from safe, healthy and well-managed homes." Investment has had a direct impact on reducing hospital admissions through the prevention of falls and excess cold. It has also reduced the fear and incidence of crime and anti-social behaviour and increased residents' satisfaction with their home and neighbourhood as a place to live.

10. The work of services across the Council and within The Gateshead Housing Company aim to tackle the following key challenges:

Improving public sector homes and estates beyond decency

11. **Council Stock**

12. Due to Government measures, including the 1% rent reduction, and the required sale of high value stock, the ongoing viability of the Council's Housing Revenue Account is at risk. Work is ongoing to help the Council understand long term needs.

12. Gateshead Council had a property stock of 19,803 @ 1 April 2015.

The age profile of the stock is:

Age Band	Total
Pre 1919	58
1919 - 1944	5,549
1945 - 1964	8,218
1965 - 1974	4,051
1975 - 1989	1,847
Post 1989	80
TOTAL	**19,803**

13. The property stock includes 25 multi-storey blocks, for which Gateshead Council does not accept applications for housing from families with children. Around 20% of the stock is classed as being of non-traditional design. Stock of non-traditional construction includes the majority of the high rise blocks, but also a wide range of other non-traditional dwellings around the borough. Some of these properties can present challenges due to their construction type, and work has previously been undertaken to eradicate issues including work to enhance thermal insulation.

14. A Decent Homes programme for all properties was completed in 2011, but ongoing investment is needed to continue to sustain decency, and to respond to issues not covered under Decent Homes. Gateshead Council delivers a capital programme of work each year, but the investment needs of the stock are high.

15. Condensation within properties is a problematic issue for some tenants. Although some measures can be carried out to reduce the likelihood or impact of condensation (such as increasing insulation of higher risk areas), it is difficult to eradicate, and does lead to reports of health issues. In recent years an increasing number of council tenants have reported difficulties in meeting fuel costs or effectively running their heating system.

16. Improving the thermal efficiency of properties continues to be a priority, but due to the nature of the stock that is in the greatest need of this type of investment, the works are complex and can be costly. This has a potential knock on effect on the Council's ability to maintain decency across the stock. A reduction in external funding through the energy markets has also impacted on the pace at which properties can be improved.

17. Registered Social Housing Providers (Housing Associations)

18. These organisations are experiencing significant uncertainty in the light of the extension of Right to Buy, 1% p/a rent reduction, and changes to Government funding models. The impact on their financial viability will inevitably affect their ability to invest in housing conditions and management initiatives that improve tenant wellbeing.

19. Providers of specialist and extra care accommodation will be undergoing financial pressures, finding it increasingly difficult to manage quality of both care and accommodation, in spite of the anticipated growth in demand.

Helping low income households maintain and improve their homes

20. There are approximately 52,000 owner-occupied homes in Gateshead. Approximately 8% (4,160) have a category one hazard, as defined by the Health and Housing Safety Rating System (HHSRS), relating to falls on stairs and around 4% (2,080) have a category one hazard relating to excess cold.

21. There are over 1,100 admissions to hospital a year due to falls among people aged 65+ (significantly higher than the rate for England).

22. There are around 90 excess winter deaths each year, most of which are considered preventable.

23. Home owners (especially older home owners) on lower incomes struggle to meet the ongoing costs of home repair and maintenance; this can have a negative effect on their ability to live independently at home for longer. There is already evidence of this amongst households who have bought their ex council or housing association home, and within areas of lower value, older stock in higher density neighbourhoods.

24. North East local authority areas suffer the greatest mismatch between the availability of reputable forms of affordable credit and those that require it. Those excluded from mainstream banking and borrowing options are often those living in the worst housing conditions. In response to this Gateshead Council has helped to create 'Helping Hand' a partnership of North East local authorities that are able to lend to elderly and financially excluded homeowners to help to carry out essential repairs. This framework remains in place but funding with which to make new loans is currently unavailable.

25. The Private Sector Housing Team currently focus activity on reducing the incidence of Category two hazards that have the biggest health impact in Gateshead:

(i) falls on stairs
(ii) excess cold

These hazards affect 9% and 5% of private sector homes respectively.

26. The Falls Prevention Scheme operated by the Private Sector Housing Team and supported by Council and Public Health funding improves homes with the highest risk of falls. This is an innovative and nationally recognised scheme.

Improving standards in the private rented sector

29. The private rented sector has seen unprecedented growth in recent years, from on average 10% of the housing stocking in 1999 to 18% today. There are approximately 12,000 private rented homes in Gateshead. These homes are concentrated in the lowest value neighborhoods, are the worst effected by disrepair, and are often the most difficult to treat in terms of measures to tackle excess cold. (BRE Stock Condition Projection Model for Gateshead 2013).

30. There has been a role change for the rented sector, with an increasing proportion of tenants being families with children. In addition, over a third of tenants were classed as vulnerable (in receipt of at least one main means tested benefit or disability benefit) in the last Gateshead stock condition survey. There are continued issues with poor property and tenancy management standards and unscrupulous property owners and agents, which disproportionately affects vulnerable households.

31. In recent years, the Private Sector Housing Team has continued to successfully engage with landlords and tenants to improve the condition and management of privately rented homes.

32. Members of the Gateshead Private Landlords Association, an independent organisation facilitated by the Council have benefited from training in relation to good property management.

33. More than 1,200 rented homes have been included within designated 'Selective Landlord Licensing' areas, with associated checks of 'fit and proper' status of landlords, and property inspections having ensured that standards have been driven up in some of the lowest demand areas of the borough, landlords have been encouraged to invest and improve close to 900 of these homes beyond the legal minimum to the Council's 'Accredited Standard'.

34. A further 900 homes have been improved to this standard outside of these areas following intervention by the Team.

35. Close to 100 'houses in multiple occupation' have been inspected and improvements to property and management standards required.

36. In spite of this proactive work, more than 1000 requests for help continue to be received each year from tenants seeking advice and help to tackle the poor standard of their home or issues with the way that their home is being managed.

37. This demand is reflected by an equally unprecedented array of new legislation relating to the control of standards within the private rented sector. New and emerging powers which the Council will have either a duty or role to enforce are extensive and cover a wide range of both physical conditions and housing management issues, which is designed to give extra protection to tenants.

38. Recent concerns about the loss of tax relief for landlords is certain to impact on the sector's ability, and willingness to invest in property conditions.

Ensuring housing supply meets local needs

29. New build

30. Market volume builders will inevitably look to build to minimum required standards, particularly where housing markets are weaker.

31. The ability of Registered Social Housing Providers to maintain previous development standards will be fettered by changes affecting their business viability.

32. Newcastle University have been commissioned by Gateshead Council to carry out a research project on changes to the National Planning Policy Framework relating to design and space standards for housing; their findings are expected in January 2016. There will be a balance to be struck between raising standards and the market's concern about the impact on viability.

Recommendation

33. The Health and Wellbeing Board are invited to consider the contents of this report and use the intelligence contained to steer and influence future considerations within this area of work.

Contact: Lisa Philliskirk (0191) 4332689

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Gateshead Council

HEALTH AND WELLBEING BOARD
15 January 2016

TITLE OF REPORT: **Achieving More Together Programme: Update and diary notification**

REPORT OF: **Carole Wood, Director of Public Health**

Purpose of the Report

1. The purpose of this report is to inform the Gateshead Health and Wellbeing Board about a programme of work to accelerate and strengthen an asset based approach in order to build stronger, more resilient and connected communities within Gateshead. Board members are asked to support and participate in an event in March 2016, at which we aim to agree a common direction for this approach and how it will be implemented in Gateshead.

Background

2. Strengthening engagement and building capacity in local communities through an asset based approach is already a well-established aspect of delivering Gateshead's Vision 2030 and the Health and Wellbeing Strategy. Gateshead has been developing this approach over a number of years. This approach values the capacity, skills, knowledge, connections across the whole community and partners, and is linked with:

    - Increasing community, individual and council resilience
    - Enabling local people to realise their full potential
    - Building stronger social connections
    - Developing a sense of pride and local identity
    - Encouraging collective/shared responsibility-working together with partners and communities
    - Understanding our assets in the widest possible sense and making the most of them
    - Increased ownership in developing solutions
    - Promoting, supporting and encouraging positive behaviour, including that which relates to health improvement and self-care.

3. The approach has come into renewed focus in the Gateshead Council Plan, which was revised in Autumn 2015. The Plan is clear that to achieve the desired outcomes over the next 5 years, this approach will require developing at a wider scale, with further acceleration and full system engagement from partners and organisations and communities across Gateshead. An early discussion with the

Gateshead Strategic Partnership took place in September 2015 and work will be ongoing to ensure full engagement with all stakeholders as the programme of work progresses.

4. The council has initiated a programme of work under the title “Achieving More Together” to progress this approach through a delivery plan to facilitate change. This work underpins the Change Programme led by the Chief Executive, and is co-ordinated by the Director of Public Health. The delivery plan is emerging and includes a number of interlinking elements that are designed to support culture shift, behavioural and service change over the life of the Council Plan. Specific work streams are in place to look at how the asset based approach can be developed, with activities underway such as: stakeholder mapping, gathering intelligence about databases and information systems linked to future options within the council’s digital strategy; inclusion in the councillor development programme, examination of new commissioning approaches, along with consideration of supporting the development of the voluntary and community sector.

5. This programme of work is especially relevant for the health and wellbeing agenda. Work in the Live Well Gateshead programme includes capacity building in local communities and mapping of assets and resources. A social prescribing programme is also under development in partnership with the Clinical Commissioning group. A new delivery model for adult social care is under development and includes a specific redesign of how people’s needs are understood and responded to. There is also a work stream looking at how the approach can be best mobilised to support objectives relating to ensuring a clean and healthy environment.

6. A number of activities are emerging on similar themes, and which are currently being lead separately from Gateshead and Newcastle. For example Gateshead Health and Wellbeing Board held a social prescribing conference in November 2015. Work is emerging from Newcastle Gateshead CCG which is linked to Newcastle Council and Health and Wellbeing Board, under the title of “Connected Communities Connected People” for which the focus is on social isolation. A workshop is being planned for Spring 2016, that intends to include Newcastle and Gateshead.

7. Discussions are being held with CCG and Newcastle Council colleagues about how we can ensure these developments are better aligned.

For noting and consideration

8. To develop and accelerate the approach requires a paradigm shift and an important starting point will be engage key people in a conversation to develop a view on the approach needed, and the intentional actions that need to be taken forward to develop citizen led approaches to building communities. In principle support for the approach and shared development event was agreed at the Gateshead Strategic Partnership meeting on 24th November, in order to foster wide engagement with the approach.

9. Gateshead Council has secured 2 days of input from Cormac Russell on 14th and 15th March 2016. Cormac is an internationally-linked expert facilitator on developing asset based ways of working. He has worked with a range of NHS and local authority partners in the UK to help them develop their collective thinking with regard to principles and approaches.

10. Planning is underway to schedule facilitated sessions by Cormac. The proposed objectives for 2 day session are:

    - To get support and engagement from councillors, lead officers and key partners for this shared approach at a strategic level- key principles, changing views, perceptions.
    - To understand our current position with building community resilience asset based ways of working noting existing work-
    - Look at examples of how this approach has been developed elsewhere eg Kirklees.
    - Identify where we want to focus/ways of working to accelerate and develop at scale across Gateshead - examples of how we can roll out existing work.
    - Unpick some of the risks, challenges and issues so we can be clear how to make this approach succeed.

11. The exact nature of the sessions is still under discussion. It is likely that several sessions will be held with different stakeholder groups. One “Master class” event for system leaders is being proposed, which would include Health and Wellbeing Board members, along with other key partners such as representatives from the Gateshead Strategic Partnership. Additional sessions with key people to develop the practical elements of implementation are also being planned.

Recommendation

12. The Health and Wellbeing Board is asked to:

    (i) Note and comment on the strategic priority being given to strengthening and accelerating asset based approaches in Gateshead through a partnership approach.
    (ii) Note the activities being planned, including the sessions with Cormac Russell on 14th & 15th March 2016 (for which prioritisation in diaries is encouraged).
    (iii) Note the scope for further collaboration with Newcastle Health and Wellbeing Board to progress this approach.

CONTACT: Carole Wood, Director of Public Health: (0191) 4333066

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Gateshead Council

Health and Wellbeing Board

15th January 2016

TITLE OF REPORT: Mental Health Employment Trailblazer Pilot - Update

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Purpose of report

1. The purpose of the report is to provide a progress update on the Mental Health and Employment Trailblazer project being led by Northumberland County Council on behalf of the North East Combined Authority (NECA).

Key issues

2. The links between mental health and employment are well established. The right employment has positive mental health impacts and poor mental health negatively impacts job prospects. Nationally, over 40% of Employment and Support Allowance claimants have mental or behavioural disorders as their primary condition and almost nearly 25% of Jobseekers Allowance (JSA) claimants also experience mental health issues. The NE Local Enterprise Partnership area has almost 45,000 claimants with a mental health condition, almost 10,000 of whom are required to seek work.

3. In July 2014, the Government announced via the Growth Deal for Local Enterprise Partnerships, the commissioning of four two-year pilots to better integrate mental health and employment support in the North East, Greater Manchester, Blackpool, and West London.

4. On completion of a credible business case, the North East Combined Authority was awarded £1.1m Transformation Challenge Award funding from DCLG with an expectation to match using European Social Fund to a total £2.2m programme. Due to delays in the European programme the programme will start later than expected.

5. The main outcomes anticipated from the trailblazer are:
    - Supporting people to compete in the open-labour market
    - Better job entry and sustainability
    - Improved clinical recovery rates
    - Benefit off-flows
    - Improved service integration

Context

6. The North East Combined Authority Area has 44,970 residents claiming Employment and Support Allowance (ESA) ESA for a mental or behavioural disorder (February 2015). 9,800 of these are in the ESA Work Related Activity Group (WRAG) and receive benefits conditional on involvement in jobsearch activity. However, this shows only those where mental health is the primary reason for the claim, and a greater number may have mental health as a secondary condition. Further, many Jobseekers Allowance (JSA) claimants are also known to have a mental health condition.

7. This is compounded by a lack of integration between employment and wellbeing interventions and with no coordination between referrals to mental health services and employment support. As a consequence, employment support programmes have performed poorly in securing job outcomes for benefit claimants with mental health conditions.

8. In 2013 the Department of Work and Pensions (DWP) and the Department of Health (DH) commissioned RAND Europe to investigate further the links between mental health and employment and to report on prospective interventions which could tackle the issue. In January 2014, RAND recommended feasibility tests of four Psychological Wellbeing and Work pilots to better support those with mental health needs into work. A number of six month pilot programmes were tested, including one in Durham and Darlington. Evaluation of the pilots (An Evaluation of the 'IPS in IAPT' Psychological Wellbeing and Work Feasibility pilot, The Work Foundation, March 2015) recommended a longer term and larger scale trial.

9. In July 2014, the Government announced in Growth Deal for Local Enterprise Partnerships the commissioning of four Mental Health Trailblazers to better integrating mental health and employment support in the NECA, Greater Manchester, Blackpool, and West London. DCLG Transformation Challenge Award (TCA) of £1.1m was approved in early 2015 and an application for European Social Fund (ESF) 50% match was submitted in May 2015. Delays in the European programme have resulted in a subsequent delay to the Trailblazers. However, TCA funds were received in August 2015 and a successful ESF decision is expected mid December to allow the programme to start in early 2016.

North East Mental Health Trailblazer

10. The North East Growth Deal included the commitment that: 'the North East LEP and partners will work with the Government to jointly design and develop a mental health and employment integration trailblazer to inform future national and local support for people with mental health conditions. The trailblazers will further test support to boost employment and clinical outcomes for people with mental health conditions, as well as testing integrated and better sequenced delivery models to better complement public services at the local level at scale'. Trailblazers will implement the Individual Placement and

Support (IPS) model, endorsed by the Centre for Mental Health. The IPS model is characterised by full integration of employment support with mental health care and treatment. It focuses on paid employment only and aims to find work for people quickly. Intensive and flexible support is at the core of the model, employment coaches will have optimum caseload sizes of 30, and jobsearch is based on the type of job, location and hours sought to suit the individual. Jobsearch begins almost immediately without stepping stones of 'work preparation' activities. The key IPS principles are:

- Competitive paid employment is the goal;
- Everyone who wants it is eligible for employment support;
- Job search consistent with individual preferences;
- Job search is rapid: beginning within one month;
- Employment specialists and clinical teams work and are located together;
- Employment specialists develop relationships with employers;
- Support is individualised
- Welfare benefits counselling

11. Employment Coaches will be co-located with and fully integrated into teams delivering Increasing Access to Psychological Therapies (IAPT) services.

12. Participants will have access to intensive and flexibly delivered tailored support from an employment coach working in co-ordination with a clinical therapist. This will include job brokerage and job matching. The Coaches will be able to link into vacancies identified through existing Employer Engagement functions within each individual local authority. Coaches will broker additional support (such as debt advice, housing etc.) where needed. Once placed in-work, the coach will continue to offer support for 26 weeks to help job sustainability.

13. The target cohort is in large part ESA claimants experiencing mental health conditions, but other benefit claimants seeking a mental health treatment will also be eligible. The only exceptions will be those engaged in mandatory DWP activities, such as Work Programme. The trailblazer is expected to engage and support 1,500 participants over two years.

Outcomes

14. The main outcomes anticipated from the trailblazer are:

- Improved job entry rates for people with mental health conditions
- Better job sustainability rates
- Benefit off-flows
- Improved clinical recovery rates (measured by IAPT GAD7 and PHQ9 assessments).

15. Service integration is a key principle of the model. The model is testing effectiveness of employment support integrated into psychological well-being services to help more of the cohort into work. Employment Coaches will be fully integrated into the teams delivering IAPT services. The model fits within the wider context of better integrating public services for residents who need a range of support from different agencies.

Evaluation

16. Government has commissioned the Behavioural Insights Team (BIT) to conduct a meta-evaluation of all four trailblazer areas. Evaluation metrics will cover out-of-work benefit off-flows, job starts and sustained job outcomes, and clinical recovery rates (measured by GAD7 / PHQ 9 scores). The evaluation will utilise a Random Control Trial (RCT) methodology, measuring impact by comparing users of the IPS service with a control group receiving IAPT 'treatment as usual'. The BIT evaluation team have regularly reported to the steering group and consulted the research and evaluation leads of Northumberland, Tyne and Wear and Tees, Tees, Esk and Wear Valley NHS Foundation Trusts.

17. Evaluation ethics protocols will ensure participants' have given their informed consented to take part. Data will be treated confidentially and anonymously. The trial protocol is registered on the ISRCTN Trial Registry as per the requirements set out by the World Health Organization (WHO) International Clinical Trials Registry Platform (ICTRP) and the International Committee of Medical Journal Editors (ICMJE) guidelines to ensure a level of scrutiny that is sufficiently high and directly relevant to the intervention. NHS ethical clearance is being sought and will be sought and an outcome is expected following the NHS ethics panel by early December.

Progress and Next Steps

18. All IAPT providers across the seven LA areas have been engaged with and are ready to support the programme by integrating employment coaches into their clinical delivery teams. The IAPT providers include:
    - Northumberland Talking Therapies
    - Newcastle Talking Therapies
    - North Tyneside Talking Therapies
    - Gateshead and South Tyneside Talking Therapies
    - Sunderland Psychological Wellbeing Service
    - Talking Changes Durham

19. DWP has been engaged at national and local levels to ensure the model is fully supported with referrals and put effective mechanisms in place for referral and monitoring. This has included consultation with Jobcentre managers and frontline Jobcentre staff to better understand the needs and issues faced by claimants. Development of the model nationally has been led by the DWP / DH Work & Health Joint Unit.

20. Performance management will be carried out in area clusters: North Tyne

(Northumberland, North Tyneside and Newcastle), South Tyne (Gateshead, South Tyneside and Sunderland) and a separate Durham group in recognition of the different DWP / CCG boundaries and ESF regional categorisation. Operational groups in each cluster will monitor performance and address any under- performance. Groups are composed of the IAPT providers, LA representatives, and DWP Jobcentre staff.

21. A multi-agency group with representatives of local authorities, CCGs, NHS Trusts and DWP will continue to provide strategic direction and scrutiny. Health and Well Being Boards will receive progress reports.

22. Northumberland County Council is acting as lead on behalf of NECA and will project manage and recruit and employ all staff. A project manager was employed in late August to complete development work and begin the implementation phase. Recruitment of Employment Coaches will commence in late January 2016; staff will undergo training and be placed with respective IAPT teams to begin the first phase of implementation by Early 2016.

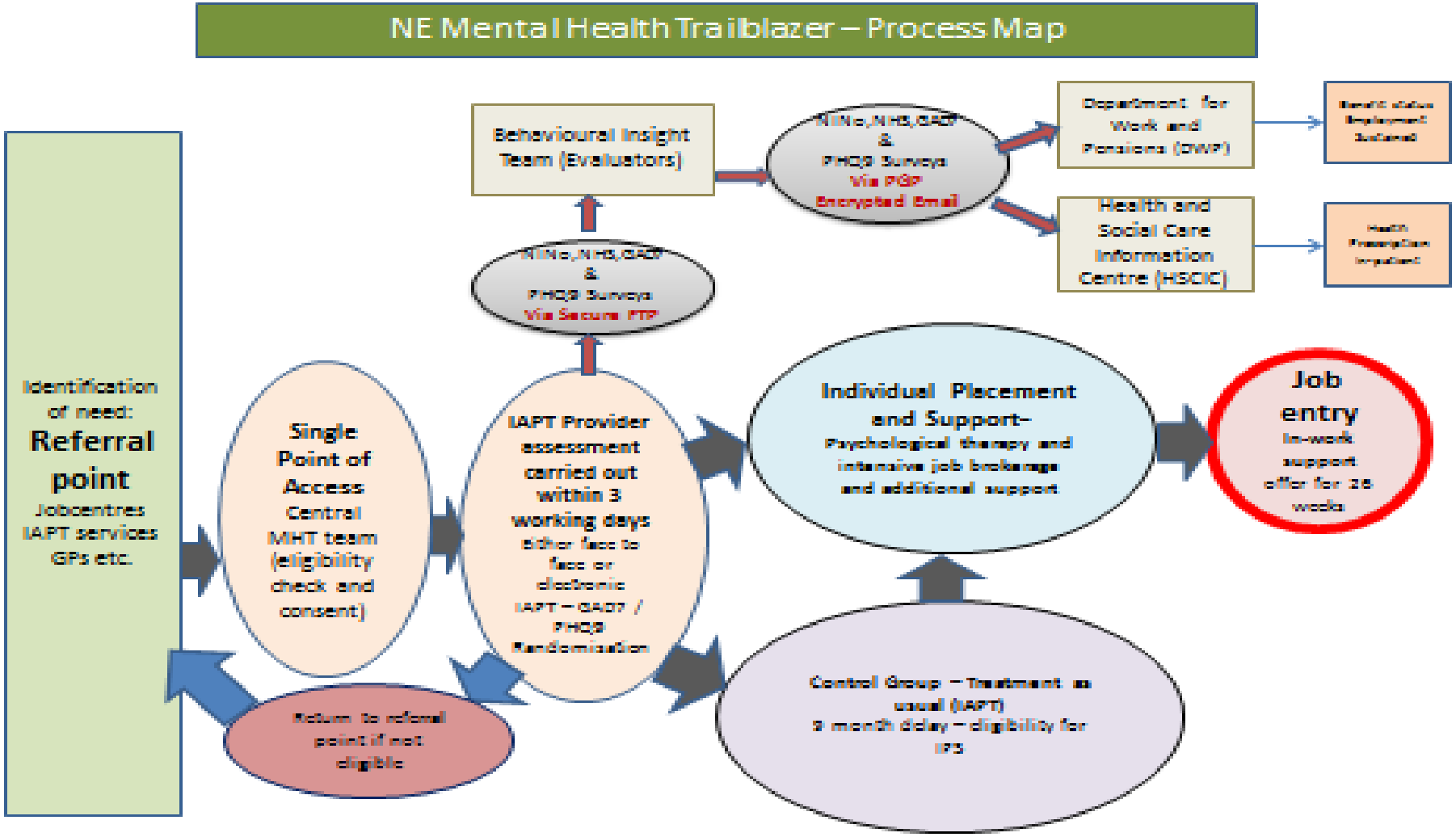
23. The 2–year pilot programme will commence from the day delivery starts.

Recommendations

24. The Health and Wellbeing Board is asked to:

    (i) consider the progress made in developing the Mental Health and Employment Trailblazer pilot and the next steps set out above.

Contact: Alan Jobling (4332057)


NE Mental Health Trailblazer – Process Map
Identification of need:
Referral point
Jobcentres
IAPT services
GPs etc.
Single Point of Access
Central MHT team (eligibility check and consent)
Return to referral point if not eligible
IAPT Provider assessment carried out within 3 working days
Either face to face or electronic
IAPT – GAD7 / PHQ9
Randomisation
NINo, NHS, GAD7 & PHQ9 Surveys
Via Secure FTP
Behavioural Insight Team (Evaluators)
NINo, NHS, GAD7 & PHQ9 Surveys
Via PGP Encrypted Email
Department for Work and Pensions (DWP)
Health and Social Care Information Centre (HSCIC)
Individual Placement and Support–
Psychological therapy and intensive job brokerage and additional support
Control Group – Treatment as usual (IAPT)
9 month delay – eligibility for IPS
Job entry
In-work support offer for 26 weeks

Gateshead Council

HEALTH AND WELLBEING BOARD
15 January 2016

TITLE OF REPORT: Performance Report for the Health & Care System

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Purpose of the Report

1. This paper provides an update on performance within health and social care to enable the Health and Wellbeing Board to gain an overview of the current system and to provide appropriate scrutiny.

Background

2. An initial Performance Report was considered by the Board on 17 July 2015. That report proposed a suite of indicators to form the basis for a Performance Management Framework for consideration by the Health and Wellbeing Board on a regular basis.

3. The report focused on metrics and did not consider other aspects such as financial performance or monitoring of action plans as these are addressed through other processes. The Health and Wellbeing Board considered the suggested indicators to be appropriate and a reporting schedule was agreed with a second report produced for the meeting on 23 October 2015.

Update

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

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

Overview of Current performance

6. Tables providing fuller details of performance are provided as appendix 1. Indicators highlighted for this report are:

Public Health

7. For most of the Public Health Strategic Indicators, Gateshead is currently considered to be significantly worse than the England averages. However, some improvements have been achieved.

8. Indicator CHW01 Reduce Mortality from Causes Considered Preventable (Rate per 100,000) did not reach the required target for 2014/15 of 230.6 per 100,000. It reduced from 239.6 per 100,000 to 234.1 per 100,000. Gateshead is still considered to be significantly worse than the England average of 182.7 but is considered similar to the North East average of 224.9 per 100,000.

9. Gateshead's rate of alcohol admissions per 100,000 for 14/15 is still currently provisional but has been revised since the previous report. Based on this provisional data Gateshead's rate of alcohol admissions per 100,000 has reduced from 956.0 per 100,000 in 13/14 to 923.5 per 100,000 in 14/15. This has still surpassed the required target of 924 per 100,000 that was set for 14/15, however Gateshead is still considered significantly worse than both the current England average of 642 per 100,000 and the North East average of 824 per 100,000.

10. Indicator CHW10a Gap in Life Expectancy at birth between each local Authority and England as a whole (Male) surpassed the required target for 14/15 of -1.9 years. It reduced from -2.0 years to -1.8 years. However, for females, the same indicator did not meet the required target for 14/15 of -1.8 years. It increased from -1.9 years to -2.0 years. NB both figures are still provisional.

11. Indicator CHW11 Reduce Excess weight in 4-5 year olds surpassed the required target for 14/15 of 24.0%. It reduced from 25.0% in 2013/14 to 22.7% in 2014/15. Gateshead is now considered to not be significantly different to the England average of 21.9%. A similar improvement has been achieved for 10 – 11 year olds which reduced from 37.2% in 2013/14 to 34.0% in 2014/15. Again, Gateshead is now considered to not be significantly different to the England average of 33.2%.

12. Indicators CHW05, CHW09a/b, F01, F12 and F13 have not changed since the previous report

Gateshead Better Care Fund Plan:

13. Challenging targets were set and performance is mixed so far.

14. Particular issues include permanent admissions of older people to residential or nursing care. Using the Better Care Fund definition, there were 224 permanent admissions during April to November 2015 - this represents 592.0 admissions per 100,000. This measure has been the subject of closer scrutiny to challenge the need for permanent admission. During the same period last year, there were 228 permanent admissions which, although an improvement, makes achievement of the year end target a risk.

15. Older people still at home 91 days after hospital discharge. This indicator has improved to 84.6% from the quarter 1 position (81.2%) and the April to August figure (83.6%)

previously reported to the Board. However, it is still below the target of 87.7%. The regional average for 2014/15 was 86.4% whilst the England average was 82.1%.

16. Non-elective admissions – current activity pressures have been the subject of a deep dive which has been shared with the provider and will form the basis of discussions going forward. Improvements are anticipated given the impact of ambulatory care activity where revised reporting arrangements are being implemented to reflect the changes in the clinical pathway.

17. For delayed transfers of care, there was a substantial increase in delays during the period April to July 2014 which made achievement of the final target challenging. This increase largely took place at hospitals out of area (Newcastle hospitals and NTW). Further work has been implemented following this to enable close monitoring of delays in this area.

18. The locally selected Patient Experience Measure which measures the patients with a long term condition (LTC) answering 'yes definitely' to the question who have had enough support from local services or organisations has shown a reduction in the recent GP survey. Particular focus is ongoing to tackle the care for people with LTCs with both physical and mental health components, with the aim of improving the score in Gateshead.

Newcastle Gateshead CCG Strategic Indicators

19. "Everyone Counts Planning for Patients 2014/15 to 2018/19" sets out the outcomes which NHS England wants to deliver for its patients.

20. These outcomes have been translated into the 7 specific measureable Outcome Ambitions (OA) by NHSE, as detailed in appendix 1 and a defined set of national indicators used to track progress against these outcomes are mapped against each ambition.

21. Progress against the national indicators is detailed in appendix 1. Key areas which are currently off track and the associated mitigating actions are as follows:
    - Securing additional years of life for the people of England with treatable mental and physical health conditions (OA1) - The priority diseases areas to close the life expectancy gap in Gateshead include Cancer, CVD, Gastrointestinal mortality and Respiratory conditions. The CCG continue to work with Public Health and the LA to embed early identification and intervention with a specific focus on those at increased risk including Health checks programmes, cancer profiles for practices and targeting work, case finding atrial fibrillation and the practice engagement plan (PEP) programmes for disease prevalence, as well as a review of the diagnostic pathways.
    - Particular focus is ongoing to tackle the care for people with LTCs with both physical and mental health components, with the aim of improving the score from the GP patient survey in this area which showed a decrease in 2013/14 (OA 2). There has been some improvement, however, not to the required amount.
    - Work continues in reducing the time people spend in hospital avoidably (OA 3) by further implementation of the Better Care Fund (BCF) programmes of work which include 11 BCF schemes.

- OA 4 is linked to the BCF work programme and national metric to support older people to live independently (see BCF section).
- On-going work pathway redesign to encourage care closer to home and promote a positive experience with care provision by our providers of community services and General Practice continues to improve OA 6
- The Healthcare Acquired Infection Partnership across Newcastle, Gateshead and Northumberland continues to closely monitor trends and to develop action plans in conjunction with commissioner and provider organisations which links to OA7.

Gateshead CCG Quality Premium 2014/15

22. The quality premium (QP) is intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reductions in inequalities in access and in health outcomes.

Gateshead CCG achieved 60% of the total allocation for 2014/15 Quality Premium.

A 25% reduction was then applied to this for non-compliance with the NEAS response times target.

Indicators which Gateshead CCG failed to achieve in 2014/15 were:

- Reducing potential years of life lost through causes considered amendable to healthcare
- Avoidable Emergency admissions

Newcastle Gateshead CCG Quality Premium 2015/16

23. The 2015/16 quality premium will be based on a set of measures that cover a combination of national and local priorities as detailed in appendix 1. Areas which are currently at risk are as follows:
    - Reducing potential years of life lost through causes considered amendable to healthcare – also OA1 as detailed above
    - Reduction in the number of people with severe mental illness who are currently smokers. This is embedded within the CCG practice engagement plan (PEP)
    - Improved antibiotic prescribing in primary and secondary care – work is ongoing with practices with Medicines Optimisation through the Prescribing Incentive Scheme.
    - Delivery of the Quality Premium indicators is linked to achievement of key NHS constitution standards. A summary of performance against a number of the key constitution standards is outlined below.

NHS Constitution

24. The NHS constitution establishes the principles and values of the NHS and sets out the rights for patients and the public including the rights patients have to access services.
    - Key constitution indicators have been outlined in appendix 1.
    - Recent pressures in echocardiography and non-obstetric ultrasound at Gateshead are now back within the 6 weeks standard at the end of November 2015.
    - Pressures have arisen at both Gateshead and Newcastle against the 4 hour waiting time standards in A&E.
    - NEAS ambulance response times are currently under target and a recovery plan is in place with the Trust.

Children's Strategic Outcome Indicators

25. Performance overall is positive with this year's figures demonstrating continued improvement in F02 Children achieving a good level of development at age 5. The educational attainment of children in Gateshead remains strong although to be noted that the data provided in this report is provisional only.

26. The rate of referrals into children's social care fell during 2014/15 in line with the regional picture; however, the current figures show an overall increase of 12% over the past 12 months to November 2015. The number of children subject to child protection plans has remained stable between the end of April (252) and the end of November (251) 2015, although it did drop as low as 217 in July 2015. At the end of November, Gateshead has seen an increase in the number of children becoming subject to a CP plan for a second or subsequent time, however, this is still below the national picture of 16.6% and that of Gateshead's statistical neighbours (15.7%). While there will always be changes in circumstances that make it appropriate for a child to become subject to a CP plan for a second or subsequent time, a low rate is an indication that CP plans are effective at providing support to families so that once ended they result in a safe stable situation for the child.

27. Since April there has been a marked increase in the number of children becoming looked after, up by 8% on the end of year position. However, the proportion of Looked After Children living continuously in the same placement continues to improve (83.9%) and is well above the England average (67%).

Adult Social Care Outcome Indicators

28. Please also see the Better Care Fund section.

29. Performance is variable. Whilst targets for service users and carers receiving self-directed support have been met, the proportion of service users receiving direct payments has improved but missed the target slightly. Gateshead at 19.5% remains below national and regional averages for service users receiving direct payments (the 2014/15 North East average was 24.1% and the England average was 26.3%). 30.3% of carers receive direct payments, significantly below the 2014/15 North East and England averages for this indicator (48.1% and 66.9% respectively).

30. Targets were achieved for the number of adults with learning disabilities living in their own home or with family. However, the target for adults with learning disabilities in paid employment has not been achieved. 36 people or 7.5% are in paid employment, identical to the same period last year. Checks of the current employment status for 55 people are underway which may increase this figure.

31. The target for the proportion of adults with secondary mental health services living independently has been not met and remains below national and regional averages. Work has been initiated to share information between Gateshead Council and NTW Mental Health Trust which should enable a more joined up approach in this area.

Recommendations

32. The Health and Wellbeing Board is asked to consider current performance and comment on any amendments required for future reports.

Contact: David Oates, Gateshead Council **Tel:** 433 3874

Appendix 1

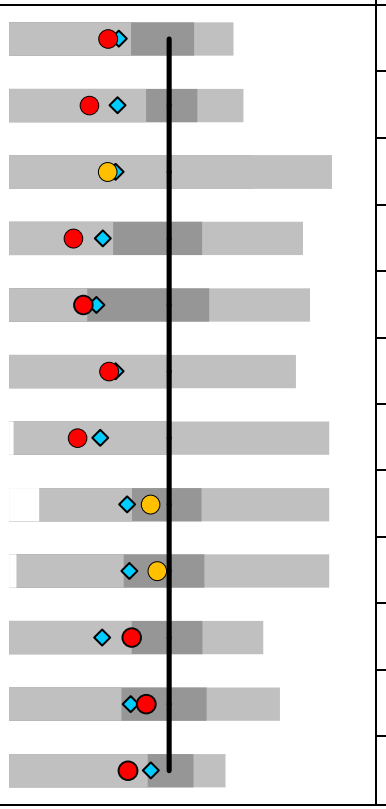
Gateshead Local Authority Public Health Strategic Indicators (Compared to England Value)

Significantly better than the England Average

Not significantly different to the England Average

Significantly worse than the England Average

North East Average

Indicator	Data Period	Count	Gateshead Value	N/E Average	England Average	England Worst	England Range	England Best
CHW01. Reduce Mortality from Causes considered preventable (per 100,000)	2012-14	1334	234.1	224.9	182.7	317.5		128.6
CHW02. Stabilise rate of Hospital Admissions, per 100,000 for Alcohol related Harm	2014/15	1809	923.5	824.0	642.0	1207.7		379.8
CHW05. Decrease the % of people who are Dissatisfied with life	2014/15	-	6.3	6.1	4.8	8.7		2.8
CHW09a. Healthy Life Expectancy at birth (Male) (Years)	2011-13	-	57.5	59.3	63.3	53.6		71.4
CHW09a. Healthy Life Expectancy at birth (Female) (Years)	2011-13	-	59.4	60.1	63.9	55.5		71.3
CHW10. Gap in life expectancy between each LA and England as a whole (Male) (Years)	2012-14	-	-1.8	-1.6	0.0	-4.8		3.8
CHW10. Gap in life expectancy between each LA and England as a whole (Female) (Years)	2012-14	-	-2.0	-1.5	0.0	-3.4		3.5
CHW11. Reduce Excess weight in 4-5 and 10-11 year olds (4-5 yo) (%)	2014/15	465	22.7	23.7	21.9	27.5		15.0
CHW11. Reduce Excess weight in 4-5 and 10-11 year olds (10-11 yo) (%)	2014/15	646	34.0	35.9	33.2	43.6		22.3
F01. Prevention of Ill Health: (% of Mothers Smoking at time of Delivery)	2014/15	344	15.1	18.0	11.4	27.2		2.1
F12. Proportion of Children in Child poverty: Reduce Child Poverty Rate (%)	2013	8195	20.5	22.20	18.0	35.5		5.9
F13. Equalities Objective: Hospital Admissions for self-harm (per 100,000) (10-24 yo)	2013/14	214	626.5	507.20	412.1	1246.6		119.1

Gateshead Better Care Fund National Metrics

Indicator	CCG / Provider / LA	Latest Data Period	Month Actual	Actual to Date	Target to Date	2015/16 Target	Risk to Year End
Permanent admissions of older people (65+) to residential and nursing care homes, per 100,000 population	Gateshead Local Authority	April – Nov 2015	-	**592.0**	817.2	817.2	**Risk**
Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Gateshead Local Authority	April – Nov 2015	-	**84.6%**	88.7%	88.7%	**Risk**
Estimated diagnosis rate for people with dementia (All Ages)	Gateshead Local Authority	2015/16 Q2	67.8%	67.8%	69.0%	69.0%	**Risk**
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) NHS and Social Care Attributed delays	Gateshead Local Authority	2015/16 Q2	264	1926	2209		**No current risk**
Non-Elective Admissions (average per month)	Gateshead Local Authority	2015/16 Q2	**6211**	**6211**	6374	25,693	**No current risk**
Patient Experience Measure: Patients with a LTC who have had enough support from local services or organisations answering yes definitely	Gateshead Local Authority	Jan - Sept 14	**43.0%**	**43.0%**	46.0%	46.0%	**Risk**

Newcastle Gateshead CCG Quality Premium 2015/16

Indicator	CCG / Provider / LA	Latest Data Period	Month Actual	Actual to Date	Target to Date	2015/16 Target	Risk to Year End
Potential years of life lost through causes considered amenable to healthcare and including addressing locally agreed priorities for decreased premature mortality	NHS Gateshead CCG	2014		2606.9		2151.3	Risk
Delayed transfers of Care - NHS attributed	NHS Newcastle Gateshead CCG	Oct-15	703	3675		Reduction compared to 2014/15	No current risk
Reduction of Severe Mental Health Illness (SMI) patients who smoke	NHS Newcastle Gateshead CCG	Nov-15	42.2%	42.2%	42.0%	42.0%	Risk
Childhood Asthma - increase in the proportion of annual reviews which result in a management plan	NHS Newcastle Gateshead CCG	Nov-15		37.2%		10%	No current risk
Young Carers	NHS Newcastle Gateshead CCG	Nov-15		279		68	No current risk
Antibiotic prescribing in Primary and Secondary Care	NHS Newcastle Gateshead CCG	Oct-15		Part A 1.233		Part A 1.2	Risk
				Part B 8.1%		Part B 11.3%	No current risk

Newcastle Gateshead CCG Strategic Indicators- Outcome Ambitions

Indicator	CCG / Provider / LA	Latest Data Period	Month Actual	Actual to Date	Target to Date	2015/16 Target	Risk to Year End
OA1: Potential years of life lost through causes considered amenable to healthcare and including addressing locally agreed priorities for decreased premature mortality	NHS Gateshead CCG	2014		2606.9		2151.3	Risk
OA2: Improving the health related quality of life for people with one or more long term conditions. Average score (in the GP patient Survey) for people with Long Term Condition.	NHS Newcastle Gateshead CCG	Jul 14 to Mar 15		0.711		0.718	Risk
OA3: Reducing avoidable emergency admissions	NHS Newcastle Gateshead CCG	Oct-15	202.4	1582.6	Reduction compared to 2014/15		
OA4: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Gateshead Local Authority	2015/16 Q2	83.6%	83.6%	88.7%	88.7%	Risk
OA5: Patient experience of hospital care	Gateshead Health	May-15		8.4 out of 10		10	Not at risk
OA6: Patient experience of GP out-of-hours services	NHS Newcastle Gateshead CCG	Jul 14 to Mar 15	66.9	66.9	67.1	67.1	Risk
OA7: Health Care Associated Infections - C.Difficile	NHS Newcastle Gateshead CCG	Nov-15	18	142	60	142	Risk
	Gateshead Health	Nov-15	4	29	15	19	Risk
	Newcastle Hospitals	Nov-15	15	64	53	77	No current risk
% people who access psychological therapies (IAPT)	NHS Newcastle Gateshead CCG	Oct-15		10.1%	8.8%	15.0%	No current risk
People accessing IAPT moving to recovery	NHS Newcastle Gateshead CCG	Oct-15	48.4%	48.4%	50.0%	50.0%	Risk

Indicator	CCG / Provider / LA	Latest Data Period	Month Actual	Actual to Date	Target to Date	2015/16 Target	Risk to Year End
Estimated diagnosis rate for people with dementia (All Ages)	Gateshead Local Authority	2015/16 Q1	68.99%	68.99%	69.0%	69.0%	Risk
Unplanned hospitalisation for chronic ambulatory care sensitive conditions	NHS Newcastle Gateshead CCG	Oct-15	75.2	611.2			Risk
Unplanned hospitalisation for asthma, diabetes and epilepsy (under 19s)	NHS Newcastle Gateshead CCG	Oct-15	22.9	211.1			Risk
Unplanned admissions for conditions not usually requiring hospital admission	NHS Newcastle Gateshead CCG	Oct-15	121.9	950.1			Risk
MRSA	NHS Newcastle Gateshead CCG	Oct-15	0	1	0	0	Risk
MRSA	Gateshead Health	Oct-15	0	0	0	0	No current risk
	Newcastle Hospitals	Oct-15	2	7	0	0	Risk
Improved reporting of medication related safety incidents	NHS Newcastle Gateshead CCG	Nov-15	57	355			No current Risk
Care Home admissions (Data no longer available from 2014/15 Q4 onwards)	Gateshead	2014/15 Q4		6454	6814		No current Risk
Flu vaccination uptake 65 years and over	NHS Gateshead CCG	Sept 15 - Nov 15	68.5%	68.5%	75.0%	75.0%	Risk
Flu vaccination uptake under 65 years at risk groups, including pregnant women	NHS Gateshead CCG	Sept 15 - Nov 15	44.3%	44.3%			Risk

NHS Constitution

Indicator	CCG / Provider / LA	Latest Data Period	Month Actual	Actual to Date	Target to Date	2015/16 Target	Risk to Year End
18 Week Referral to Treatment (Incomplete Pathways)	NHS Newcastle Gateshead CCG	Oct-15	93.7%	93.7%	92.0%	92.0%	No current risk
	Gateshead Health	Oct-15	93.0%	93.0%	92.0%	92.0%	No current risk
	Newcastle Hospitals	Oct-15	94.1%	94.1%	92.0%	92.0%	No current risk
RTT 52 weeks for treatment	NHS Newcastle Gateshead CCG	Oct-15	1	1	0	0	No current risk, reported in error to be removed via UNIFY
	Gateshead Health	Oct-15	0	0	0	0	No current risk
	Newcastle Hospitals	Oct-15	0	0	0	0	No current risk
A&E Under 4 Hour Waits	NHS Newcastle Gateshead CCG	Oct-15	95.3%	95.3%	95.0%	95.0%	No current risk
	Gateshead Health	Dec-15	94.05%		95.0%	95.0%	Risk
	Newcastle Hospitals	Nov-15	92.7%		95.0%	95.0%	Risk
Over 12 hour trolley waits	Gateshead Health	Oct-15	0	0	0	0	No current risk
	Newcastle Hospitals	Oct-15	0	0	0	0	No current risk

Indicator	CCG / Provider / LA	Latest Data Period	Month Actual	Actual to Date	Target to Date	2015/16 Target	Risk to Year End
Red Category 1 Ambulance Calls with < 8 Minute Response Time	NHS Newcastle Gateshead CCG	Nov-15	81.2%	81.2%	75.0%	75.0%	No current risk
	NEAS	Oct-15	72.5%	72.5%	75.0%	75.0%	Risk
Urgent Suspected Cancer GP Referrals seen within 2 Weeks of Referral	NHS Newcastle Gateshead CCG	Oct-15	93.7%	93.7%	93.0%	93.0%	No current risk
% > 6 weeks for the 15 diagnostics tests	NHS Newcastle Gateshead CCG	Oct-15	1.26%	1.26%	1.0%	1.0%	Risk
	Gateshead Health	Oct-15	2.12%	2.12%	1.0%	1.0%	Risk
	Newcastle Hospitals	Oct-15	0.99%	0.99%	1.0%	1.0%	No current risk

Children's Strategic Outcome Indicators

Indicator Description	Year End 2013/14	Target 2014/15	Previous year end Performance 2014/15	Performance end November 2015	Target 2015-16	Traffic Light
F02 - Readiness for school: Children achieving a good level of development at age 5 (Early Year Foundation Stage scores) – New Definition	34%	42%	57%	63.7%	59%	
F04 -Educational attainment primary (% pupils achieving level 4 in Reading, Writing and Maths at Key Stage 2) – Slight amend on definition.	80% (academic year 2012/13)	81%	80% (academic year 2013/14)	82% (academic year 2014/15)	82%	
F05 -Achievement of 5 or more A*- C grades at GCSE or equivalent including English and Maths	61.70%	63%	58.50%	57.4% (provisional)	59%	
Rate of children's services referrals per 10,000 (cumulative indicator)	602.5	587.6	436.9	326.7	450	
F08 - Number of Children with a Child Protection Plan per 10,000	68.5 per 10,000 (276 CYP)	64 per 10,000	64.2 per 10,000 (258 CYP)	62.6 per 10,000 (251 CYP)	62 per 10,000	
Children who are subject to a second or subsequent child protection plan	10.2%	Less than 15%	11.3%	15.1%	Less than 15%	
Number of looked after children per 10,000	88.6 per 10,000 (358 cyp)	Less than 85 per 10,000	84.8 per 10,000 (341cyp)	91.5 per 10,000 (367 CYP)	Less than 84.9 per 10,000	
F10 - % of Looked After Children living continuously in the same placement for 2 years	75.60%	75%	78.8%	83.9%	78%	

Adult Social Care Strategic Outcome Indicators

Indicator Description	Previous Year End 2014/15	Current Month Previous Year	Performance end November 2015	Monthly pro-rata target/ Year End target	Year End Target	Traffic Light (based on monthly target)	Trend (Compared to same period last year)
ASCOF 1C (part 1A) Proportion of Clients receiving self-directed support	82.3%	82.7%	**90.4%**	**86.0%**	86.0%	Met Target	↑
ASCOF 1C (part 1B) Carers receiving self directed support	86.3%	92.8%	**98.3%**	**90.0%**	90.0%	Met Target	↑
ASCOF 1C (part 2A) Proportion of clients receiving direct payments	19.1%	17.2%	**19.5%**	**20.0%**	20.0%	Not Met Target	↑
ASCOF 1C (part 2B) Proportion of carers receiving direct payments	12.1%	17.2%	**30.3%**	**16.0%**	16.0%	Met Target	↑
ASCOF 1F Proportion of adults with secondary mental health services in paid employment	3.8%	3.9%	**4.0%** (April – Sept 2015)	**4.0%**	4.0%	Met Target	↑

Indicator Description	Previous Year End 2014/15	Current Month Previous Year	Performance end November 2015	Monthly pro-rata target/ Year End target	Year End Target	Traffic Light (based on monthly target)	Trend (Compared to same period last year)
ASCOF 1H Proportion of adults with secondary mental health services living independently	38.6%	42.8%	**32.3%** (April – Sept 2015)	**45.0%**	45.0%	Not Met Target	↓
CP06a (ASCOF 1E) Proportion of adults with learning disabilities in paid employment	7.7%	7.5%	**7.5%**	**7.8%**	8.0%	Not Met Target	→
CP06b (ASCOF 1G) Proportion of adults with learning disabilities living in their own home or family	73.0%	43.8%	**53.6%**	**38.9%**	76.5%	Met Target	↑