Gateshead Council

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GATESHEAD HEALTH AND WELLBEING BOARD AGENDA

Friday, 19 October 2018 at 10.00 am in the Whickham Room - Civic Centre

From the Chief Executive, Sheena Ramsey

Item	Business
1	**Apologies for Absence**
2	**Minutes** (Pages 3 - 8)
2a	**Action List of Previous Meeting (Pages 9 - 10)**
3	**Declarations of Interest**
	Members of the Board to declare an interest in any particular agenda item.
	<u>Items for Discussion</u>
4	**Update on Gateshead Health & Care System Approach** (Pages 11 - 22)
5	**JSNA Update / Refresh** (Pages 23 - 40)
6	**Personal Health Budgets Update** (Pages 41 - 42)
7	**Consultation on Proposal to End the Sale of Energy Drinks to Children** (Pages 43 - 52)
	<u>Assurance Items</u>
8	**Better Care Fund Quarter 2 Return to NHS England** (Pages 53 - 56)
9	**Updates from Board Members**
10	**Any Other Business**

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GATESHEAD METROPOLITAN BOROUGH COUNCIL

HEALTH AND WELLBEING BOARD MEETING

Friday, 7 September 2018

PRESENT Councillor Lynne Caffrey (Gateshead Council) (Chair)

Councillor Paul Foy	Gateshead Council
Councillor Mary Foy	Gateshead Council
Councillor Malcolm Graham	Gateshead Council
Councillor Gary Haley	Gateshead Council
Councillor Michael McNestry	Gateshead Council
Mark Adams	Newcastle Gateshead CCG
Dr Mark Dornan	Newcastle Gateshead CCG
Alice Wiseman	Gateshead Council
Sir Paul Ennals	LSCO/SAO

N ATTENDANCE:

Michael Brown	Gateshead Healthwatch
Sir Paul Ennals	Local Safeguarding Children's Board
Lindsay Henderson	Fulfilling Lives
Tim Docking	Northumberland Tyne and Wear NHS Trust
John Costello	Gateshead Council
Dave Escott	Tyne and Wear Fire and Rescue Service
Michael Laing	Gateshead Community Partnership
Claire Reid	Gateshead Council
Kristina Robson	Gateshead Council
Councillor Hugh Kelly	Gateshead Council
Steph Downey	Gateshead Council
Alison Dunn	Gateshead Council

HW47 APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Ron Beadle, Councillor Martin Gannon, Bill Westwood, Caroline O'Neill, James Duncan, John Pratt and Sheena Ramsey.

HW48 MINUTES

It was highlighted that the apologies of Councillor Gary Haley were not noted on the previous minutes – this will be updated online.

An overview of items to be fed in to the Boards forward plan was also provided from the Action List report.

RESOLVED:

(i) The remaining minutes of the meeting held on 20 July 2018 and Action List were agreed as a correct record.

HW49 DECLARATIONS OF INTEREST

Members of the Board to declare an interest in any agenda item.

RESOLVED:
(i) There were no declarations of interest.

HW50 LGA GREEN PAPER FOR ADULT SOCIAL CARE AND WELLBEING - STEPH DOWNEY

Steph Downey attended to provide the Board with an overview of the LGA Green Paper on the future of adult social care. It was highlighted that the paper provides an excellent opportunity for a whole system response to the proposals.

It was noted from the report that the LGA will reflect on the consultation findings in a future publication to influence the Government's plans for their Green paper, budget, the NHS Plan and the Spending Review.

A presentation was delivered to the Board providing further information and detail on the Green Paper. It was noted from the presentation that adult social care has been underfunded for many years and that things cannot continue as they are. It was further highlighted that this is a nationwide debate about how to fund the care we want for adults of all ages and how social care, the NHS and other public services can work together to support and improve people's wellbeing.

It was noted that as a Health & Wellbeing Board our focus should be on three of the six areas covered by the Green Paper which are: Funding for adult social care, options for change and how changes should be paid for.

From the presentation an overview of the Council's role in improving health and wellbeing was provided in addition to a breakdown of the questions being asked of Councils from the Green Paper.

It was said that whilst the presentation provided many facts and figures the issue of funding adult social care is largely a moral issue. It was further stated that the question of funding social care should be a public decision, particularly if there is the likelihood of increased taxation. It was highlighted that the current funding model is unsustainable in light of Council budget cuts and increasing social care expenditure.

A comment was made that those who work within the adult social care sector often have little to no options for career progression and are poorly paid; it was said that this is a strain on the workforce which impacts on service delivery across the country and this needs to change.

It was noted that profiteering from social care provision needs to stop and that a progressive taxation would be needed to fund provision. It was also agreed that the voice of those working within the sector should be heard in this consultation and could be done so via trade unions.

The prevention agenda within Gateshead was highlighted noting that preventative care will reduce demand for many adult social care services. It was also noted that whilst Gateshead is trying its best there is still inequality of funding across the country for care services which is unfair.

It was said that currently, the adult social care system and the way it is funded provides a false economy. It was also stated that the prevention agenda and the funding of mental health services should be made a priority.

A comment was made that health services acknowledge the pressures on adult social care services and that the Green Paper should receive a strong response from NHS Leaders. It was also noted there is inequality in the offer of free prescriptions between those with dementia and those with cancer.

It was agreed that input into the whole system response should be received no later than 26 September 2018.

RESOLVED:

(i) The Board noted the contents of the report and presentation and agreed to coordinate a system wide response to the LGA Green Paper.

HW51 FULFILLING LIVES - LINDSAY HENDERSON

The Board received a briefing paper and presentation outlining the new Fulfilling Lives Newcastle Gateshead model introduced in April 2018.

From the presentation the Board were advised that Fulling Lives is a Big Lottery Fund Learning Programme funded for 8 years up to 2022. It was highlighted that the new model will run five streams of work:

- Direct client work: pilot new model until 2020
- Experts by Experience Network: Co Production
- Workforce Development: system wide training and skills mapping
- System Change: strategic priorities 2018-20
- Research and Evaluation

It was noted that no new referrals will be taken to the programme to prevent a ‘cliff edge’ in year 7 – it was further noted that the current caseload will remain and be worked with. It was also highlighted that the programme has just recruited a female engagement worker.

An overview of the system change strategy 2018-20 was provided. It was also noted that universal credit case studies are being collated to help improve access to benefits for those with multiple needs – this is being done in partnership with DWP.

A summary of client findings and outcomes was provided highlighting that 267 people have been worked with since 2014, of this caseload 109 are female. It was

also noted that accepted client needs at referral include homelessness, history of offending, mental health problems and substance misuse.

The Board were provided with an overview of Fulfilling Lives' responses to the Health Needs Assessment that was undertaken of people who are homeless / have multiple complex needs.

A comment was made that within Gateshead, people with multiple and complex needs should be seen as a priority group requiring a whole system response. A further comment was made noting that the report was useful with particular reference to the homeless needs assessment.

RESOLVED:

(i) The Board noted the contents of the report and presentation.

HW52 UPDATE ON INTEGRATED CARE SYSTEM / INTEGRATED CARE PARTNERSHIP - MARK ADAMS (PRESENTATION ONLY)

The Board received a presentation to provide an overview of the NHS Direction of Travel regarding an integrated care system for the North East and Cumbria.

It was noted from the presentation that there are 12 Clinical Commissioning Groups,12 unitary local authorities and 2 county councils with districts within the footprint covered by the NE and North Cumbria ICS. A breakdown of the 13 provider trusts within the ICS was also displayed noting that the North East is the biggest provider of specialised services in the country.

A series of slides were presented highlighting why an integrated care system is needed. It was noted that the North East and Cumbria work together well which is why performance within the districts is high.

From the presentation it was also noted that 'place-based' statutory decision making is important. An overview of the four integrated care partnerships was also summarised.

The Board were provided with a further overview of the re-prioritised work streams which reinforced the need to work together for the benefit of all. It was also noted that all 14 work programmes have been reviewed to determine priority areas and to distinguish between established programmes and gaps.

The NHS Funding Settlement was also highlighted noting that a 10-year plan has been developed. From the presentation an overview of Government proposals was also summarised.

A comment was made that the presentation was very informative. It was also asked whether people from other parts of the UK are travelling to the North East for care due to the high standards and performance – it was noted that there is no evidence of this although for many children's services Newcastle hospitals do serve a wider geography.

It was said that the issue of underfunding remains despite increases in demand. It was also asked what is being done to engage with the public – it was noted that there is a communications lead who has been made responsible for overseeing engagement with partners. It was further noted that an update on the communication plan will come back to a future Health & Wellbeing Board meeting.

RESOLVED:
(i) The Board noted the contents of the presentation.
(ii) The Board agreed to receive further updates at a future meeting.

HW53 HEALTH & WELLBEING STRATEGY REFRESH - ALICE WISEMAN

The Board received a report to propose an inclusive approach to refresh the Gateshead Health and Wellbeing Strategy.

It was highlighted from the report that during 2017/2018 partners of the Health & Wellbeing Board signed up to the pledge to 'make Gateshead a place where everyone thrives'. It was also noted that the Thrive pledge provides a central policy position by which decisions, across the partnership, will be considered and made.

It was noted from the report that the Council and its partners should target resources to those individuals and communities most in need. It was further highlighted that robust evaluation of reach and impact should be undertaken regularly using a Health Equity approach.

An overview of the proposed approach to refreshing the strategy was then provided, in addition to the proposed establishment of a steering group and the holding of a late Autumn conference to shape the emerging strategy content.

RESOLVED:
(i) The Board endorsed the approach and agreed to identify partners for the steering group.

HW54 LOCAL SAFEGUARDING ADULTS BOARD ANNUAL REPORT - SIR PAUL ENNALS

The Board received a report to seek views on the Safeguarding Adults Board Annual Report 2017/18 and the 2016/19 (2018 update) Strategic Plan. It was noted that the Local Safeguarding Children's Board Annual Report would be presented at a future meeting.

It was highlighted from the covering report that key areas of work in 2017/18 include the development of a performance dashboard, the development of practice guidance for adult sexual exploitation, the implementation of a community and engagement strategy, improved links with the voluntary and community sector, maintaining compliance with Deprivation of Liberty Safeguards and a revised approach for responding to statutory Safeguarding Adult Reviews. It was further noted that during

2017/18 the Safeguarding Adults Board continued to explore opportunities for working collaboratively at a regional level.

It was asked how relevant discussions at the Health & Wellbeing Board (HWB) feed in to the Safeguarding Adults Board (SAB) – it was noted that there are Board members who sit on/are represented on the SAB. It was further noted that as Sir Paul Ennals is an associate member of the HWB and as part of this role he also provides feedback to and from the respective Boards where appropriate.

It was then asked how the Safeguarding Adults Board plans to engage with partners in preparing for the next three year strategy; it was noted that this engagement activity lies with the Board members.

RESOLVED:

(i) The Board accepted the report.

(ii) The Board agreed to receive updates from the SAB at future meetings.

HW55 UPDATES FROM BOARD MEMBERS

The upcoming 'Falls Awareness Week' was highlighted – it was agreed that further information on this would be sent to Board members for information.

HW56 A.O.B

RESOLVED:

(i) There was no other business.

GATESHEAD HEALTH AND WELLBEING BOARD
ACTION LIST

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Matters Arising from HWB meeting on 7th September 2018			
LGA Green Paper on Adult Social Care	Coordinate a system wide response to the LGA Green Paper.	Steph Downey	Completed.
Update on Integrated Care System / Integrated Care Partnership	To receive further updates as required.	Mark Adams	To feed into the Board's Forward Plan.
Health & Wellbeing Strategy Refresh	To identify partners for the proposed steering group.	Alice Wiseman / All	Ongoing.
Local Safeguarding Adults Board Annual Report	To continue to receive updates from the SAB as required	Sir Paul Ennals	To feed into the Board's Forward Plan.
A.O.B.	Information on Falls Awareness Week to be circulated to Board Members.	Melvyn Mallam-Churchill	Completed.
Matters Arising from HWB meeting on 20th July 2018			
Gateshead Healthy Weight Needs Assessment	To bring back an update on progress in developing a whole system strategy in approx. 6 months' time.	Emma Gibson / Alice Wiseman	To feed into the Board's Forward Plan.
Drug Related Deaths in Gateshead	The Board agreed to receive a further update later in the year.	Gerald Tompkins / Alice Wiseman	To feed into the Board's Forward Plan.
Updates from Board Members	An update on HealthWatch Gateshead priorities to be provided at a future Board meeting.	HealthWatch Gateshead	To feed into the Board's Forward Plan.

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Matters Arising from HWB meeting on 15th June 2018			
Reflections on Gateshead Health and Care System Development Report-out	An initial report on a work plan to be presented to the Board in the Autumn.	All	On the agenda of 19th October meeting of the Board.
Matters Arising from HWB meeting on 20th April 2018			
CAMHS	Further updates to be provided to the Board on CAMHS waiting times	Catherine Richardson / Chris Piercy	To come to the 30th November meeting of the Board.
Matters Arising from HWB meeting on 1st December 2017			
Gateshead Newcastle Deciding Together, Delivering Together	Progress report to be brought to the Board.	Chris Piercy	To come to the 30th November meeting of the Board.
Matters Arising from HWB meeting on 8th September 2017			
Joint Strategic Needs Assessment Update	An update report on the JSNA to be received by the Board in September 2018. Consideration to be given to the relationship between poverty and peoples' mental health.	Alice Wiseman	On the agenda of the 19th October meeting of the Board.

HEALTH AND WELLBEING BOARD
19th October 2018

TITLE OF REPORT: **Integrating Health and Care in Gateshead**
REPORT OF: **Gateshead Health and Care System Board**

Purpose of the Report

1. The report provides an update from local system leaders on progress in taking forward the integration of health and care in Gateshead, building upon the recommendations agreed by the Board on 8th September 2017 and a 'report-out' from a week-long workshop to Board members on 20th July.

2. The report describes current thinking in taking forward a Gateshead 'place' based approach to integration and seeks the views and continued support of the Health and Wellbeing Board.

Background

3. A report was brought to the September 2017 and April 2018 Board meetings which set out the thinking of the health and care system leaders in Gateshead about the opportunities for integrating health and care services with the explicit aim of improving the health and wellbeing outcomes of Gateshead residents.

4. It was reported to the Board that there is whole system support for an integrated approach to health and care in Gateshead, shared by accountable officers, their commissioners and their providers, to meet three core objectives:

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

5. The report described a shared vision and proposals for taking this work forward which were endorsed by the Board and led to a week-long workshop in June to develop our emerging ideas further. The outcomes from the workshop were presented to Board members at a report-out session before its July meeting and a commitment was made to bring a progress update back to the Board in the Autumn.

6. This progress update:

   - takes stock of where are now as a system;
   - considers some key issues that have been identified from our recent work and how they are being addressed;
   - sets out some next steps which have been identified

A Gateshead 'Place' based approach to Health and Care that supports the 'Thrive' agenda

7. A key outcome from the June workshop was the commitment to pursue a 'primacy of place' approach in taking forward health and care integration in Gateshead. This means that, as far as possible, integrated planning (commissioning and provision) of services takes place at a Gateshead Place level with services being provided as close to peoples' homes as possible whilst ensuring quality and safe care that is responsive to peoples' needs. In short, Gateshead System designed, locally delivered, health and care.

8. It also means that we recognise the importance of local people, local politicians and local professionals being directly involved in shaping health and care services in Gateshead as well as decisions about the future of those services.

9. Our place-based approach has implications for our relationship with wider footprints/ 'collaborative areas' at Integrated Care System (ICS) level and Integrated Care Partnership (ICP) North level that include Gateshead. As a local system, we have made it clear that we see the role of the ICS/ICP as being to support our journey and local working arrangements across health and social care. This is best represented by the inverted 'pyramid' diagram at Appendix 1 where local place is placed at the top, followed by the ICP layer and then the ICS layer at sub-regional and regional levels.

10. This means that we need a clear, shared and consistent narrative on what we are seeking to achieve for the benefit of local people so that our local 'ask' from the ICP/ICS is clear. We have continued to develop this since our workshop through the various strands of work underway and through key themes, such as the link to Gateshead's Thrive agenda.

11. It is also clear that there are opportunities to address some of the key enablers to integration at a broader footprint such as workforce, IT etc. that local areas can shape further to progress their ambitions and plans (see below).

12. Finally, enabling decisions to be made as close to 'place' as possible will strengthen local democratic accountability in developing and implementing new models of care going forward. As leaders of place with a population focus, local government also has a key role in shaping an environment that creates the conditions which facilitate good health across the life-course - housing, economy, employment etc.

Integrated Planning (Commissioners and Providers Working Together replacing the Commissioner v Provider split) / Getting the most from the Gateshead £

13. A key element of our narrative is that we are determined to plan and deliver health and care differently for the people of Gateshead. The development of integrated health and care planning is complex, challenging and multi-faceted. At the same time, it provides a unique opportunity to shape, guide and bring together our health and care system in pursuit of a common set of key outcomes that are owned collectively by local health and care partners and by local people. This means a step change in our approach:

    - No purchaser provider split in Gateshead – partners are bound together in interests of the Gateshead population;
    - Outcomes focused strategic planning;

- Being prepared to make some radical changes;
- Resources are wrapped around health and care pathways rather than organisations;
- Perverse incentives are removed.
- A system designed to remove as many barriers to joint working as we can.

14. It also provides us with an opportunity to jointly address key challenges facing our local health and care economy, whilst also making the most of opportunities to do things differently through our joint working arrangements. This means:

    - We aim for all health and care to be in scope (through a phased approach);
    - Joint planning and delivery system for Gateshead;
    - Starting with planning for 2019-20.

15. We believe that by working together at a system leadership level in Gateshead, we can develop solutions which best meet the needs of the population and ensure best use of the "Gateshead public pound". NHS Partners also recognise that it is not possible to "fix" the NHS financial position, without addressing the social care financial position.

16. As part of this, we also recognise that the voluntary and community sector continues to face financial challenges and that it does not have easy access to funding to maximise its contribution to the health, care and wellbeing of local communities. In practice, many voluntary organisations operate on a mix of funding sources that include contract, grant and income generation. To gain the best from the sector in a redrawn future environment for health and social care, a similarly diverse offer of funding opportunities will need to be available.

17. A Gateshead Plan is being developed to capture the key components of our approach. It is not a strategy – it will set out the narrative/story about why we have come together as organisations and how that will shape our approach going forward. It will include:

    - how we see our relationships with each other, with local people and with broader collaborative areas;
    - a direction of travel for the medium and longer term, whilst also having a focus on what can be done now in the short term i.e. from 2019/20 onwards (see below);
    - the financial position across the system – financial pressures and our approach to savings/efficiencies proposals from a whole system perspective for 2019/20;
    - details of system demand, encompassing health and social care demand growth;
    - plans for key priority areas for 2019/20 (see below);
    - plans for transformation programmes of work (see below);
    - expected priority areas of the NHS Plan (Cancer; Cardiovascular & Respiratory; Mental health; and Learning Disability and Autism) and the Government's Green Paper on adult social care.

2019/20 Approach to Budget /Service Planning

18. There is a collective desire to see what can be done now to begin to align and jointly shape our budgetary and planning arrangements – i.e. for the 2019/20 round. This

has been the subject of discussion with Directors of Finance across our system and through the Thursday afternoon System Group.

19. This means reviewing our planning / budget cycles and processes to align with a joint system approach to be agreed (e.g. currently, health and social care are on different timeline schedules, with NHS partners required to adhere to central planning guidance requirements). It also means looking at how health and care system partners can input, in practical terms, to each other's budget planning arrangements so that there is a better understanding as a system of our collective pressures and proposals to address them/mitigate their impact etc.

System-level finance:

20. Both the CCG and Council have shared medium-term financial projections and the next step will be to confirm available resources to meet health and care needs for 2019/20. This is currently being worked through. Consideration will also be given to the scope for resources to be moved between organisations to mitigate pressures across the health and care system for the benefit of local people in 2019/20.

21. It is also proposed that organisations share potential savings/efficiencies plans as they are being developed so that there is an opportunity to consider system wide impacts.

System demand:

22. The Council's medium term financial strategy sets out details of social care demand growth over the medium term. Health partners are working together to provide a similar, corresponding picture for health care over the medium term which can then be shared and discussed from a whole system perspective, informed by Gateshead's Joint Strategic Needs Assessment.

System Priority Areas 2019/20:

23. Discussions to-date have identified three priority areas to be considered as part of our system planning arrangements for 2019/20:

    - Children and young people's mental health and wellbeing
    - Frailty
    - People with multiple, complex needs

24. There are existing working arrangements in place for each of these areas and lead officers have been tasked to set out a system view on what needs to be done/ what can be done in 2019/20. This will cover how an integrated system approach can be progressed, as well as linkages to the system 'Outcomes Wheel' (see appendix 2). The outcomes from this work will then feed into the Gateshead Plan that is being developed.

System Behaviours:

25. Discussions have identified the need for a better way of having conversations regarding the contracting round – contracts/volumes etc. As a first step, arrangements are being made to get appropriate people together to have a conversation on an approach to contracting for 2019/20, including associated behaviours. This work stems from key principles identified during the workshop

week around behaviours needed to support our new ways of working. They included:

- Ensuring that the behaviors of all staff align to our system values
- Working together based on trust with a focus on what is best for local people
- Planning health and care together
- Delivering health and care together
- Moving away from a transactional approach to contracting
- Joint problem solving
- No blame approach
- Working together to improve services, mitigate our risks and reduce our costs
- Using our money and people wisely and well
- Breaking down barriers between health and care
- Keeping the momentum going

10 Transformation Areas

26. During the Gateshead System workshop week, it was agreed to oversee a number of transformation programmes. The rationale for doing this was:

    - To share our transformation capacity, especially people;
    - To align our current and future transformation activity to our joint planning arrangements;
    - To avoid duplication and unintended consequences
    - To reduce meetings covering the same activities
    - To provide direction in working to deliver the outcomes framework
    - To resolve any barriers/issues to taking work forward
    - To reduce the 'burden' of 'over consultation' on patients and carers
    - To mitigate our financial challenges, manage demand and enhance service quality and safety.

27. We were clear that:

    - We wanted to act together to mitigate our financial challenges;
    - We would concentrate on high value, system wide transformation activity;
    - It is important to link transformation activity, finance and service planning.

28. To ensure our work programme is manageable and our oversight effective, we have made the distinction between:

    i. Transformation programmes which aim to change services across the system and have implications for more than one partner;
    ii. Bi-lateral discussions between partners;
    iii. Service developments which are predominantly about improving the internal operations of one partner;
    iv. Operational and transactional matters which highlight individual cases or minor changes.

29. The following transformation programmes have been identified and have now been included as part of the Group's work programme:

    - Deciding Together, Delivering Together

- Children and Young Peoples' emotional health and wellbeing
- Frequent attenders
- Residents with multiple and complex needs
- Community Services
- Falls
- Frailty
- End of Life Care
- Intermediate Care
- Community Model for Learning Disabilities

30. Work is also underway to scope other potential opportunities for 2019/20 by getting the right people together across the system including CCG clinical leads, provider organisation staff etc.

31. The leads for the transformation areas have been asked to consider the following questions:

    - What can be done differently to join up our approach across the system for the benefit of local patients/ service users?
    - Is there anything that can be done to differently to reduce cost within the system in the short and longer term?
    - Is Gateshead an outlier currently and, if so, what can/is being done to address this?

Moving the lens from an organisational focus to a system focus – reporting on quality, performance, finance/planning

32. It has been recognised that there needs to be a greater focus on reviewing quality/ performance/ finance/ planning at a system level i.e. moving the lens from a focus on individual organisations to a focus on the system as a whole. Work is underway to identify where most value can be gained from this approach and how this can be put in place.

A Relationship based on Trust - MoU

33. A memorandum of understanding is being developed to capture our new working relationships, building upon the existing memorandum of agreement in place for Gateshead Care Partnership. The draft MoU will describe the arrangements around which we will work together for the benefit of local people, within available resources. Key components include:

    - An extended partnership membership, reflecting a whole system approach;
    - An MoU based on trust – not a non-legally binding document;
    - A statement of commitment from partnership members – to play a significant, active and ongoing contribution to enhancing the health, care and wellbeing of local people in a way that is locally sustainable;
    - It does not replace the legal frameworks or responsibilities of our organisations;
    - Nothing in the MoU will prevent organisations from meeting their statutory responsibilities;
    - Decision making would be based upon a consensus approach, with a voting arrangement in place as a backstop measure only.

Role of Voluntary and Community Sector (VCS)

34. The contribution of the VCS (small, medium and large sized voluntary and community organisations) is recognised by the local system, of which they are a key part, whether or not they provide contracted health and care services. The presence of VCS organisations within local communities, the trust they earn by being rooted in and for the community and the opportunities they provide for social activity creates the conditions for wellbeing that are important in ensuring people receive the care they need. In this way, they are well placed to be an agent of positive change within a Gateshead place based health and care system.

35. The voluntary and community sector provides a means to link with and involve older people, BAME communities, people with physical or learning disabilities, people with drug and alcohol problems, with mental health issues and individuals or families trying to manage on low or no incomes.

36. It is also recognised that although the voluntary and community sector can bring much in the way of provision that can indirectly support health and care services, there are also established voluntary and community organisations that do deliver contracted health and care services. Locality based VCS delivery partnerships/ consortia, such as Blue Stone Consortium, can be a useful way for VCS organisations to engage with and deliver contracts to support health and care in Gateshead. The consortium is represented at the weekly Gateshead system meetings.

37. HealthWatch Gateshead has a particular role to play as the independent champion for people using health and social care services in Gateshead. As well as helping people to find out about services and listening to what people think of services, HealthWatch Gateshead has a key role to play in helping system partners to understand what people want to meet their health and care needs and how this can be done in a way that is sustainable for the local system as a whole.

38. We recognise, however, that we need a better understanding across the local system of how the VCS, and the significant potential it represents, can best shape and contribute to future place-based work for the benefit of local people.

Enablers – in particular, Workforce and IT

39. There are a number of important enablers to health and care integration and prominent amongst these include our workforce and information technology.

Workforce

40. It is widely recognised that there is a pressing need to address health and care workforce challenges and that this needs to be a system wide solution between social care and health, given the interface between both the clients/patients who use services and the people who work in delivering social and health care in the public sector, the voluntary sector and the independent care sector.

41. Recruitment and retention of a comprehensive social care work force, paid a fair wage for the work they do has to be a high priority. There is an urgent need to address the negativity and "stigma" associated with a job within the care sector. There are also particular challenges relating to attracting and retaining NHS staff within the north east which is impacting upon GP primary care, nursing and

secondary care. More broadly, there is a need to address the likely impact of Brexit, given the number of people from outside the UK who work in this field.

42. As many of the challenges we are facing are similar to those experienced across the north east, there are opportunities to address some of these issues across a broader footprint (regional level). At a Gateshead place level, the need to develop an integrated People Strategy has been identified which will look to ensure that the approach being taken in Gateshead builds upon and adds value to the work taking place at a NE level.

Information Technology (IT)

43. There is already a significant piece of work taking place at a regional level through the development of the Great North Care Record - a new way of sharing medical information across the North East and North Cumbria by health and social care practitioners. It means that it will be possible to share key information about peoples' health such as diagnoses, medications, details of hospitals admissions and treatments between different healthcare services including hospitals, out of hours and ambulance services. The programme is a collaborative piece of work including local NHS, social care, academia, local charities and third sector providers.

44. There is also scope for local integrated data sets using population segmentation to support predictive care planning at different levels e.g. borough level, practice level and individual patient level, linked to clinical and financial data. This can help to target patients and service users through a system wide approach. As we develop our IT systems locally, we will need to make the most of these emerging opportunities.

Communications & Engagement

45. It is essential that decisions on local health and care services are not only understood by local people but have their active involvement. This means:

- Public engagement - telling our story and enabling people to shape our future direction;
- Understanding peoples' needs and how we can work together to address them;
- Testing out with people and evolving proposals in the light of their input;
- Gateshead people being able to relate to a single health and care system that seeks to meet their needs within available resources and in a way that is consistent with the Thrive agenda.

46. There is also a need to communicate and engage with our staff in taking forward different strands of work. A key part of the transformation programmes outlined in this report, for instance, is the engagement and involvement of clinicians and staff.

National Consultations

47. We have also taken the opportunity individually and collectively through national consultations to make the case for local place-based approaches to health and care and to put forward the thinking that underpins our approach in Gateshead e.g. the LGA Green Paper on Adult Social Care; developing the long-term plan for the NHS etc. Consideration is currently being given to the national consultation on an Integrated Care Provider Contract.

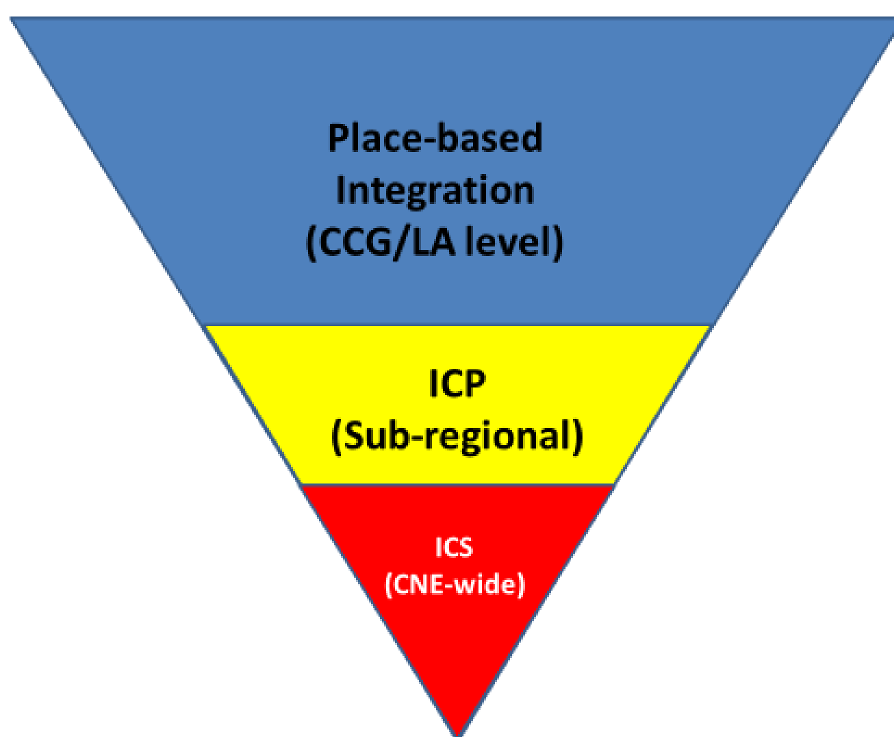
Recommendations

48. The Board is asked to:

    (i) Consider the progress update set out in this report and the issues which have been identified;
    (ii) Receive further update reports as required.

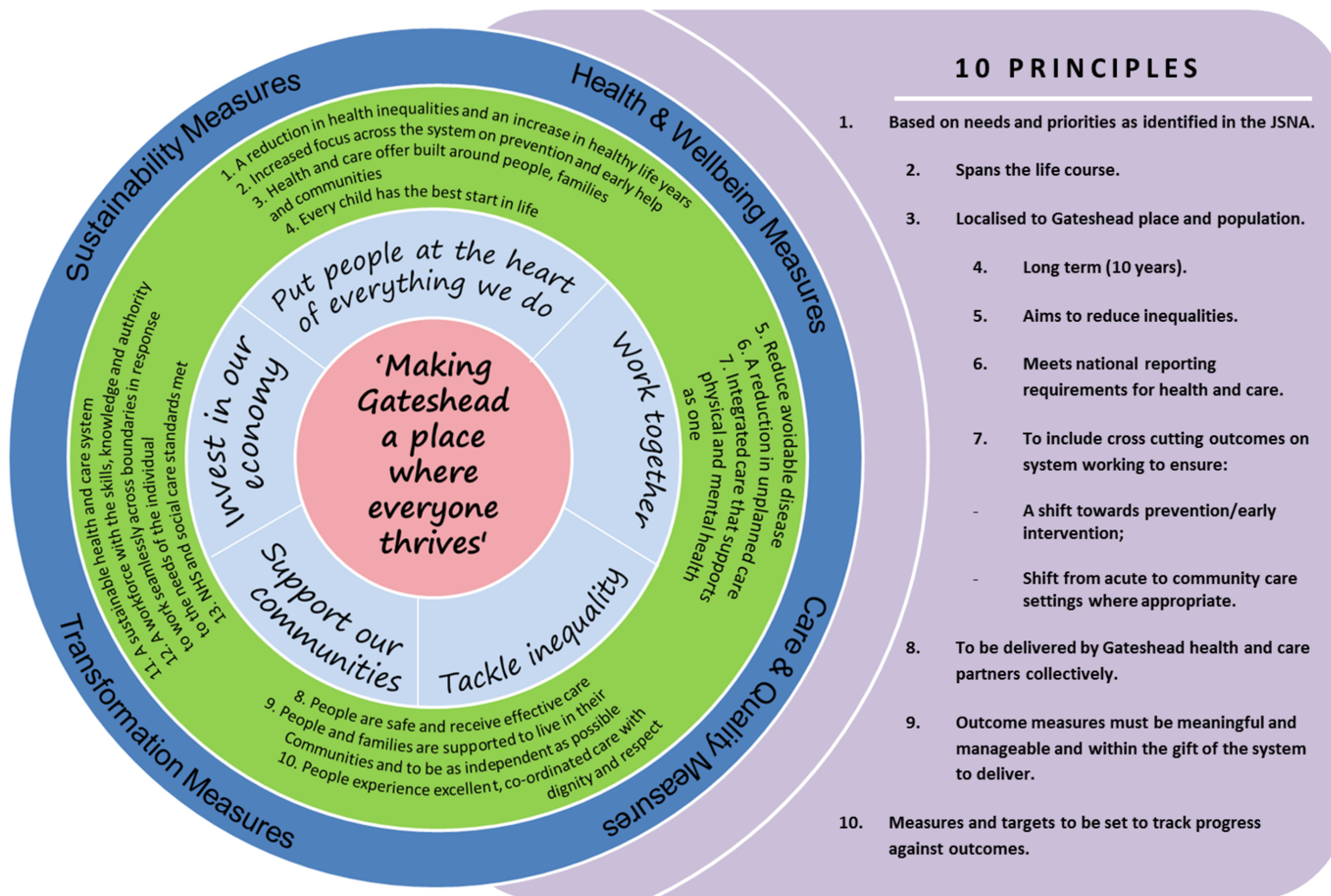
Contact: John Costello (0191) 4332065 and Gateshead Health and Care System Representatives

Gateshead 'Primacy of Place' based approach to health and care integration



Appendix 2

GATESHEAD CARE PARTNERSHIP FRAMEWORK FOR BETTER OUTCOMES



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HEALTH AND WELLBEING BOARD
October 2018

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

Purpose of the Report

1. To update Gateshead's Health and Wellbeing Board (HWB) on progress made against ongoing action areas and "Next Steps" identified in the Gateshead Joint Strategic Needs Assessment (JSNA) paper to the HWB on 08 September 2017. This includes areas identified by Board members.

2. The paper also seeks the views of the Board on priority areas identified in Appendix 1, outlining the evidence base and rationale for prioritisation for the coming year.

Background

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

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

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

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

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

Progress made against areas of action discussed in the Gateshead Joint Strategic Needs Assessment (JSNA) paper to the HWB in September 2017

Area of Action 1 - Develop a film on 'How to use the JSNA'

7. At the beginning of 2018 the information contained within the JSNA website was successfully transferred to the Council's new digital platform. On this new platform, the JSNA was given its own web address (www.gatesheadjsna.org.uk). In addition to moving the information across, the website design was refreshed and new features added. These include an improved search function available on every page, 'date last updated' markers, a 'Contact us' form, and the introduction of a permanent menu containing the six sections (Why is it important, What the data tells us, Groups most at risk, What are we doing and why, What would success look like, and Challenges – as well as Case Studies where appropriate) down the right hand side of each thematic page to make navigation easier.

Gateshead JSNA
Contact us
Find...
GATESHEAD JSNA
Watch our introductory VIDEO to find out more about Gateshead's Joint Strategic Needs Assessment (JSNA)
See More
Priorities: Best start in life
Priorities: Living well for longer
Priorities: Ageing well
Population and deprivation
Behaviour and lifestyle
Illness and death
Communities of interest
Economy, transport, housing, environment, crime and poverty
Ward profiles and maps
Further information
Key strategies
Other needs assessments
Online data tools
Health inequalities

8. A film to promote the Gateshead JSNA has been produced involving Dr Mark Dornan, GP and Alice Wiseman, Director of Public Health. The film can be found on the home page of the JSNA website at https://www.gatesheadjsna.org.uk/article/5102/Gateshead-JSNA This film not only promotes the JSNA but also takes visitors through the key areas of the site, identifying key health issues for Gateshead and what is being done to improve health for our residents.

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

9. The Gateshead JSNA now has a Poverty section which includes data and information on local action in relation to Child Poverty and Fuel Poverty and will also include a section on Welfare Reform and Austerity. At this present time there is Headline data, and the six sections as agreed by the HWB will be added in the coming year.

10. Since the Health and Wellbeing Board in September 2017 the Gateshead Poverty Board has been formed. This is in response to the identified needs of key groups of people in Gateshead, including those who are being moved over to Universal Credit, who are bearing the impact of an economic downturn and the government's austerity agenda. The Researcher in Residence, based in the Public Health Team, is currently undertaking research to understanding the impact of the roll out of Universal Credit in Gateshead. The research report will be available in November 2018. Emerging findings include:

    Debt
    Increased arrears / increased risk of sanctions / increased hardship / debt / fuel poverty / risk of eviction / destitution / homelessness. Impact on relationship with landlord / landlady. Serious hardship / Borrowing causes further problems / Reliance on family / friends / food insecurity.

    Adverse effects were reported for the following groups in particular: Disabled people, those with mental health issues, long-term or complex health conditions, people with learning disabilities, hearing impairments or communication issues, dementia, people with literacy issues, refugees and asylum seekers, people with cognitive impairments or memory issues, prisoners, ex-offenders and homeless people, families with children and lone parents or people who need interpreters / help to navigate the system.

    The information will also help populate the section on Welfare Reform and Austerity as mentioned above.

11. Also, since September 2017, we have seen the publication of the Gateshead Directors of Public Health Annual Report 2017 “Inequalities; It never rains but it pours”, a major conference “Thriving for All - Tackling Poverty in Gateshead” and more recently a themed network discussion on “Tackling Poverty in Gateshead - Child Poverty”. All identifying the inequalities faced by people in the Borough and all looking at solutions to helping every person in Gateshead Thrive.

12. On the back of the research carried out in partnership with Northumbria University and the positive findings of the value of benefits advice, Citizens Advice Gateshead continue to offer packages of support for benefits claims and Universal Credit, both at their base on Swan St, Gateshead and at Gateshead Civic Centre.

13. Our Gateshead provides information on a range of support structures for people in need, for example Food Cooperatives, and the JSNA has links to and from the site.

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

14. Members from key organisations / people working in the Refugee and Asylum Seeker (RAS) community have worked together to develop the section on the JSNA. The Expert Authors were keen to ensure that this captured the members' Collective Voice on distinct health challenges facing RAS and the views of the Health & Wellbeing Working Group has been included in one of the six key areas. There was not always published research relating to the points they made but, just like the case studies included elsewhere in the JSNA, this 'qualitative research' brings a real-life example of need. This area of work is in the process of being uploaded to the site.

Area of Action 4 - Get agreement, and plan, a Members seminar on the JSNA.

15. A member's seminar– "What the JSNA says about my Ward" was held on Wednesday 4 October 2017 at 2.00 pm. The focus was on using the JSNA to identify key health issues in members' wards. Councillors attended with their iPads and there was an interactive session which helped to look at the value of the JSNA, including Ward profiles.

Area of Action 5 - Explore Physical Disability and Sensory Impairment (PDSI) issues.

16. A Health Needs Assessment (HNA) of adults with Physical Disabilities and Sensory Impairments (PDSI) was conducted over the past 12 months by a member of the Gateshead Public Health team. This has been fed into the Gateshead PDSI group and is being utilised by the group to help identify priority actions and direction on developing a work programme into the future. Although the work was completed there were issues with attaining data from North East Commissioning Support (NECS) and following circulation of the draft action plan, members of the Eye Health Network and Northumberland Tyne and Wear Local Optical Committee have come forward with further suggestions for inclusion.

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

17. There have been a number of areas taken forward to incorporate local intelligence in the JSNA about how community assets are helping to support local health and wellbeing needs. This has been achieved through links to Our Gateshead from the relevant sections of the JSNA. For example the smoking section contains a logo which takes you to a link to groups and support for smoking cessation https://www.ourgateshead.org/stopsmoking

18. The JSNA Steering Group organised a workshop for their members with an analyst from Public Health England (PHE) North East titled “Putting the A in the JSNA”. This looked at a new PHE Fingertips site on a Health Assets profile” https://fingertips.phe.org.uk/profile/comm-assets/data#page/0 and identifying factors which are an asset to an area rather than deficits as usually identified in profiles. Discussions are still taking place on how best to incorporate this into the Gateshead JSNA.

19. The example of the Refugee and Asylum-seeking community linking with the expert authors is another recent example of community assets supporting the JSNA as is some potential work in development with Mental Health commissioners and supported housing providers for people with mental health issues.

Area of Action 7 - To review and update the 'expert authors' list and to continue to engage 'expert authors' in developing and reviewing the content of the JSNA and to secure the outstanding updates required.

20. Work has been ongoing in securing support from a range of partner organisations in the development of the sections of the JSNA with nominations and agreement coming forward for “Expert Authors”. Identification of Expert Authors has been completed although work has still to be initiated for the following sections: Illicit Drug use, Children Protection and Looked After Children and Teenage Parents, Air Quality, Climate Change, Food Safety and Heatwaves. The last four of these being latest additions to the site. Members of the JSNA Steering group are in conversations with the necessary authors.

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

Next steps

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

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

24. The next steps for the Steering Group will be:

- Continue to engage 'expert authors' in developing and reviewing the content of the JSNA;
- To add more examples of the 'lived experience' of local people in the form of case studies to bring additional richness to the JSNA;
- Continue to integrate intelligence on Gateshead's assets into the JSNA and engage public involvement as outlined above.

Recommendations

25. It is recommended that the HWB Board:

- Note the progress on the continuing development of the JSNA;
- Note and support the planned next steps in developing the JSNA;
- Agree to retain the existing strategic priorities for October 2018 onwards with the addition of Air Quality;
- Receive an update report in September 2019.

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

Evidence and rationale for prioritisation
(Source: Gateshead JSNA website as at September 2018 unless otherwise stated)

A. Best Start in Life

Education and skills

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

2. Levels of early years development is improving, with 69.9% of children achieving a good level of development at age five, this is just below the national average of 70.7%.

3. Educational inequality starts early. For children who receive free school meals, 56.4% achieved a good level of development, which is just above the national average of 56%. Nationally there is a gap of around 9% achieving a good level of development at the end of reception between the richest and poorest areas (based on IMD 2015 deprivation).

4. Although young people in Gateshead are slightly below the national average when entering primary school, the progress they make throughout the school system, both primary and secondary, means that they catch up and slightly outperform the national average when they leave school. This is demonstrated by the fact that 40.1% of of pupils achieved grade 5 or above in English and Maths GCSEs (similar to a high grade C or low grade B in the old grading), compared with the national average based upon all schools of 39.6%.

5. In Gateshead, the Attainment 8 score was 46.8, above the national average of 44.6.

6. In the ‘Progress 8’ measure for Year 11 pupils (aged 15/16) a score of 1.0 means pupils make on average a grade more progress than the national average; a score of -0.5 means they make on average half a grade less progress than the national average. In Gateshead, disadvantaged pupils had a -0.74 progress 8 score, which is significantly lower than the score for all other pupils of 0.09.

7. In the last few years the number of children with a statement of Special Educational Needs (SEN)/ Educational Health & Care (EHC) Plan has increased and was 965 in 2018. This represents 3.2% of all pupils, which is slightly higher than the national and regional averages (2.9% and 3.1% respectively).

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

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

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

10. Gateshead adults are performing just below the national average for attainment of level 2 qualifications and above (72.1% v 74.7%). However, only 49.8% of Gateshead adults attained level 3 qualifications and above compared to 57.2% nationally and 29.5% attained level 4 and above compared with 38.6% nationally[2].

11. The local economy is continuing to undergo a number of challenges, one being unemployment in young people. Post 16 learning and training is an important stepping stone into the world of work. We need to ensure that the skills developed, the choices made, and the pathways followed are realistic and effective at preparing young people for an increasingly competitive jobs market. The number of young people completing apprenticeships has been fairly stable over recent years - in 2015/16 there were 1,390 apprenticeship completions in Gateshead.

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

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

Emotional Health and Wellbeing

14. Giving every child the best start in life is crucial to reducing health inequalities across the life course. Research shows that emotional wellbeing in childhood and young adulthood is one of the most important factors in predicting whether an individual will be socially mobile and experience good mental health in later life.

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

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[2] Adult Skills, Annual Population Survey, ONS Jan 2016 – Dec 2016 (NOMIS website)
[3] Meltzer, H et al (2000) The Mental Health of Children and Adolescents in Great Britain

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

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

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

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

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

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

21. In 2016/17 there were 147 young people aged 10-24 admitted to hospital for self-harm. As a rate per 100,000 (DSR) this was 422.7, similar to the England average of 404.6. In previous years Gateshead has been consistently higher than the England average.

Starting and staying healthy and safe

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

23. Lifestyle choices at an early age are a good predictor of lifestyle choices later in life. It is very important that young children are encouraged and supported to lead active lifestyles, built into their daily lives, and that this continues across the life course.

[4] Gateshead School Health and Wellbeing Survey 2016/17
[5] http://www.1001criticaldays.co.uk/buildinggreatbritonsreport.pdfc

Gateshead continues to face challenges around obesity, healthy eating, low physical activity, sexual health and risky behaviour in some young people. The needs of our most vulnerable children and young people warrant particular attention.

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

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

B. Living Well for Longer

Economic Factors

26. The UK is experiencing radical welfare reform amid a period of slow recovery from recession and continued austerity. This includes the introduction of 100% digital universal credit claims together with changes to housing benefit payments i.e. direct payment to the claimant rather than to the landlord. There are concerns about the impact this may be having on the physical and mental health of vulnerable people.

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

28. The most recent data on local levels of child poverty available is from 2015, when there were 7,720 or 19.4% of children in Gateshead in poverty, significantly higher than the England average of 16.6%. The North East average was 21.5%. There is a concern that increases in zero hours and part time contracts is having a negative impact on Gateshead families (this is often referred to as 'in work poor'). The Income Deprivation Affecting Children Index (IDACI) ranks Gateshead as 78th out of 326 local authorities in England. 28% (9,991) of dependent children aged 0-15 live within one of the 20% most deprived areas in England in terms of IDACI.

29. Economic wellbeing is the priority need for a large number of people in Gateshead, there is a strong association between wealth and health. People on low incomes are more likely to experience poor health compared to those on higher incomes, and research shows that a range of conditions have a strong relationship with deprivation, including: chronic respiratory disease, and alcohol related conditions, diabetes, heart disease and mental illness.[6] The reasons for these relationships are

[6] Health inequalities and determinants in the physical urban environment: Evidence briefing. Marcus Grant, Caroline Bird and Penny Marno, March 2012.

complex and linked to wider societal issues such as employment type and status, housing, transport, education, and access to health services.

30. There are currently 4,910 people aged 16+ claiming Jobseekers Allowance or Universal Credit, which represents 3.8% of the population, compared with 2.2% nationally, as at July 2018 (ONS Experimental Data). However, as at November 2016 there were a further 10,070 residents claiming Employment Support Allowance or Incapacity Benefit, with another 1,170 claiming Disability benefits and 2,960 carers claiming an out of work benefit.

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

Mental Health and wellbeing

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

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

34. Around 9% of people in the NewcastleGateshead CCG area had a diagnosis of depression in 2016/17. This figure continues to rise in line with the national trend. In Gateshead it was estimated that there were 22,447 people with a generalised anxiety disorder or mixed depression and anxiety disorder in 2012, a figure which is also likely to have increased.

35. The NewcastleGateshead CCG area continues to have a higher rate of antidepressant prescribing compared with the England average.

[7] Royal College of Psychiatrists (2010) No Health without public mental health: The case for action.
[8] Department of Health (2011) No health without mental health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages.

36. The rate of admissions for self-harm is reducing in Gateshead but remains significantly higher than the England average.

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

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

Tobacco Control and Smoking

39. It is estimated that 16.5% of Gateshead's adult population smoke. This increases to 24.5% for those adults in routine and manual occupations. There is a general downward trend in smoking prevalence, in line with the national trend.

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

41. Smoking is estimated to cost the NHS in England £2.7 billion a year and £13.7 billion in wider costs to society through sickness, absenteeism, the cost to the economy, social care, environmental pollution and smoking-related fires.[9] This burden impacts on every GP surgery and hospital, every local authority and every family whether they smoke or not. In Gateshead, the smoking attributable hospital admissions rate is 2,746 per 100,000 compared to the national rate of 1,685 per 100,000.

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

43. Smoking is closely related to lung cancer, causing nearly 9 out of 10 cases and in Gateshead there is a significantly higher rate of people with lung cancer than across England as a whole. As the highest smoking rates are in the most deprived areas, it is no surprise that lung cancer also strongly correlates with areas of deprivation, with wards in the most deprived quintile having a rate around twice that of the least deprived quintile.

44. Chronic obstructive pulmonary disease (COPD) is the second most common cause of emergency admission to hospital and one of the costliest diseases in terms of acute hospital care. Over 90% of COPD cases are caused by smoking and continued

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

smoking is strongly associated with a higher frequency and greater severity of exacerbations.[11]

45. At delivery, 14.5% of all women giving birth in Gateshead were known to smoke. This is significantly higher than the England average of 10.7%.

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

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

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

Alcohol Misuse

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

50. The (age-standardised) rate of alcohol-related hospital admissions in Gateshead is 990 per 100,000 population (DSR). This is significantly higher than both the regional average (866) and the England average (636). The general trend in alcohol related hospital admissions is up and the gap between Gateshead and the England average is getting wider.

51. Liver disease is one of the few major causes of premature mortality that is increasing in England (including Gateshead). Major causes include obesity, undiagnosed hepatitis infection and harmful alcohol use. Between 2014 and 2016 there were 140 deaths from liver disease among people aged under 75 in Gateshead, with 9 in 10 considered to be preventable. In recent years, much of the increase is attributable to a sharp rise in deaths of women. For example, in 2004-06 there were just 26 female deaths due to liver disease, rising to 58 in 2014-16, whilst the number of male deaths has decreased in the same period from 95 to 82.

[11] Public Health England State of the North East 2017: Respiratory Health
[12] World Health Organisation, February 2018, Alcohol Fact sheet available at: http://www.who.int/news-room/fact-sheets/detail/alcohol

52. In 2016/17 there were 225 hospital admissions episodes for alcohol related mental and behavioural disorders due to the use of alcohol. As a rate per 100,000 (DSR) this was 114, compared with the England average of just 72.

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

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

55. 12% of all crime recorded in Gateshead in the last 12 months was deemed to be alcohol-related (this is recorded at the discretion of the police officer dealing with the crime). More specifically, 22% of violence against the person offences were deemed to be alcohol-related. 15% of robbery offences and 11% of thefts from vehicles were also believed to have been influenced by alcohol.

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

Healthy weight and physical activity

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

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

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

60. In Gateshead 69.1% of adults are obese or overweight according to survey data, significantly worse than the England average of 61.3%. A wide range of health conditions may result from being overweight or obese; these include heart disease,

[13] World Health Organisation Fact Sheets 2009
[14] Halpin HA, Morales-Suárez-Varela MM, Martin-Moreno JM. Chronic disease prevention and the New Public Health. Public Health Reviews 2010;32:120-154.

diabetes, hypertension, breast and prostate cancer, arthritis, physical disabilities, stress, anxiety and depression.

61. Local survey data highlights wide variations of adult obesity across Gateshead with the highest levels in the most deprived wards. For example in the most deprived areas of Gateshead the proportion of obese adults is almost double that in the least deprived areas. There were also variations across age groups, with highest levels of obesity in those aged 55 to 64 and lowest levels among 18 to 24 year olds. However a Healthy Weight Health Needs Assessment is currently being undertaken and this should provide an update to the data for the JSNA in the coming months.

62. Of children attending Gateshead schools, 22% of 4-5 year old's increasing to 38.5% of 10-11 year old's were classified as overweight or obese (excess weight). This compares to the England averages of 22.6% and 34.2% respectively. For both age groups, there has been little variation in recent years. A high percentage of those children are likely to become obese and overweight adults unless they can access sufficient support to make lifestyle changes for themselves and their families.

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

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

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

Air Quality

66. Our understanding of the effect that poor air quality has on human health is becoming increasingly clear. High concentrations of nitrogen dioxide (NO_2) are known to cause health effects including lung problems, sensitivity to allergens and can trigger asthmas[15]. There are also strong relationships between fine particulate concentrations (known as PM2.5) and cardiovascular and respiratory diseases, such as strokes and heart diseases[16]. There is a growing body of evidence linking air pollution with brain health.

67. In 2016, the Royal College of Physicians released a study[17] which estimated the UK's annual mortality burden from exposure to outdoor air pollution to be equivalent

[15] Associations of long-term average concentrations of nitrogen dioxide with mortality – A report by the Committee on the Medical Effects of Air Pollutants, 2018.
[16] The Mortality Effects of Long-Term Exposure to Particulate Air Pollution in the United Kingdom – A report by the Committee on the Medical Effects of Air Pollutants, 2010.
[17] Every breath we take – The lifelong impact of air pollution, Royal College of Physicians/Royal College of Paediatrics and Child Health, Report of a working party, February 2016.

to around 40,000 deaths. We have estimated that in Gateshead this equates to 110 deaths.

68. We are all affected because we breathe in the air around us. Whilst much of Gateshead has air quality that is relatively good, there are areas where levels of NO_2 exceed EU limits – but there is no safe level of air pollution. Risk increases with greater exposure, and our primary concern is with the effects of chronic exposure. Air pollution particularly affects the most vulnerable in society: children and older people, and those with heart and lung conditions. There is also often a strong relationship with poor air quality affecting lower average household income areas.

69. Lots of things affect the quality of the air, however the main activity that causes locally high levels of air pollution is the use of motor vehicles – particularly those with diesel engines. Nationally there is a focus on achieving reductions in NO_2 emissions, but it is anticipated that many of the measures taken to address this will also benefit the levels of fine particulate matter (PM2.5 – technically referred to as airborne particulate matter with an aerodynamic diameter of 2.5μm or less).

70. Gateshead, along with Newcastle and North Tyneside Councils, has been directed by the Government to develop a plan to bring air quality (NO2) exceedances within compliance of EU limits.

C. Older People

Frailty

71. The population of Gateshead (around 202,400 people) experiences wide variations in health outcomes across different groups and communities. The Gateshead population is ageing and it is projected that by 2041 there will be an additional 12,100 people aged 65 years or older in Gateshead, an increase of 31%.

72. Much of the debate about our ageing society has focused on the costs of ageing in respect of pensions, healthcare, welfare payments or social care. This has reinforced the idea that as people get older, they become more of a burden or drain on society and the cost of supporting them outweighs the financial and social contribution they make to our community.[18]

73. Research shows that older people make a positive contribution to the UK economy and as the number of people over 65 increases and people remain healthier for longer, opportunities to make a positive contribution through work or volunteering are growing.[18] This is demonstrated by the Gateshead commitment to community capacity building and its engagement with older people.

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

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

75. Social isolation is associated with poor physical, mental and emotional health including increased rates of cardio-vascular disease, hypertension, cognitive decline and dementia. Individuals who are socially isolated are between two and five times more likely to die prematurely than those who have strong social ties.[19] The risk of social isolation increases with age. In Gateshead in 2011, 12,138 (34.4%) people 65 years of age or older were living alone and therefore could be at risk of social isolation.

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

77. After adjusting for age, the rate of emergency admissions for injuries due to falls in people 65 years of age or older is significantly higher in Gateshead than in England overall. It is predicted that there will be a 37% increase to 14,065 in the number of people aged 65+ affected by falls between 2017 and 2035. It is also predicted that there will be a 42% increase to 1,149 in the number aged 65+ admitted to hospital as a result of falls by 2035.

78. The rate of hip fractures in people 65 years of age or older is similar to the England average; there were 229 admissions for hip fracture in this age group in 2016/17.

79. In 2016/17 a total of 718 people (0.4%) aged 50+ in Newcastle and Gateshead CCG area had osteoporosis. This compares to an England average of 0.5%.

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

Long term conditions

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

82. We are seeing an increasing number of individuals with multiple and complex needs, who are being identified earlier, at the same time as our population is becoming

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

older. This presents an opportunity for individuals to better manage their condition and takes pressure off acute health and social care services.

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

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

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

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

Mental Health and Wellbeing

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

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

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

90. The JSNA recognises that while a significant number of people do develop dementia or depression in older age, decline in mental wellbeing should not be viewed as an inevitable part of ageing. Many factors affecting mental health and wellbeing for older people are the same as for the general population.

HEALTH AND WELLBEING BOARD
19 October 2018

TITLE OF REPORT: Personal Health Budgets - Update

Purpose of the Report
There is a requirement to advise the Health and Wellbeing Board (HWB) how Newcastle Gateshead Clinical Commissioning Group (NG CCG) will continuously develop the local offer for Personal Health Budgets (PHB).

Background

The NHS Five Year Forward View sets out the vision for the future NHS including a new relationship with patients and communities that supports people to gain far greater control of their own care when they need health services. A key part of this is developing how Personalised Care is offered to individuals.

On May 12th 2018 all CCG's received a communication from NHS England that asks that all Continuing Healthcare (CHC) home care packages of care be delivered as Personal Health Budgets (PHBs) by April 2019.

There is strong evidence of improved outcomes as a result of the introduction of personal health budgets, including increased quality of life and reduced need for unplanned NHS care such as emergency hospital admission.

As a result NHS England believes that all NHS CHC funded packages delivered in a home care setting, excluding fast track NHS CHC, should be managed as a personal health budget, and that they should become the default operating model for this group by April 2019. This means that individuals know what their budget is, are involved in personalised care and support planning and have greater control over how the budget is used, including the option of a direct payment.

http://www.personalhealthbudgets.england.nhs.uk/asset.cfm?a=%2F_assets%2Fsecure%2Fphb/2018/Personal-health-budgets-in-NHS-Continuing-Healthcare-letter.pdf

PHBs offer people a chance to take as much or little control over the care that they receive as they want to take. Many people in receipt of CHC have chosen to have a Direct Payment PHB which allows them to have more choice over who provides their care; and how they spend the budget based on agreed health outcomes.

However lots of other people don't want to have the responsibilities that come with having a Direct Payment PHB and have chosen to have a "notional" PHB. This option will be attractive to those people who are happy with their care arrangements and want very little or nothing to change at present. People can change this if they choose to in future.

A “notional” PHB is based on an essential Support Plan in which health outcomes are agreed with a Case Manager, and this shows how someone’s care and support is to be provided. CHC patients will be provided information about the different PHB options, the amount of money available for their care and with help to complete the Support Plan.

CCG Progress to date

The CCG has an agreed trajectory to meet with regards to the numbers of PHBs offered and in place. Initially, progress against this trajectory was slow but in 2018/19, we have refreshed our approach. In Quarter 1 of 2018/19 the CCG was on track to achieve its trajectory and are performing well against other CCGs nationally.

In response to the NHS England letter in May 2018, the CCG have changed processes to ensure that individuals know what their budget is and what options they have for managing this budget.

In our bid to continuously develop our offer, we have joined a mentorship programme and have engaged in sharing best practice with Hull CCG. We participate in the North East Regional PHB Network and take up opportunities to learn and share with CCGs around the country. To ensure that people using a personal health budget are supported to do so, the CCG have piloted a Brokerage service. This pilot is due to end in March 2019 and the CCG Clinical Executive Committee is considering options for the future commissioning of support and brokerage services later in October 2018.

Recommendations

1. The Health and Wellbeing Board is asked to consider progress to date and assurance that the CCG will achieve the aim of the May 2018 letter to ensure that PHBs are the default for all CHC patients.

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Gateshead Council

HEALTH AND WELLBEING BOARD
October 2018

TITLE OF REPORT: **Consultation on proposal to end the sale of energy drinks to children**

Purpose of the Report

1. To consult the Health and Wellbeing Board on the proposed response to the Department of Health and Social Care's consultation on the proposal to end the sale of energy drinks to children.

Background

2. The Department of Health and Social Care launched an online consultation in August 2018 on the proposal to end the sale of energy drinks to children. This was announced as part of Childhood Obesity: a plan for action, chapter 2. The aim of the policy is to prevent excessive consumption of high-caffeine energy drinks by children.

3. Energy drinks are soft drinks that contain higher levels of caffeine than other soft drinks and may also contain a lot of sugar (though low or zero calorie energy drinks are available). One study found that regular energy drinks contain, on average, 60% more calories and 65% more sugar than other regular drinks and may therefore contribute to obesity and dental problems in children.

4. Evidence suggests that excessive consumption of energy drinks by children is linked to negative health outcomes: affecting children's physical and mental health as well as sleep latency and duration. Research has found that adolescents (aged 12 to 18) who consume energy drinks several times a day are 4.5 times more likely to report experiencing headaches, 3.5 times more likely to report sleeping problems, and 3.4 times more likely to report experiencing tiredness than adolescents who do not consume energy drinks.

5. Manufacturers are currently required by European Law to label all energy drinks containing over 150mg of caffeine per litre as 'not recommended for children'. Despite the warning labels children are still consuming these drinks; recent evidence shows that more than two thirds of UK children aged 10-17, and nearly a quarter of those age 6-9 are energy drink consumers.

6. The Government has heard strong calls from parents, health professionals, teachers and some industry bodies and retailers for an end to the sale of high

caffeine energy drinks to children. Many large retailers and supermarkets have voluntarily stopped selling energy drinks to under 16's but there are still many retailers who continue to sell these drinks to children. Legislating to end the sale of high-caffeine energy drinks to children would create a level playing field for businesses and create consistency, helping ensure that children do not have access to energy drinks in any shop.

The consultation

7. The Government is aware that the evidence base around energy drinks and their effects is complex. The aim of the consultation is to gather further views and evidence on the advantages and disadvantages of ending the sale of energy drinks to children, and on alternative options, before making a decision. They are also seeking views on how a restriction on sales of energy drinks to children would be enforced in a way that is fair and proportionate, and on the implementation period, in the event that they decide to take such an approach.

8. The consultation covers the following:
    - Whether ending the sale of energy drinks to children by all retailers is the right approach to take
    - Would the energy drinks in scope be any drink, other than tea or coffee, which contain over 150mg of caffeine per litre
    - Whether the age limit for a restriction on sales to children should be 16 or 18 years of age
    - Should the restriction be implemented by all retailers in England, including on-site and online sales
    - Should the sale of energy drinks from vending machines also be restricted

9. Please see appendix one which details the draft public health response to the consultation questions.

Recommendations

10. It is recommended that the HWB Board:

- Comment on the draft response and offer any further evidence or views, where appropriate
- Agree the response to the consultation prior to online submission on 21st November 2018

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Appendix 1

Department of Health and Social Care
Consultation on proposal to end the sale of energy drinks to children

Questions for consultation

1. Should businesses be prohibited from selling high-caffeine energy drinks to children?

   YES

   Please explain your answer:

   A survey conducted across 16 European countries found that young people aged 10 to 18 years in the UK consumed more energy drinks on average than their counterparts in other countries (3.1 litres per month, compared to around 2 litres) (Nomisma-Arete Consortium 2013). Two-thirds (68%) of young people surveyed in the UK had consumed energy drinks in the past year and 13% were identified as high chronic consumers (i.e. consuming 4-5 times a week or more), compared with an average of 8% across Europe.

   Around half (53%) of the young energy drink consumers reported co-consumption with alcohol. This finding is supported by a recent survey on smoking, drinking and drug use among 11 to 15-year-olds in England (NatCen Social Research and National Foundation for Educational Research 2015). The 2014 survey included questions about energy drinks for the first time; 69% of respondents said they had consumed energy drinks and 6% said they had consumed them with alcohol (increasing to 15% of 15-yearolds). Young people mixing energy drinks with alcohol are an increasing focus of concern.

   Data from retrospective analyses of poison centre data indicated that consumption of energy drinks by children and young people may be linked to adverse health outcomes. Of the 2.4 million calls to the National Poison Data System in the USA between 2010 and 2011, 4854 calls were related to energy drink exposure cases and 46% of these involved children under six years old (Seifert, Seifert et al. 2013). However, adolescents reported the largest proportion of moderate or major effects such as cardiac rhythm disturbances and hyperthermia. Similar studies conducted in Australia and Italy have reported a range of symptoms that included hyperactivity, palpitations, fainting, abdominal pain, agitation, flushing, tachycardia, delirium, vomiting (Gunja and Brown 2012, Vecchio, Chiara et al. 2013).

   Evidence from large-scale, often school-based surveys demonstrated that reported use of energy drinks by school-aged children was generally high and that it was associated with a number of unhealthy behaviours. Positive associations with smoking or susceptibility to smoking, alcohol use (including binge drinking and heavy drinking) and substance use (including marijuana and prescription drugs) have been observed in several studies.
   (Gambon, Brand et al. 2011, Locatelli, Sanchez et al. 2012, Cotter, Jackson et al. 2013, Gallimberti, Buja et al. 2013, Hamilton, Boak et al. 2013, Petrova, Duleva et

al. 2013, Azagba and Sharaf 2014, Larson, DeWolfe et al. 2014, Terry-McElrath, O'Malley et al. 2014).

Energy drinks have no therapeutic benefit, and many ingredients are understudied and not regulated. The known and unknown pharmacology of agents included in such drinks, combined with reports of toxicity, raises concern for potentially serious adverse effects in association with energy drink use. Children and young people are not always aware of the fact that energy drinks are stimulants, nor are they aware of the effects they can have on their body and that the effects on children and young people can vary.

Consumption of energy drinks can lead to a variety of different behaviours including lack of concentration and hyperactivity which can impact far wider than just the person who has consumed the energy drink e.g. in a classroom setting. Consumption of energy drinks among adolescents is associated with potentially negative health and behavioural outcomes which include sensation seeking behaviour, use of tobacco and other substances and binge drinking which are all associated with a greater risk for depression and injuries that may require medical treatment.

We are already facing challenges in Gateshead around obesity and healthy weight where 9.6% of 4-5 year olds and 24.6% of 10-11 year olds living in Gateshead were obese in 2016/17. The proportion for 4 -5 year olds is the same as the England average of 9.6%. However, the proportion for 10-11 year olds is significantly higher than the England average of 20.0%.

Of children attending Gateshead schools, 22.0% of 4-5 year olds and 38.5% of 10-11 year olds were classified as overweight or obese (excess weight). Whilst the proportion for 4-5 year olds is similar to the England average of 22.6%, the proportion for 10-11 year olds is significantly higher than the England average of 34.2%

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

Whilst the levels of overweight or obese children in Gateshead cannot be solely attributed to the sale of energy drinks given the easy availability of these drinks in shops and other outlets, not limiting these sales can only potentially add to the challenge of reducing obesity rates. A reduction in obesity rates could be expected to yield savings to the NHS and other organisations.

Research has highlighted that children and adolescents with eating disorders, especially anorexia nervosa, may regularly consume high amounts of caffeine including energy drinks to counter caloric-restriction– associated fatigue, suppress appetite etc. and given that children and adolescents with eating disorders have a propensity for cardiac morbidity/mortality consumption of high-caffeine energy drinks may put them at further health risks.

FUSE research indicated that whilst children/young people were generally well informed about the fact that energy drinks usually contain high volumes of caffeine and sugar the caffeine content, in particular, was often highlighted as being the main difference between energy drinks and other types of beverage. There

appeared to be less knowledge about how much sugar or caffeine was in these drinks. Even when this information was included on the label there were concerns that some children/young people might have difficulty interpreting what it meant.

There were 193 hospital episodes for teeth extractions (one or more primary or permanent teeth) for the 5-19 age group in 2016/17 (99 aged 5 to 9, 56 aged 10 to 14, and 38 aged 15-19). Again, whilst these cannot be solely attributed to the sale of energy drinks given the high sugar content levels in these drinks this is another potential contributory reason why energy drinks should not be sold to under 18's.

High acidity levels in the energy drinks erode the tooth enamel, the glossy outer layer of the tooth. Damage to tooth enamel is irreversible, and without the protection of enamel, teeth become overly sensitive, prone to cavities and more likely to decay.
A 340ml serving of an energy drink can have an acid PH as low as 2.4 (water=7, battery acid=1) and as much as 13 tea spoons of sugar. Advice says children aged 11 or over and adults should consume no more than seven teaspoons of added sugar a day (30g) equal to less than a single can of Coca-Cola which contains 39g. Children are consuming energy drinks primarily for their taste rather than stimulant properties, hence experience health decrements as an unintended consequence.

2. Are there any other approaches that you think should be implemented instead of, or as well as a prohibition on sales of energy drinks to children, in order to address the issue of excess consumption of energy drinks?

   YES

   We think these measures should be implemented in addition to a prohibition on sales of energy drinks to children under 18:

   Better awareness raising amongst children, young people and their parents about energy drinks and the effects they can have on a child/young person. This should include school based activities such as assemblies and classroom discussions. Teachers who took part in the FUSE research highlighted potential curriculum areas such as science, citizenship and PSHE where energy drinks could be used to provide a "real life " relevant case study in terms of health education for young people.

   FUSE research indicates that children are keen to be involved in peer led interventions and training young people as advocates or experts on energy drinks who could provide advice for other children of a similar age. Children could be involved in the development of resources to raise awareness around the impacts/effects of energy drinks.

   Marketing and branding of energy drinks needs to be considered. Currently they are marketed explicitly as a way to relieve fatigue and improve mental alertness illustrated by one well known marketing strapline "red bull gives you wings". As part of the FUSE research young people identified that the branding and packaging of energy drinks helped them to stand out and made them more attractive to children and young people. Some were identified as targeting boys in particular, through the brand names, size of the cans, the colours used on the packaging and the association with extreme sports.

Set a minimum price for energy drinks. Research undertaken by FUSE in County Durham with school children, September 2015, suggested that the relatively low cost and widespread availability of energy drinks represent key factors influencing such purchases by children/young people. It also highlighted that the purchase of energy drinks were at least partially motivated by straightforward economics – energy drinks were among the cheapest drinks available locally allowing them to purchase in greater quantities.

Introduce a "challenge" approach in all establishments that sell energy drinks in line with alcohol and tobacco challenge approaches.

3. Which age limit would be the most appropriate for a prohibition on sales of energy drinks to children?
    - 16 years old
    - 18 years old
    - Any other (please specify)
    -

   18 years old

   Please explain your answer:

   The age limit should be on the same basis as purchase of alcohol and tobacco given that energy drinks are stimulants and that they have no therapeutic benefit, and many ingredients are understudied and not regulated. The known and unknown pharmacology of agents included in such drinks, combined with reports of toxicity, raises concern for potentially serious adverse effects in association with energy drink use.

   By law, energy drink labels must include the warning 'not recommended for children' and yet participants in the FUSE research as young as 10 years of age told us they could purchase these products in almost any shop, at affordable prices.

4. Should a prohibition on sales of energy drinks to children apply to any drink that contains over 150mg of caffeine per litre, except coffee and tea?

   YES

   Please explain your answer:

   A single can of popular brands of energy drinks on the market can contain around 160mg of caffeine, while the European Food Safety Authority recommends an intake of no more than 105mg caffeine per day for an average 11-year-old.

5. Should a prohibition on sales of energy drinks to children apply to all retailers who operate in England, including online businesses and the out-of-home sector (cafes, restaurants, takeaways and so on)?

   YES

   Please explain your answer:

   If prohibition on sales of energy drinks to children is not applied to all retailers then they will still be available for purchase at other outlets such as local cafés or

takeaways. Whilst the cost for purchasing at such retailers will be potentially higher this will not deter some children. The same restrictions should apply as for the purchase of alcohol and tobacco so there is a very clear message and this is understood by all retailers.

6. Should children be prevented from buying energy drinks from vending machines?

   YES

   Please explain your answer:

   Children who are unable to purchase energy drinks in shops/other retail outlets would potentially revert to purchasing from vending machines and there would be no challenge associated with this purchase. The only thing that may deter children purchasing from vending machines would be the cost and availability e.g. vending machines may potentially be stocked with the higher price brands with a set price and no special offers/deals. In addition they would not be able to be bought in bulk due to the higher cost.

7. If children are prevented from buying energy drinks from vending machines, how should this be done?

   - All sales of energy drinks from all vending machines should be prohibited, regardless of the age of the person buying them
     YES – if sales of energy drinks are not prohibited from all vending machines there would be no way to challenge children or young people and therefore they would still be able to purchase these freely.

   - Sales of energy drinks from vending machines should be prohibited in specific locations with high child footfall, for example educational establishments, sports centres and youth centres
     NO

   - Other approach (please give details of the approach you are suggesting).
     NO

8. If the sale of energy drinks to children is prohibited, would 12 months be an appropriate implementation period for all businesses?

   NO

   Please explain your answer:

   Whilst we can appreciate that to implement this measure may take time we would ask that that careful consideration be given to implementing this proposal as soon as practicably possible. The longer implementation takes then we are potentially allowing more children/young people to access these energy drinks with the negative impacts they may have on their health for example.

9. If you are a business selling energy drinks, have you already imposed limits on sales to children?
   Not applicable - for business completion

10. If you have not already limited sales of energy drinks to children, have you committed to do so or are you planning to do so in the future?
Not applicable - for business completion

11. If you have already limited sales of energy drinks to children, have you faced any obstacles this effectively?
Not applicable - for business completion

12. If you have already limited sales of energy drinks to children, please explain how this has affected your business, either positively or negatively, providing supporting evidence where possible.
Not applicable - for business completion

13. If you have any suggestions for how this requirement could be enforced in a way that is fair and not overly burdensome, please provide details.
Not applicable – for business completion

14. If you have any further evidence or data you wish to submit for us to consider for our final impact assessment, please provide it here.
Not applicable

15. If you have any further evidence or data that you would like to submit specifically on the likely cost that may occur to your business as a result of the proposal, please provide it here.
Not applicable - for business completion

16. Are there any other potential impacts of restricting the sale of energy drinks to children that you think we should consider?

    None the restriction of sales to children can only be seen as a positive move in terms of reducing the potentially negative health and behavioural outcomes as outlined in the response to question 1.

17. Do you think that this proposal would be likely to have an impact on people on the basis of any of the following characteristics?

    - Age – Yes potentially if a minimum price were introduced for energy drinks this would impact upon consumers of all ages, rather than affecting only children. The impact on adults could be considered disproportionate given the policy objective is to limit children's consumption.
    - Sex
    - Race
    - Religion
    - Sexual orientation
    - Pregnancy and maternity
    - Disability
    - Gender reassignment
    - Marriage/ civil partnership

With the exception of the age protected characteristic we do not anticipate any negative impact of the proposal and, therefore, do not foresee any other group being disadvantaged by this proposal. We feel that the proposal will in fact only have a positive impact on all people under 18 regardless of any protected characteristics.

18. Do you think this proposal would help achieve any of the following aims?

    - Advancing equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
    - Fostering good relations between persons who share a relevant protected characteristic and persons who do not share it.
    - Where applicable, please provide more details on how you think the measure would achieve these aims.
    - If you do not think this proposal would help achieve any of these aims, please explain why and whether the proposal could be changed to help achieve these aims.

    We acknowledge that this proposal would not advance any of the aims. As mentioned at question 17 the only protected characteristic group that might be affected would be age but the negative impact on the older group is outweighed by the positive impact on children and young people.

19. Do you think that this proposal would be likely to have any impact on people from lower socio-economic backgrounds?

    Yes but in a positive way such as contributing towards a reduction in overweight and obese children as outlined at question 1. The UK government has already announced a tax on sugary drinks as a step towards tackling childhood obesity, but energy drinks usually contain high amounts of both sugar and caffeines.

    People from a lower socio-economic background are more likely to have dental decay so any reduction in this will reduce pain/infection risk and have wider implications such as less time off school/college and improved self-confidence with better aesthetics.

    The FUSE research indicated that a number of school staff associated energy drink use with a certain demographic of young people where positive parental influence and supervision might be lacking.

20. If there are any further matters that you would like to raise or any further information that you would like to provide in relation to this consultation, please give details here.

    Attach link to FUSE report: The HYPER (Hearing Young People's Views on Energy Drinks: Research) Study Final Report Septembers 2015

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HEALTH AND WELLBEING BOARD
19th October 2018

TITLE OF REPORT: Better Care Fund: 2nd Quarterly Return (2018/19)

Purpose of the Report

1. To seek the endorsement of the Health & Wellbeing Board to the Better Care Fund return to NHS England for the 2nd Quarter of 2018/19.

Background

2. The HWB approved the Gateshead Better Care Fund (BCF) submission 2017-19 at its meeting on 8 September 2017, which in turn was approved in full by NHS England on 27 October 2017.

3. NHS England is continuing its quarterly monitoring arrangements for the BCF which requires quarterly template returns to be submitted. As part of the reporting arrangements for 2018/19, the return also incorporates how Improved Better Care Fund (IBCF) funding (announced at the Spring budget 2017) is being used to support initiatives / projects, including those addressing adult social care pressures. Previously, this was reported in a separate return to DCLG during 2017/18.

Quarter 2 Template Return for 2018/19

4. In line with the timetable set by NHS England, a return for the 2nd quarter of 2018/19 is required to be submitted by the 19th October. The return sets out progress in relation to budget arrangements, meeting national conditions, performance against BCF metrics and implementation of the High Impact Change Model for managing transfers of care. It also includes a narrative progress update.

Proposal

5. It is proposed that the Board endorse the 2nd Quarter BCF return for 2018/19 to be submitted to NHS England (attached as an excel document).

Recommendations

6. The Health and Wellbeing Board is asked to endorse the Better Care Fund 2nd Quarter return for 2018/19.

Contact: John Costello (0191) 4332065

Better Care Fund Template Q2 2018/19

6. Additional improved Better Care Fund

Selected Health and Wellbeing Board:	Gateshead
Additional improved Better Care Fund Allocation for 2018/19:	£ 3,233,333

These questions cover average fees paid by your local authority (including client contributions) to external care providers.

We are interested only in the average fees actually received by external care providers from local authorities for their own supported clients (including client contributions). The averages should therefore exclude:

-Any amounts that you usually include in reported fee rates but are not paid to care providers e.g. the local authorities' own staff costs in managing the commissioning of places

-Any amounts that are paid from sources other than the local authorities' funding (including client contributions), i.e. you should exclude third party top-ups, NHS Funded Nursing Care and full cost paying clients.

The averages will likely need to be calculated from records of payments paid to social care providers and the number of client weeks they relate to, unless you already have suitable management information.

This single average should include fees paid under spot and block contracts, fees paid under a dynamic purchasing system, payments for travel time in home care, any allowances for external provider staff training, fees directly commissioned by your local authority and fees commissioned by your local authority as part of a Managed Personal Budget.

If you only have average fees at a more detailed breakdown level than the three service types of home care, 65+ residential and 65+ nursing (e.g. you have the more detailed categories of 65+ residential without dementia, 65+ residential with dementia) please calculate for each of the three service types an average weighted by the proportion of clients that receive each detailed category:

1. Take the number of clients receiving the service for each detailed category.
2. Divide the number of clients receiving the service for each detailed category (e.g. age 65+ residential without dementia, age 65+ residential with dementia) by the total number of clients receiving the relevant service (e.g. age 65+ residential).
3. Multiply the resultant proportions from Step 2 by the corresponding fee paid for each detailed category.
4. For each service type, sum the resultant detailed category figures from Step 3.

If you are unable to provide rates for both 2017/18 and 2018/19, please ensure that you provide the estimated percentage change between 2017/18 and 2018/19 in the table below. Please leave any missing data cells as blank e.g. do not attempt to enter '0' or 'N/A'.

	2017/18	2018/19	If rates not yet known, please provide the estimated uplift as a percentage change between 2017/18 and 2018/19
1. Please provide the average amount that you paid to external providers for home care in 2017/18, and on the same basis, the average amount that you expect to pay in 2018/19. (£ per contact hour, following the exclusions as in the instructions above)	£ 13.76	£ 15.38	
2. Please provide the average amount that you paid for external provider care homes without nursing for clients aged 65+ in 2017/18, and on the same basis, the average amount that you expect to pay in 2018/19. (£ per client per week, following the exclusions as in the instructions above)	£ 551	£ 581	
3. Please provide the average amount that you paid for external provider care homes with nursing for clients aged 65+ in 2017/18, and on the same basis, the average amount that you expect to pay in 2018/19. (£ per client per week, following the exclusions in the instructions above)	£ 551	£ 581	
4. If you would like to provide any additional commentary on the fee information provided please do so. Please do not use more than 250 characters.	Represents band 1 rates. EMI rate is £605. Residential and nursing care paid at same rate for LA care with FNC payable in addition for nursing		