Gateshead Council

Public Document Pack

HEALTH AND WELLBEING BOARD AGENDA

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

From the Chief Executive, Jane Robinson

Item	Business
1.	**Apologies for Absence**
2.1	Minutes (Pages 3 - 10) The minutes of the meeting held on 10 June 2016 are attached for approval.
2.2	Action List (Pages 11 - 14) The Action List following from meeting held on 10 June is attached for approval.
3.	**Declarations of Interest** Members of the Board to declare an interest in any particular agenda item.
	Items for Discussion
4.	**Child and Adolescent Mental Health Services (CAMHS) and Waiting Times for Gateshead** Presentation by Catherine Horn, Newcastle Gateshead CCG
5.	**Substance Misuse Strategy for Gateshead** (Pages 15 - 46) Report of the Director of Public Health
6.	**Live Well Gateshead Evaluation** (Pages 47 - 50) Report of the Director of Public Health
7.	**Primary Care Co-commissioning Update** (Pages 51 - 58) Report of Newcastle Gateshead CCG
8.	**Health and Wellbeing Board Forward Plan and Meetings Schedule for 2016/17** (Pages 59 - 66) Report of the Strategic Director, Care Wellbeing and Learning

Items for Assurance

9. Healthwatch Gateshead Annual Report 2015/16 and Priorities for 2016/17 (Pages 67 - 88)

Report of Healthwatch Gateshead

Performance Management Items

10. Performance Report for Health and Care System (Pages 89 - 104)

Report of the Strategic Director, Care Wellbeing and Learning

Items for Information

11. Updates from Board Members

12. Any Other Business

13. Date and Time of Next Meeting

Friday 9 September 2016 at 10am

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

GATESHEAD METROPOLITAN BOROUGH COUNCIL

HEALTH AND WELLBEING BOARD MEETING

Friday, 10 June 2016

PRESENT

Councillor L Caffrey (Chair)

J Green	Gateshead Council
M Graham	Gateshead Council
M McNestry	Gateshead Council
M Gannon	Gateshead Council
M Foy	Gateshead Council
R Beadle	Gateshead Council
B Westwood	Federation of GP Practices
M Dornan	Newcastle Gateshead CCG
J Duncan	Northumberland Tyne and Wear NHS Foundation Trust
S Young	Gateshead Voluntary Sector
A Wiseman	Gateshead Council

IN ATTENDANCE:

Joe Corrigan	Newcastle Gateshead CCG
Susan Watson	Gateshead Health NHS Foundation Trust
Steve Jamieson	South Tyneside Foundation Trust
Elizabeth Saunders	Gateshead Council
Iain Miller	Gateshead Council
Michael Laing	Gateshead Council
John Costello	Gateshead Council
Sonia Stewart	Gateshead Council

HW35 APOLOGIES FOR ABSENCE

Apologies for absence were received from Alison Elliott, Douglas Ball and Ian Renwick.

HW36 MINUTES

The minutes of the previous meeting held on 10 April were agreed as a correct record, subject to it being noted that Susan Watson was in attendance representing Gateshead Health NHS Foundation Trust.

HW37 DECLARATIONS OF INTEREST

None

HW38 ACTION LIST

The Action List highlighted several items which will be included within the Board's Forward Plan for 2016/17.

HW39 NORTHUMBERLAND, TYNE & WEAR SUSTAINABILITY AND TRANSFORMATION PLAN 2016/17 TO 2020/21

The Board received a presentation from Joe Corrigan of Newcastle Gateshead CCG on the STP for Northumberland and Tyne and Wear 2016/17 – 2020/21.

The STP covers 6 local authorities in Northumberland and Tyne and Wear. There is also a component part around North Durham.

The plan is a whole system plan and there are narrative sub-levels covering the 3 local economies – Northumberland and North Tyneside, Sunderland and South Tyneside, and Newcastle Gateshead.

The plan is place based and population based and is not organisation based. Nationally there are 44 STP areas which NHS England will need to manage.

An initial submission was made on 11 May with a further submission on 30 June. There will be an assessment process undertaken in July. The plan needs to address and provide a whole system narrative on how we will close the gap relating to the Triple Aims relating to health and wellbeing, care and quality, and funding and efficiency.

There are 10 lines of enquiry:

1. How are we going to prevent ill health and moderate demand for healthcare.
2. How are we engaging patients, communities and NHS Staff.
3. How will we support, invest in and improve general practice.
4. How will we implement new care models that address local challenges.
5. How will we achieve and maintain performance against core standards.
6. How will be achieve our 2020 ambitions on key clinical priorities.
7. How will we improve quality and safety.
8. How will we deploy technology to accelerate change.
9. How will we develop the workforce you need to deliver change.
10. How will we achieve and maintain financial balance.

It is felt that Sustainability and Transformation Plans (STPs) are an opportunity to develop a route map to an improved, more sustainable, health and care system by:

- Bringing organisations together to work much more closely, beyond organisation boundaries

- Sharing of good practice and expertise
- Identifying those areas where a single or small group or organisations would, or is, having difficulty transforming services
- Identifying areas where the common agenda suggests we can do something once well, rather than several times less effectively
- Alignment with the work of the NECA Commission for Health and Social Care Integration

Key areas for transformation include:

- Acute hospital collaboration across clinical pathways
- Reconfiguration of services between acute providers
- Out of hospital collaboration
- Radical upgrade in prevention and wellbeing
- Development of accountable care systems
- Financial stability

The Board were advised that this was very much a system wide process with a narrative for the Newcastle Gateshead footprint linking with the narrative for other local health economies to form an overarching Northumberland Tyne & Wear narrative. In this way, there will be a tiered approach to the work. It was noted, however, that the funding gap by 2020 is expected to be around £80m for Gateshead, £200m for Newcastle Gateshead and approximately £960m across the whole NTW footprint for health and social care.

There are several layers to governance including an STP Programme Board which includes Newcastle and Gateshead. It was noted that his is still very much a work in progress and work is ongoing towards the next stage submission by 30 June. Further discussions will need to take place before final sign off.

Health & Wellbeing Boards are not required to approve or to be consulted at this stage, but NHS England need assurance that the plans reflect a shared view from the STP leadership team, based upon the needs of patients and taxpayers.

More formal engagement with Boards and partners will take place following the July conversations.

It was felt that it is important to be up front with local people regarding the extent of the financial challenges facing the local health and care system and implications of this for services in future years. This also has implications for levels of investment in prevention and early intervention.

It was queried how the Board can best raise its concerns regarding the challenges posed for the local system. It was noted that a leadership meeting is being arranged between Newcastle and Gateshead Council representatives which could look at this and related issues in the first instance. A view can then be taken on the next steps.

It was felt that the Board has an important role to play and needs to be part of the decision making process going forward.

RESOLVED - That the presentation and issues raised be noted.

HW40 SMOKING STILL KILLS; SMOKE FREE VISION 2025

The Board received a presentation from Iain Miller, Public Health Lead on Tobacco Control. The Board were advised that our vision is to reduce smoking to 5% prevalence in adults by 2025 in order to achieve a smoke free future for our children.

The Board were advised that smoking continues to remain as the biggest killer in Gateshead and is the single most preventable cause of premature death. Currently 42,000 people in Gateshead smoke (1,400 are aged 16 or under) and it is known that 32,000 of these wish to stop smoking. If we had the lowest smoking rate in England at 8.4% only 16,816 would smoke.

It is proposed that we review the work of our SmokeFree alliance using a national standard and identify its strengths and areas for improvement. The Board were asked to consider the following recommendations for Action:

1. Ensure a great focus on tobacco control activity by all partners on the Health and Wellbeing Board for Gateshead.
2. Undertake a CLeaR review of the Gateshead Smokefree Tobacco Alliance in July 2016 in partnership with HWB members.
3. For officers to work with young people in Gateshead to establish their views and build local action.
4. Develop a local 10 year delivery plan based on both the output of the CLeaR assessment and national, regional and local intelligence (November / December 2016).
5. Maintain public support for action, communicate a clear understanding of the harm caused by Tobacco and the benefits of stopping smoking in partnership with FRESH NE.
6. Ensure the Sustainability and Transformation Plan (STP) includes challenging actions and targets for reducing smoking locally.

RESOLVED - That the actions outlined be agreed by the Board.

HW41 DRUG RELATED DEATHS IN GATESHEAD

The Annual Report for Drug-related Deaths (DRDs) for 2015 was presented to the Board and an overview was given of DRDs to-date in 2016.

The Gateshead DRD Panel is a local multi-agency group that undertake inquiries into all deaths where drugs are suspected to be a direct cause of the death of a person in Gateshead.

The Board were advised that in 2015 there were 17 DRDs. To-date (January to May 2016) there have been 13 potential DRDs in Gateshead which is a significant increase. Whilst there has been an increase in DRDs nationally, the number in Gateshead is of significant concern.

The cases will be looked at and discussed at the next DRD panel; however, it is clear from information gathered to-date that the areas of concern are identical to those which have been highlighted within the 2015 annual report and, in particular:

- Dual Diagnosis
- Involvement with Social Services and the Criminal Justice System
- Unemployment
- Not in Drug Treatment
- Prescribing
- People present at the death not being aware of the signs of an overdose
- Previous overdoses (intentional and accidental); and
- Complex/chaotic lifestyle

Public Health are commissioning an audit of shared care arrangements to gain a better understanding of how we are working together and can improve services.

RESOLVED - (i) That the current work is noted which will also be reported to the Safeguarding Adults Board.
(ii) That an update report be brought to the December Board meeting.

HW42 SAFEGUARDING ADULTS STRATEGIC PLAN

The Board were presented with a report on the Safeguarding Adults Board Strategic Plan 2016-2019 and the Annual Business Plan 2016/17.

The Care Act 2014 enshrined in law the principles of Safeguarding Adults which will not only ensure that the most vulnerable members of society are afforded appropriate support and protection, but will also help them to live as independently as possible, for as long as possible.

It is the legal duty for the Local Authority to have a Safeguarding Adults Board and the Board must produce a Strategic Plan and Annual Report.

This is the first strategic plan for the now statutory Safeguarding Adults Board. The Board is committed to making Safeguarding in Gateshead person-led and outcome focused by adopting and implementing a preventing model.

The Board has established five strategic priorities for 2016/19

- Quality Assurance
- Prevention
- Community Engagement and communication
- Improved Operational Practice
- Implementing Mental Capacity Act / Deprivation of Liberty Safeguards

These strategic priorities will be underpinned by the six Principles of Safeguarding identified within the Care Act.

- Empowerment – people being supported and encouraged to make their own decisions and give informed consent
- Prevention – it is better to take action before harm occurs
- Proportionality – the least intrusive response appropriate to the risk presented
- Protection – support and representation to those in greatest need
- Partnership – local solutions through services working with their communities
- Accountability – accountability and transparency in safeguarding practice

RESOLVED - That the Safeguarding Adults Board Annual Report be brought to a future meeting of the Health and Wellbeing Board.

HW43 LEARNING DISABILITY JOINT HEALTH & SOCIAL CARE SELF-ASSESSMENT FRAMEWORK

A report was presented to the Board on the Learning Disability Joint Health and Social Care Self-Assessment Framework. The Board were advised that this year's assessment was undertaken on a light touch basis on the understanding that a more in-depth assessment will be undertaken next year.

The data provides a comparison for Gateshead against the North East and England and this information will feed into the JSNA and Commissioning Intentions.

The information will also be used by the Learning Disability Partnership Board to set its objectives for the coming year. It was requested that a report be brought back to the Board when these objectives are set.

RESOLVED –
(i) That the information in the report be noted.
(ii) That a report be brought back to the Board when the Learning Disability Partnership Board has set its objectives for the coming year.

HW44 BETTER CARE FUND: QUARTER 4 RETURN FOR 2015/16 TO NHS ENGLAND

A report was presented to the Board to seek formal endorsement of the BCF Quarter 4 Return for 2015/16 which was submitted to NHS England on 27 May. It was noted that the return reflects key trends that have previously been reported to the Board. 2016/17 will be used as a transition year whereby schemes link with new models of care. Guidance is awaited from NHS England on monitoring arrangements for 2016/17.

RESOLVED - That the BCF Quarter 4 return for 2015/16 be endorsed by the Board.

HW45 UPDATE ON SUPPORT AND DEVELOPMENT SERVICE FOR GATESHEAD CVS FOR 2016/17

The Board received an update report on the current position regarding the provision of support, development, networking and representation for the Voluntary and Community Sector in Gateshead. Newcastle Council for Voluntary Service has been

awarded a one year contract to fulfil this role. It was reported that Newcastle CVS has taken up some office space with Age UK and that one member of staff had transferred across from GVOC. 2 new staff have also been appointed. There are 5 events planned over the next few weeks covering each of Gateshead's neighbourhood areas.

The main focus of the work will be around smaller community organisations and it was noted that there is a desire to re-instate the Chief Officers Group. The website is established and an information magazine will be distributed in the next few days. Currently, within the contract, there is no community empowerment network. It was also noted that it will be important to ensure that there is consultation and engagement with the voluntary and community sector during the one year contract period.

RESOLVED - That the information in the report be noted.

HW46 UPDATES FROM BOARD MEMBERS

Newcastle Gateshead CCG

As well as the STP, the CCG are working on a local digital roadmap. Significant regional work has been undertaken on this and plans will have to be submitted to NHS England. The plan is about rolling out digital technology. All providers are involved in early discussions on this issue.

Community Health Services

Work is currently ongoing as part of the mobilisation phase. There are still quite a lot of mechanics and arrangements to be addressed, including the transfer of staff. Michael Laing will be joining the team as Associate Director. The Go Live date is 1 October 2016.

HW47 ANY OTHER BUSINESS

HW48 DATE AND TIME OF NEXT MEETING

The next meeting will take place on Friday 15 July at 10am.

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GATESHEAD HEALTH AND WELLBEING BOARD
ACTION LIST

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Matters Arising from 10th June 2016 meeting of the HWB			
Smoking Still Kills	A 10 Year Tobacco Control Delivery Plan to be brought to the Board.	Iain Miller	To feed into the Board's Forward Plan
Drug Related Deaths in Gateshead	A report to go to the Adults Safeguarding Board An update report to be brought to the December Board meeting.	Alice Wiseman	Actioned To feed into the Board's Forward Plan
Safeguarding Adults Strategic Plan 2016-19	That the Safeguarding Adults Board Annual Report be brought to a future meeting of the Board.	Carole Paz-Uceira	To feed into the Board's Forward Plan
Learning Disability Joint Health & Social Care Self-Assessment Framework	A report to be brought back to the Board when the Learning Disability Partnership Board has set its objectives for the coming year.	Lisa Philliskirk	To feed into the Board's Forward Plan
Matters Arising from 22nd April 2016 meeting of the HWB			
Newcastle Gateshead CCG Operational and Commissioning Plans 2016/17	The STP submission to be considered by the Board at its June meeting.	Dan Cowie/CCG	Completed
BCF 2016/17	BCF 2016/17	John Costello	Completed

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Submission to NHS England	submission documents to be made available to Board members.		
Social Prescribing in Gateshead: Update and Next Steps	That a joint report with the CCG be brought to the Board in September.	Alice Wiseman/ CCG	To feed into the Board's Forward Plan
Personal Health Budgets	Further updates on Personal Health budgets to be brought to the Board as necessary.	Julia Young/Gail Bravant	To feed into the Board's Forward Plan
Health & Wellbeing Strategy Regional Seminar	It was agreed that the September Board meeting will take a more in depth look at whether to add to the Strategy or refresh the delivery plan.	John Costello	To feed into the Board's Forward Plan
Matters Arising from 26th February 2016 meeting of the HWB			
Older People's Strategy & Action Plan	Take forward the proposal to incorporate the Older People's Partnership into the Vanguard Pathway of Care Workstream Group.	Lesley Bainbridge	Report to be brought back to the Board at a future date – feed into the Board's Forward Plan
Vanguard Care Home Programme	The Board agree to receive further update reports regarding the progress of the programme.	Caroline Kavanagh	To feed into the Board's Forward Plan

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Matters Arising from 15th January 2016 meeting of the HWB			
Mental Health Employment Integration Trailblazer Pilot	That the Board note progress and receive a further update in 6 months.	Alan Jobling	To feed into the Board's Forward Plan
Matters Arising from 23rd October 2015 meeting of the HWB			
North East & Cumbria Fast Track Learning Disability Transformation Plan	Future reports to be brought back to the Board on progress.	Chris Piercy	To feed into the Board's Forward Plan
Child and Adolescent Mental Health Services (CAMHS) Transformation Plan	The Board to receive regular assurance reports.	Chris Piercy	To feed into the Board's Forward Plan
Children & Young People 0 – 19 Framework	The Board to receive a follow-up report when further modelling work is complete.	Carole Wood	To feed into the Board's Forward Plan
Matters Arising from 11th September 2015 meeting of the HWB			
Homeless Health: Deep-dive exercise	NTW also to be involved in this piece of work going forward. The findings of the further research work to be brought back to the Board.	Jill Harland/Lisa Philliskirk	Being progressed. To be included within 2016/17 Forward Plan
Substance Misuse Strategy Group Terms of Reference and Workplan for 2015/16	The Board to receive a draft Substance Misuse Strategy for Gateshead at a future meeting.	Alice Wiseman	On agenda of Board meeting – 15 July 2016

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Matters Arising from 5th June 2015 meeting of the HWB			
Older Peoples Wellbeing – Addressing Social Isolation	A scoping report setting out work that is already ongoing and identifying gaps to be brought back to a future meeting of the HWB.	Alice Wiseman	To be included within the 2016/17 Forward Plan
Matters Arising from 24th April 2015 meeting of the HWB			
Place shaping for health and wellbeing	That a stakeholder workshop be arranged on place shaping for health and wellbeing.	Carole Wood/Paul Dowling	To be included within 2016/17 Forward Plan

Gateshead Council

HEALTH AND WELLBEING BOARD
15 July 2016

TITLE OF REPORT: **Director of Public Health**
Gateshead Substance Misuse Strategy

Purpose of the Report

1. To seek views from the Health & Wellbeing Board on the development of the Gateshead Substance Misuse Strategy 2016-2021.

Background

2. Our vision is to reduce the harms caused by substance misuse and make Gateshead a safer and healthier place where less alcohol and no substances are consumed, and where:

   - recovery is visible, bringing about enduring change to local communities
   - substances are no longer a driver of crime and disorder
   - professionals are confident and well-equipped to challenge behaviour and support change
   - there is a reduction in the health inequalities between socio-economic groups.

3. Gateshead currently has the 7th highest rate of alcohol related admissions to hospital in England. Though recent figures show early indications of a positive downward trend in recent years, with a rate of 927 per 100,000 in 2014/15 a decrease of 3.0% on the previous year.

4. However, despite this overall decrease the rate of admissions the rate for women has increased by 30.3% since 2008/09.

5. For young people the rate of admissions for under 18's has decreased by 54% to 58.8 per 100,000, since the 2006/07 - 2008/09 period. However, the rate of admissions is still significantly higher than the England value 36.6 per 100,000.

6. Treatment service figures show a notable shift in the main substances that people seek help for. In 2015/16 alcohol was the main reason for treatment (54.1%) compared to 53.2% in 2014/15. In 2015/16 47.1% of clients cited opiates compared to 51.6% in 14/15. 16.8% of people sought help for cannabis in 2015/16.

7. The number of people in treatment in Gateshead is increasing, with 1989 clients in treatment in 2015/16 compared to 1826 in 2014/15. The majority, 69.5%, are male.

8 As previously reported to the Board, there has been a spike in drug related deaths in recent years with 17 in 2015 and 15 deaths so far this year. These local figures mirror the national trend.

Proposal

9 This is the first combined strategy for several years. The strategy has joined these two issues due to the many similarities in the actions required to address this agenda. The joint approach is highlighted by the proposed shared aims and objectives below.

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

REDUCE SUPPLY PROTECTION AND RESPONSIBILITY
Aim: To ensure all sections of the trade promote responsible retailing to support a reduction in substance misuse-related harm. To mitigate the role of substance misuse in fueling Crime, Anti-Social Behaviour, Violence and Domestic Abuse.

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

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

11 The strategy also identifies the need for high level, strategic action. It is proposed that the work to address these objectives and actions is led by the Health and Wellbeing Board and the Community Safety Board, and activity at both strategic and operational levels is reported at the Substance Misuse Strategy Group.

Recommendations

12 The Health and Wellbeing Board is asked to comment on the attached draft strategy. This is also to be presented to the Community Safety Board and relevant portfolio meetings.

Contact:
Joy Evans Public Health Programme Lead
Joyevans@gateshead.gov.uk
Telephone (0191) 433 2421

Preventing Harm Improving Outcomes Gateshead's Substance Misuse Strategy 2016-21

Foreword

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

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

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

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

We would like to acknowledge all those whose efforts have been successful in introducing effective programmes of work and policy implementation. We intend that this strategy will go above and beyond the excellent work that we have already progressed across Gateshead. Our a focus is to **reinforce the strong partnerships and collaborative working** that we have here in Gateshead **empowering our local population to make decisions and to**

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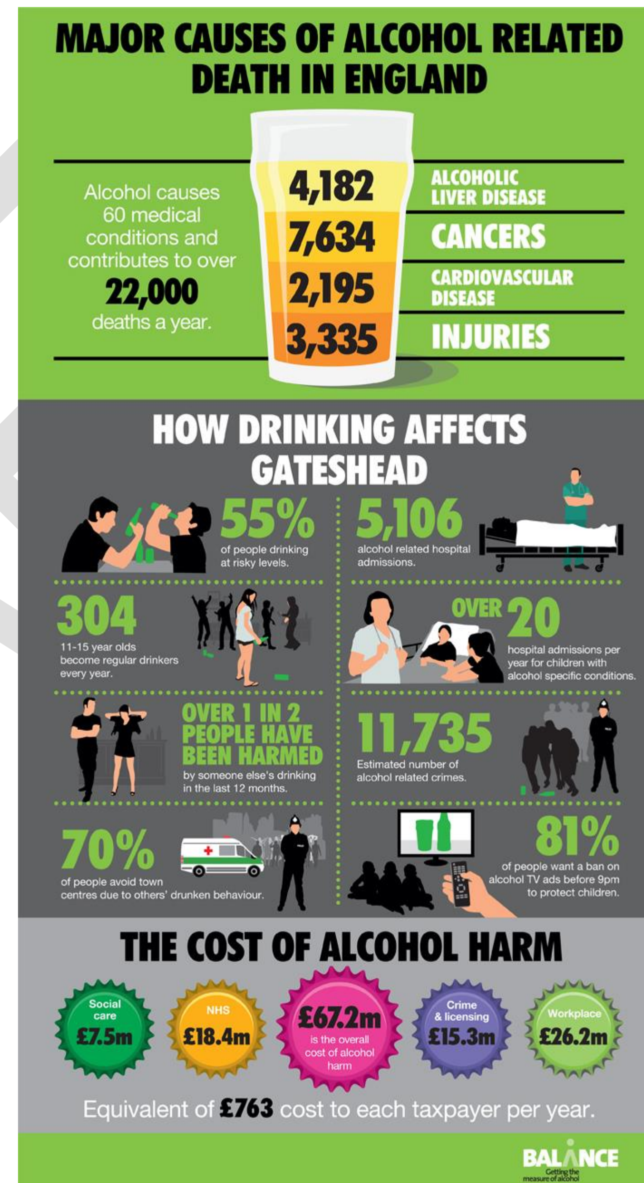
take control of their own lives, therefore impacting on long term prevention.

Governance

The Health and Wellbeing Board and the Community Safety Board are accountable for the delivery of this strategy, this will be coordinated through the Substance Misuse Strategy, which is chaired by the Director of Public Health and co-chaired by Community Rehabilitation Company. The membership comprises key partners and stakeholders, as outlined in Appendix ?, It is each members' responsibility to ensure that as the Strategy develops, they engage and liaise with their organisation, community and peers to ensure wide cascade and ownership of the Strategy. The strategy and action plans will complement other areas of work where alcohol is a significant issue, including:

- Health and Wellbeing Strategy
- Community Safety Partnership Plan
- Drug Related Deaths Annual Report
- Dual Diagnosis Action Plan



Vision

Our vision is to reduce the harms caused by substance misuse and make Gateshead a safer and healthier place where less alcohol and no substances are consumed, and where

- professionals are confident and well-equipped to challenge behaviour and support change
- recovery is visible bringing about enduring change to local communities
- substances are no longer a driver of crime and disorder
- reduction in the health inequalities between socio-economic groups

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High Level/Strategic Objectives

Challenges

- Low aspirations for good health
- Cultural acceptance of lifestyle risk taking behaviour
- High levels of deprivation and unemployment
- Historic high drinking levels
- Historic drug use
- Economy promoting move night time activities
- Complexities of addiction

Priority Actions:

Reduce demand:

- Work tirelessly to improve aspirations for good health
- Address underlying social, health and economic determinants of use
- Increased dissatisfaction amongst residents regarding price & availability of alcohol
- Promotion of alcohol-free events and provide social alternatives
- Support & develop alternative advertising, as lucrative as alcohol
- Place restrictions on promotion by regulating the promotion of and exposure to drug paraphernalia
- Ensure diversion from the criminal justice system to treatment services
- Ensure drugs awareness is statutory in education from 10 years of age

Restricting supply:

- Ensure drug supply is a key issue for the Home Office and Public Health England
- Disrupt and dismantle criminal groups involved in production, trafficking and supply of drugs
- Lobby regionally and nationally for increased taxation on alcohol.
- Lobby regionally and nationally for minimum unit price for alcohol.
- Create control on the proliferation of alcohol outlets
- Public Health work effectively leading/contributing to licensing review and Responsible Authorities Group
- Encourage and challenge the Council to model behaviour e.g. alcohol endorsed events/ advertising
- Educate local residents on the real impact of minimum unit price

Build recovery

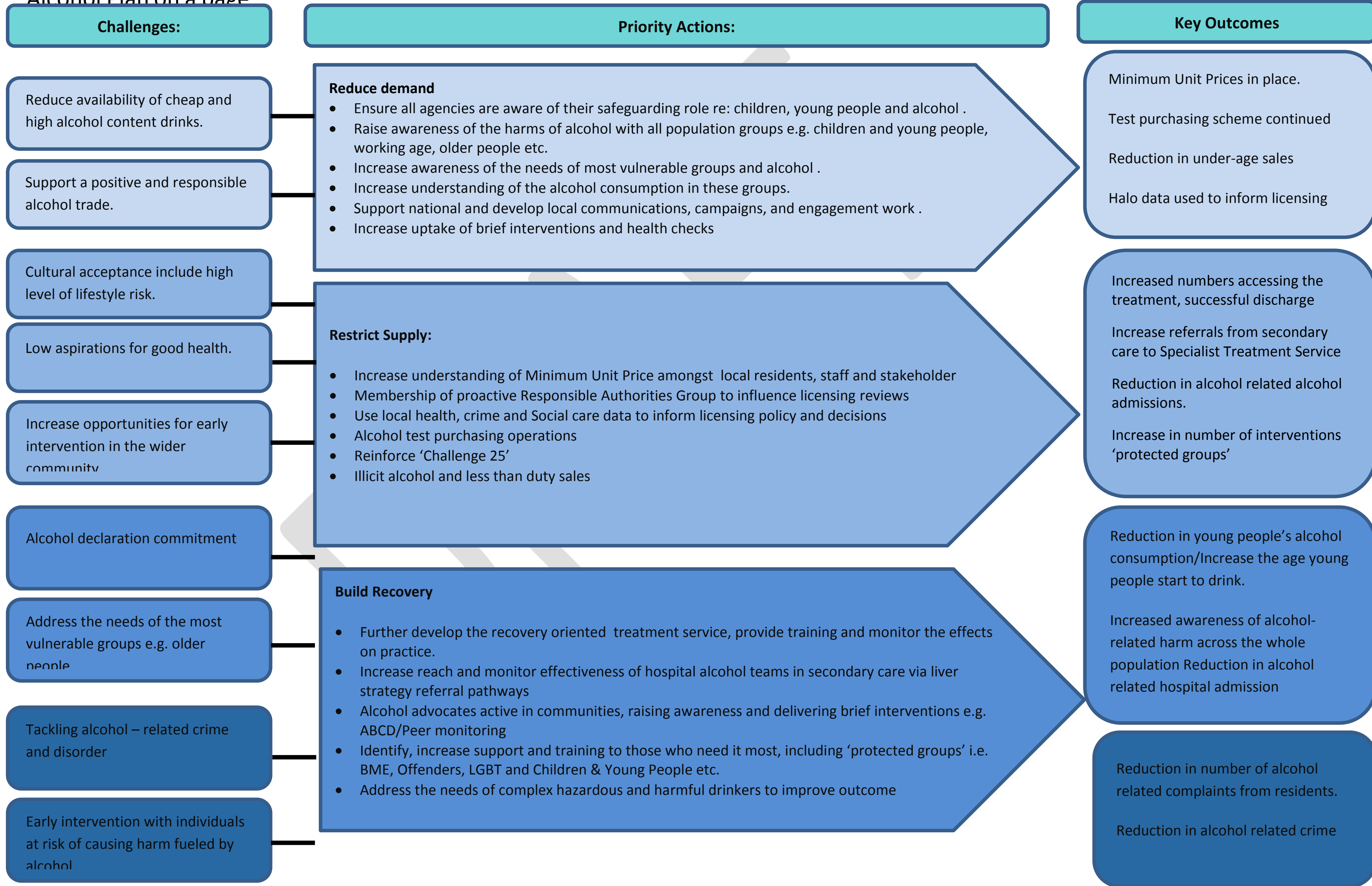
- Facilitate, support and commission treatment services and support groups and events to ensure recovery is visible in Gateshead
- Utilise opportunities for Asset Based Community Development to instill change in our communities
- Build support for this agenda within Economic Development and Vision 2030

Key Outcomes:

To be add

To be add

Alcohol Plan on a page



1. Introduction

The consumption of alcohol is an established part of life in the UK today. Perhaps contrary to common belief, nationally alcohol sales per head have actually declined since 2004[1], however, it still leaves them at roughly twice the level of the 1950s; the UK now having one of the highest levels of alcohol consumption in Europe[Error! Bookmark not defined.]. It has been suggested that even if everybody stopped drinking above recommended levels tomorrow, demands on hospitals would remain relatively high for a further decade.

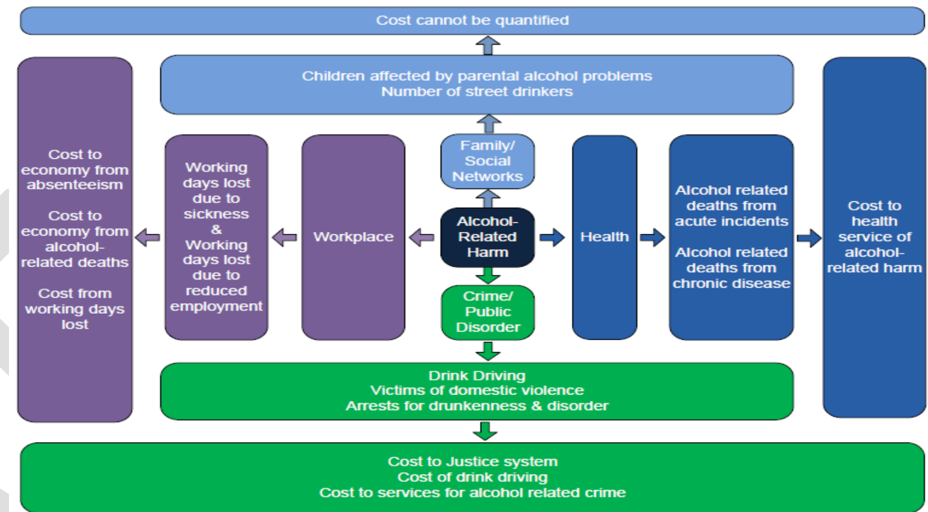
The harms caused by drinking are as complex as our relationship with alcohol. Alcohol may cause or exacerbate problems, its harms may be acute or chronic and issues may arise from individuals' binge drinking or addiction.

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

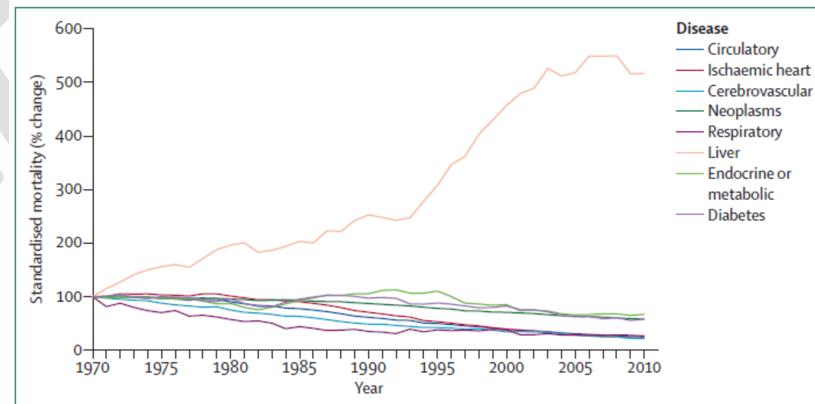
The evidence base is growing:

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

Figure 1. Passive Drinking – the harms arising from alcohol misuse



Rising trend in Liver Disease



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

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2. Current Position – Outlining the need

Current methods for estimating levels of alcohol consumption rely on self-reported surveys, and recent research [2]suggests these underestimate the amount we drink, and therefore underestimates the size of the population at risk of alcohol-related harms, which often cannot be further segmented by different population groups, such as ethnicity. We know that nationally:

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

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

Under 18's

- **For ypung people the rate of admissions has decreased by 54% to 58.8 per 100,000 since 2006/07.** However, the rate of admissions is still significantly higher than the England value 36.6 per 100,000.
- Alcohol consumption by under 18's continues to fall, however, evidence suggests that though fewer young people are drinking, those who do drink, drink at excessive and harmful levels.

Alcohol related hospital admissions (persons)

- **Gateshead currently has the 7th highest rate** of alcohol related admission to hospital in England. Though figures show **an early indication of a positive downward trend,** 927 per 100,000 in 2014/15 a decrease of 3.03% on the previous year.
- **For women,** the rate of admissions to hospital for alcohol related conditions for females has i**ncreased by 30.27%, since 2008/09.**
- **For older people** (65 and over), the number of alcohol related hospital admissions has **more than doubled** in the recent years (197,000 to 461,000 between 2002-2010; NHS Information Centre, 2011).

Emerging Trends

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

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

3. Policy and Evidence

The recent Chief Medical Officers' guideline for both men and women is that:

- You are safest not to drink regularly more than 14 units per week, to keep health risks from drinking alcohol to a low level
- If you do drink as much as 14 units per week, it is best to spread this evenly over 3 days or more. If you have one or two heavy drinking sessions, you increase your risks of death from long term illnesses and from accidents and injuries.
- The risk of developing a range of illnesses (including, for example, cancers of the mouth, throat and breast) increases with any amount you drink on a regular basis
- If you wish to cut down the amount you're drinking, a good way to help achieve this is to have several drink-free days each week.

If you are pregnant or planning a pregnancy:

- The safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum.
- Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk.

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

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

NICE describe two approaches:

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

NICE evidence based activity focuses on:

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

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

4. Our response

REDUCE DEMAND / PREVENTION ACROSS THE LIFE COURSE

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

REDUCE SUPPLY PROTECTION AND RESPONSIBILITY

Aim: To ensure all sections of the trade promote responsible retailing that supports a reduction in substance misuse related harm. To mitigate the role of alcohol in fueling Crime, Anti-Social Behaviour, Violence and Domestic Abuse.

BUILD RECOVERY / HEALTH AND WELLBEING SERVICES

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

Cross-cutting priority groups

Health Inequalities

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

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

Alcohol and its impact on Children and Young People

"The drinking behaviours of our children are some of the worst in Europe, the health consequences are alarming and this is a situation that must change."[3]

National guidance recommends that no alcohol at all should be consumed before the age of 15[3]. Drinking at age 15-17 should be confined to no more than one day a week and strictly supervised, as **binge drinking at this age may lead to violent behaviour, risky sexual activity, low educational attainment and a drift into crime and drugs.**

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

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

The issue of parental responsibility also needs to be addressed, with evidence suggesting that most young people do not buy alcohol illegally; they get it from their parents and /or older siblings[4], often within the home and sometimes without their parents realising**. Further, there is a considerable body of evidence which indicates that parental alcohol issues can lead to risky attitudes among young people and, in turn, risky behaviours can lead to problematic consumption in later adult life**. Pupils' perceptions of their parents' attitudes to their drinking is strongly related to whether or not they have drunk alcohol; if their parents would disapprove, pupils were less likely to consume alcohol.

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Alcohol and Families

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

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

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

Growing up amid the conflict and disharmony associated with alcohol misuse can result in children and young people having increased[5]:

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

Alcohol and Older People

"Between 2001 and 2031, there is projected to be a 50% increase in the number of older people in the UK. The percentage of men and women drinking more than the weekly recommended limits has also risen, by 60% in men and 100% in women between 1990 and 2006 (NHS Information Centre, 2009*a*). Given the likely impact of these two factors on health and social care services, there is now a pressing need to address substance misuse in older people"[6] and to understand the picture locally.

As we get older, the negative impact of alcohol on our physical and mental health increases. Ageing slows down the body's ability to break down alcohol and so alcohol remains in the system for longer. This in turn results in the older person reacting more slowly and they tend to lose balance more easily and lead to an increased risk of falls and other accidents, leading to long term injury and can be a cause for residential care. It may also cause serious complications with any medication(s) the individuals may be taking. Data on numbers of falls and their association with alcohol is limited and further research is needed regarding this.

About a third of older people with alcohol problems develop them for the first time in later life. Bereavement, physical ill-health, becoming a carer, loneliness, difficulty in getting around, unhappiness and depression can all lead to increased alcohol consumption[7]. Social isolation can result from a loss of contact with family members, loss of partners, loss of mobility, less contact with friends and less involvement with, and action in, the community.

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

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

Alcohol across the life course

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

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

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Identification and Brief Advice

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

Wellbeing Service

LiveWell Gateshead brings together a wide range of services into one single access point to make getting help easier. The service seeks to address some of the wider determinants of health which impact upon lifestyle and health and support people to make changes to improve health and access appropriate services. This service will communicate the health harms of drinking above the lower-risk guidelines and provide a range of tips and tools to encourage people to drink responsibly.

NHS Health Checks

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

A&E departments

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

Alcohol-related assault data

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

Recovery Orientated Treatment Service

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

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

Protected characteristics

It is well recognised that there is often a lack of information available concerning specific groups, e.g. older people, the Jewish Community, those suffering from mental ill health; unfortunately this sometimes most pronounced in the protected groups, although not exclusive. Through the development and refinement of the local action plans, we aim to gain intelligence around such barriers and challenges, identifying gaps and opportunities. We must build upon local intelligence and contribute to the refresh of the JSNA when relevant.

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Crime and Disorder

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

Many other offences can take place under the influence of alcohol, such as alcohol related violence, anti-social behaviour, domestic violence, property damage and arson. It is well evidenced that alcohol consumption is a risk factor for many types of violence, including child abuse, youth violence, intimate partner violence and elder abuse. Individuals who start drinking at an earlier age, who drink frequently and who drink in greater quantities, are at increased risk of involvement in violence as both victims and perpetrators (World Health Organization, 2012).

In its report "Alcohol misuse: tackling the UK epidemic,"[8] the British Medical Association outlined the extent and impact of alcohol-related crimes and behaviours in the UK:

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

Domestic abuse is a priority for the Borough; the number of reported incidents of domestic violence has increased to XXXX. Nationally, domestic abuse was linked to almost 70% of all child protection cases and victims of domestic abuse are 15 times more likely to abuse alcohol.

Licensing

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

- Ensure sufficient resources are available to prevent under-age sales, sales to people who are intoxicated, proxy sales (that is, illegal purchases for someone who is under-age or intoxicated), non-

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compliance with any other alcohol license condition and illegal imports of alcohol.

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

Locally, we have recently revised Gateshead's Statement of Licensing Policy to increase the emphasis on the licensee to promote the licensing objectives and public health. Gateshead has recently participated in the Public health England, Health as a licensing objective pilot, building an analytical data tool and exploring the impact a public health objective might have in licensing representations and decisions.

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Reducing Demand:
Prevention across the life-course
Aim

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

What is known to be effective

Population-level approaches are important because they can help reduce the aggregate level of alcohol consumed and therefore lower the whole population's risk of alcohol-related harm. They can help:

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

NICE Guidance, 2013.

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A life course approach, from pre- and early pregnancy through to older age, should be taken to address health and social consequences of alcohol use / misuse. IBA has been proven to reduce drinking, leading to improved health and reduced calls on hospital services. At least one in eight 'at risk drinkers' reduce their drinking as a result of IBA. The National Institute for Health and Clinical Excellence (NICE) recommends that NHS health professionals routinely carry out alcohol screening as an integral part of their practice, focusing on groups at increased risk.

Action needs to be taken to address this increasingly significant issue, such as developing the skills of frontline workers to be aware of the needs of the ageing population and to 'Make Every Contact Count'[9] with this and every group. It must also be ensured that services are accessible for older people especially those with disabilities.

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

What we will do

1. A population approach will address the needs and issues of all population groups by:
   i. Communication and engagement activities, eg Dry January, FASD Day, Balance Alcohol Campaigns
   ii. Low level interventions (further development of IBA, increased training and clear referral pathways to support).
   iii. Routine enquiry (including NHS Health Checks).

2. A targeted approach will address the needs and issues of specific groups/communities by:
   i. Supporting local people to understand the true long term health impact of alcohol.
   ii. Explore the needs of various groups eg, Jewish Community, dual diagnosis, older people living in isolation.
   iii. Empowering local people to understand the impact of alcohol misuse on their mental health and wellbeing, in particular those living in more disadvantaged areas.
   iv. Workforce development – raising awareness of the harms

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Reducing Supply: Protection and Responsibility

Aim

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

One of the biggest challenges that we face is the availability of the 'off trade' sales, i.e. the low cost sales within local supermarkets/local shops, which can be open 24 hours a day, as opposed to more controlled purchases through 'on-trade[1]' sales, i.e. pubs/clubs. Because alcohol is so cheaply available off-trade, and the strength of alcoholic drink products has increased over time, people are frequently drinking more units of alcohol at home, often without realising it. The numbers of people drinking at home are increasing, which includes those who are pre-loading (where a person drinks large amounts of alcohol before going out for the evening).

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Alcohol misuse[12] is a risk factor for many types of violence including child abuse, violence in public settings, youth violence, sexual violence, intimate partner violence and elder abuse. In England and Wales, alcohol is thought to play a part in approximately 1.2 million violent incidents per year - almost half of all violent crimes, with devastating health consequences for victims, their family, friends and the wider community. Whilst health, police and other public services deal with the consequences of alcohol-related violence, the same workers are also victims; for example, 116,000 NHS staff are assaulted each year, primarily by patients and relatives.

What is known to be effective

Controls on price and availability have been identified by the World Health Organization (World Health Organization Europe, 2011) as the most effective measures that governments can implement to reduce the harm caused by alcohol. Minimum Unit Price for Alcohol (MUP) is considered the most effective approach to reduce the levels of consumption of very low cost alcohol.
Other initiatives have been found to have a positive impact on reducing the harm caused by low cost, high alcohol content drinks, i.e. Reducing the Strength. There is evidence that initiatives which: prevent under-age sales and Challenge 25; sales to people who are intoxicated; proxy sales (i.e. illegal purchases for some-one who is under-age or intoxicated); non-compliance with any other alcohol license condition and preventing illegal imports of alcohol, are effective (NICE PH 24, 2010).

What we will do

1. We will ensure that there is commitment to address the problems associated with very cheap and high alcohol content drink; encouraging availability to be restricted in areas of most need by:
   a) Supporting and lobbying for a minimum unit price for alcohol (MUP).
   b) Exploring the opportunities to reduce the availability of super-strength alcohol that is on sale in Gateshead, focusing on the off-trade licensees, and learning from other areas.
   c) Reinforcing 'Challenge 25' at a whole system wide approach and, proxy sales messages.
2. We will ensure that we continue to develop and implement robust systems and have procedures in place to support a positive and responsible alcohol trade by:
   a) Supporting the use of 'Challenge 25' policies.
   b) Working with Trading Standards to address the sale of illicit and below duty alcohol.
   c) Ensuring robust licensing procedures , utilising HALO data to reduce the impact of alcohol related harm for the public.

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[1] On Sales refers to alcohol purchased in pubs or clubs
[2]

Building Recovery: Health and Wellbeing Services

Aim

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

The complex and problematic behaviour associated with alcohol misuse impacts negatively on the lives of others, significant pressures to bear on their own family life, their ability to function positively within society, and our public service provision They also affect a range of provisions and increase demands faced by our accident and emergency departments, hospitals and other emergency services, families and wider communities. Local Authorities, Clinical Commissioning Groups, the wider NHS, the Police and other statutory bodies and the voluntary, faith and community sector must work together to address local needs.

Treatment services which take a recovery orientated approach are already being commissioned in Gateshead and excellent services are provided. Furthermore, interventions aimed at individuals can help make people aware of the potential risks they are taking (or harm they may be doing) at an early stage. This is important, as they are most likely to change their behaviour if tackled early. In addition, an early intervention could prevent extensive damage.

What is known to be effective

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

Recovery orientated community support which goes beyond addressing the medical or mental health complexities associated with alcohol related behaviours also needs to be promoted. By reinforcing responsibility and resilience among recovery focussed networks we should promote awareness, information and advice within communities to ensure improved outcomes for all. The extension of alcohol screening involves identifying people who are not seeking treatment for alcohol problems but who may have an alcohol-use disorder; the scope for delivering these brief (and often low level interventions) is vast, for example, community pharmacists, wellbeing services, community assets.

What we will do

1. Ensure that we have high quality services for individuals and families, developed in partnership, with service user representation and volunteer advocates, which enhance the wider developing recovery system of support that is asset based.
2. Continued monitoring and development of the hospital alcohol team+ including on-going opportunities to enhance outcomes, including working collaboratively with community treatment services.
3. Support and champion the development of knowledgeable Health and Wellbeing services that promote and deliver prevention, sensible drinking and abstinence programmes as their core business, as appropriate.

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DRAFT Alcohol Strategy
Plan on a page

Challenges:

Inequality/deprivation

Dual Diagnosis

Priority Actions:

Strategic Priority 1: Reducing harm / prevention across the life course

-

Strategic Priority 2: Reducing Supply/availability

-

Strategic Priority 3: Building Recovery

- Recovery orientated workforce
- Commitment to substance misuse awareness for all frontline staff
- Tackle dual diagnosis

Key Outcomes

Reduction in Drug Related Deaths
Reduction in overdoses
The number of people who think drug dealing is an issue
Reduction in number of young people presenting with complex issues
Number of young people

Decrease in drug related crime

Offending/reoffending linked with drugs

Number of serious and organised crime groups linked to drugs

Number of people in treatment

Number of people leaving treatment and not representing

Increase in number of young people leaving treatment

Infographic

Annual cost of drug addiction to UK

- Overall annual cost to society £15.4bn
- Annual cost of drug-related crime £13.9bn
- Annual cost of deaths related to substance misuse £2.4bn
- Annual cost to NHS £488m

Parental drug use is a risk factor in 29% of all serious case reviews

A typical heroin user spends around £1400 per month on drugs (2.5 times the average mortgage)

2014/15

British Crime Survey

- Last year among 16-59 year olds 2.8 million adults used illicit drugs
    - 6.7% used cannabis
    - 2.3% used powder cocaine
    - 1.7% used ecstasy
- 279,000 adults used a NPS in the last year
- Young people are more likely to take drugs than older people
- 39% 16-24 year olds
- 21% 25-34 year olds
- 11% 35-69 year olds
- Men are more likely to use drugs than women 11.9% men 5.4% women
- Drug use is lower than 10 years ago
- 6.6% in 2014/15 vs 11.2% in 2004/05
- Young people are more likely to take drugs than older people

Gateshead 15/16

18 Drug Related Deaths

145 young people in treatment

Cannabis main substance

1989 adults in treatment

Opiates were the main substance

Average of 300 visits each month to the needle exchange

4% crime was drug related

80% of drug offences were possession

Young people – national

Fewer young people in treatment (18,349) 1 April 2014 to 31 March 2015

Most common drug is cannabis

1. Introduction

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

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

The harms caused by drugs are wide-ranging. Drug misuse may cause or exacerbate existing problems, its harms may be acute or chronic, and issues may arise from recreational use as well as dependency or problematic use. Drug misuse is strongly related to crime, but harms are not just related to crime. Substance misuse can be found amongst homeless populations and those with mental health problems. Problematic drug use is associated with unemployment, domestic abuse, poor living conditions, ill-health and safeguarding concerns.

Whilst drug dependence can affect anyone, we know that those in our society with a background of childhood abuse, neglect, trauma or poverty are disproportionately likely to be affected. In turn, the children of those dependent on drugs have to cope with the impact on their own lives and some may end up in care. Some drug concerns are familiar and long-standing – for example inter-generational substance misuse and the negative impact of parental drug use on children – however there are new concerns as well, especially around young adults and the purchasing of drugs over the internet.

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2. Current Position

Young people's statistics from the National Drug Treatment Monitoring System (NDTMS) 14/15

There continues to be a downward trend of young people in treatment 18,349, a drop of 777 compared to 13/14. The most common drug that young people need help with is cannabis. The number of young people using NPS remains relatively small and lower than most other problem drug.

Just under two-thirds of the young people accessing specialist substance misuse services were male (65%), and just over half (52%) of all persons were aged 16 or over.
The majority of young people in specialist substance misuse services have a range of problems or vulnerabilities related to their substance use (such as poly drug use and drinking alcohol daily) or wider factors that can impact on their substance use (such as self-harming, offending or domestic abuse). Therefore, specialist services need to be able to work with a range of other agencies to ensure that all a young person's needs are met. Girls are more likely to report mental health problems and self-harming while boys are more likely to be involved in antisocial behaviour and not be in education, employment of training (NEET).

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This year, for the first time, data on sexual exploitation is being reported since this is an area of concern. Five per cent (5%) of young people presenting to treatment services in 2014-15 reported sexual exploitation. This proportion was higher among females (12%) than males (just over 1%).

Waiting times to start treatment were short (average (mean) wait two days and outcomes were good, of the 12,074 young people leaving services in 2014-15, 80% did so in a planned way, no longer requiring specialist treatment. This suggests that specialist substance misuse services in England are responding well to the needs of young people who have alcohol and drug problems, and are helping young people to overcome their substance misuse problems.

Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 14/15

In all, 295,224 individuals were in contact with drug and alcohol services in 2014-15.

The age profile of people in treatment is rising. This ageing cohort is often in poor health, with a range of vulnerabilities associated with long-term drug use. These people require a wide range of support, including social care. When considering all ages, presentations to treatment for opiates have been falling over the last six years (55,494 to 44,356), reflecting the downward trend in prevalence of heroin use.

The majority of younger people (18-24) presenting to treatment in 2014-15 cited problems with either cannabis (52%) or cocaine (23%). Most presentations for new psychoactive substances (NPS) are also in the younger age groups, though the total number accessing treatment for NPS remains relatively low (1,370, 0.5%). Overall, the number of under-25s accessing treatment has fallen by 33% since 2009-10, with the largest decrease in opiates (mainly heroin) where the numbers presenting to treatment have fallen by 60%. This reflects a shift in the type of drug use among young adults.
Men made up 70% of the entire treatment population in 2014-15. The gender split varied depending on the presenting substances – 73% of people using drugs were male compared to 62% presenting with alcohol only. Individuals recorded as white British made up the largest ethnic group in treatment, (85%, 245,380) with a further 4% from other white groups.

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Since 2013 the overall rate of people exiting treatment successfully has slowed. This is mainly because the rate of opiate clients successfully completing treatment has fallen, which is likely to be a result of those now in treatment having more entrenched drug use and long-standing and complex problems.

In all, 130,609 people exited the drug and alcohol treatment system in 2014-15, with 52% (67,788) having successfully completed their treatment free of dependence. Non-opiate-only clients had the highest rates of successful exits with almost two thirds (64%) completing treatment, followed by 61% of alcohol clients. Opiate clients had a completion rate of 30%. The recovery rates for non-opiates and alcohol have remained higher and stable largely because users of these substances are more likely to have access to the personal and social resources that can aid recovery, such as employment and stable housing.

Key Local Features

Young people

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

The majority were male (66%).

75% of young people in treatment were classed as living with parents or other relatives.

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

In terms of vulnerabilities disclosed at first assessment:

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

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

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

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

Schools survey 2012

Survey of 751 year 8 and year 10s showed that 6% had taken drugs – the majority had used cannabis. 15% had been offered cannabis

Drugs

A total of 2756 pupils took part in 43 primary schools and 5 secondary and short stay schools

- q 40% of Year 5 and 44% of Year 6 pupils reported that their parents had talked to them about drugs. 20% of Year 5 and 29% of Year 6 pupils said that their teachers had.
- q 12% say they are ‘fairly sure’ or ‘certain’ they know a user of drugs (not medicines).
- q 3% of pupils said that they had been offered cannabis. 2% also said they had been offered other drugs. When asked what drugs these were, crack and solvents used as drugs were mentioned.

Adults

The number of people in treatment in Gateshead is increasing, there were 1989 clients in treatment in 15/16 compared to 1826 in 2014/15. The majority are male (xx%).
Age profile (xx).

The primary referral source in 15/16 was Self, Family & Friends with 55.2% of all new presentations to treatment coming from this referral source compared to 2014/15 where it was 50.4% of all new presentations from Self, Family & Friends.

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

In 15/16 Novel Psychoactive Substances accounted for only 1.2% of the substances cited for treatment; however since Q4 14/15 this rate has gone up from 0.7% to 1.2% (12 clients to 22 clients). This rate has increased by 84% in the percentage of clients citing this type of substance as one of the reasons for being in treatment over the last 3 quarters. This is contrast to the national picture where only 0.8% of all users cited these as their reason for treatment. This is the highest overall percentage increase of any of the substances cited as a reason for treatment.

3. Evidence base

Public Health England took responsibility of drug and alcohol treatment in 2012 and their work builds on the work of the National Treatment Agency, which spent ten years building the evidence base for treatment in the UK. With data collected via the National Drug Treatment Monitoring System (NDTMS), the UK now has a robust evidence base for treatment and interventions.

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

- Drug misuse: psychosocial interventions (CG51) 2007
- Drug misuse: opioid detoxification (CG52) 2014
- Interventions to reduce substance misuse among vulnerable young people (PH4) 2007
- Needle and syringe programmes (PH52) 2009
- Drug misuse – naltrexone (TA115) 2007
- Drug misuse – methadone and buprenorphine (TA114) 2007
- Drug use disorders (QS23) 2012

Why do we need the strategy?

The Cost to Society

The economic costs to society from drug misuse are high and there is a strong invest-to-save argument for providing drug treatment.

Annual cost of drug addiction to UK

- Overall annual cost to society £15.4bn
- Annual cost of drug-related crime £13.9bn
- Annual cost of deaths related to substance misuse £2.4bn
- Annual cost to NHS £488m

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

Drug misuse harms families and communities

Parental drug use is a risk factor in 29% of all serious case reviews

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Heroin and crack addition causes crime and disrupts community safety

A typical heroin user spends around £1400 per month on drugs (2.5 times the average mortgage)

The public value drug treatment because it makes their communities safer and reduces crime. 82% said treatment's greatest benefit was improved community safety

The focus on recovery sits comfortably alongside other local policy goals, such as asset-based community development and community integration.

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

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

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4. Our Response

THEME 1: Reducing harm / prevention across the life course

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

In Gateshead we will:

- *Take a whole systems approach, and challenge individuals in treatment on a range of issues including training, employment, housing, family relationships, etc.*
- *Provide education and information for targeted groups, e.g. Troubled Families, offenders, Looked After Child, in an effort to reduce, divert or stop potential drug use*
- *Support schools in their efforts to challenge young people's attitudes to drugs*
- *Recognise the importance of early intervention and intensive support for young people and families where there is drug misuse, and provide appropriate support and help to those who need it, in times and places which suit individuals*
- *Encourage agencies, staff and managers to have a 'dare to share' ethos, so they are willing to positively work with other agencies and share information, thereby improving experiences and services for individuals, e.g. by reducing the need for repeat assessments*
- *Ensure that long-term support is there for those who require on-going help, e.g. on-going psychological help or counselling to help individuals with childhood trauma*
- *Review of shared care model*
- *Early intervention and clear pathways to services*
- *Increase public reassurance and reduce the fear of drug related crime*
- *Deliver targeted social marketing campaigns*
- *Discussion/forum around decriminalise or greater sanctions for drug use*
- *Harm reduction*
- *Ensure delivery of the drug related death action plan*
- *Take a tough stance on shops that are selling drug paraphernalia*
-

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THEME 2: Restrict Supply/reduce availability

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

In Gateshead we will:

- Improve the quality of data collection to understand the full impact of drugs on crime, health, offending and re-offending
- *Take an early intervention approach to divert those at risk of becoming involved with drug-related crime*
- *Work with primary care to ensure that prescription drugs and over-the-counter medicines are not misused or causing patients problems*
- *Engage with communities to build strength and resilience at a local level, supporting those who are trying to keep their neighbourhoods healthy and drug free*
- *Protect vulnerable residents by providing local housing which is safe and drug-free*
- *Share intelligence and analysis in order to better target services or schemes, focusing on those in greatest need*
- *Work in partnership to tackle supply and drug-dealing in Gateshead*
- *Tackle criminal gangs and drug-dealing, especially in priority areas, and undertake robust offender management of those who have committed drug-related crime*
- There is a tougher local stance around drug supply (from small dealers to serious and organised crime)
- *Housing providers – take appropriate action* Housing providers actively take action when drugs are sold/cultivated in their properties
- Review of prescribing arrangements and overdoses in Gateshead (including take home methadone policy)

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Build recovery

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

People in drug treatment are given information and advice about the following treatment options: harm reduction, maintenance, detoxification and abstinence.
People with drug use disorders have a better chance of recovery and reintegration, and maintaining recovery in the longer term, if they are supported to access services that promote recovery.
Continued treatment and support is designed to help an individual's chances of recovery by maintaining abstinence and reducing the risk of adverse outcomes (including death). A lack of support may lead people with drug use disorders to relapse.

In Gateshead we will:

- *Support the development of a recovery-orientated workforce that is focused on all elements of recovery - housing, employment, mental health, family life - and not just medical treatment*
- *Build skills among frontline workers so that any professional can have a conversation about drugs with a resident*
- *Involve (ex)service users as to what services and interventions they find helpful or useful, utilising the Recovery Forum, feedback forms and individual comments*
- *Tackle dual diagnosis - patients who have both substance misuse and mental health problems, working in partnership with new services*
- *Encourage all providers and staff to make best use of local services, both statutory and voluntary agencies, as well as community groups and faith organisations, so that individuals are aware of and can access a full range of local support*
- *Facilitate peer support and mutual aid networks so communities become empowered and individuals who have exited services can continue to receive support that enables them to sustain their recovery*

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Priority Groups

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

Intervening early, with at-risk groups and when people are in greatest need of support is critical. 'At risk' groups include a diverse range of individuals who are particularly susceptible to drug use and are more likely than others to experience adverse outcomes and would include: children from households where there is drug use, Looked After Children, offenders, people with mental health problems and people from deprived neighborhoods.

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

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

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

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

- Adults with complex health and social problems
- Dual diagnosis patients (mental health problems and substance misuse problems)
- Offenders
- Vulnerable individuals, including rough sleepers and the homeless
- Young adults (18 – 24)

Governance

Drugs and substance misuse remains a cross-cutting theme that requires an on-going, joined-up partnership response.

The delivery of the substance misuse strategy is the responsibility of the Substance Misuse Strategic Implementation Group

The group is accountable to the Community Safety Board and the Health and Wellbeing Board, but also works closely with the xxx

A multi-agency Implementation Plan will sit underneath the Substance Misuse Strategy and provide a detailed breakdown of the actions that partners will undertake to deliver the strategy. This plan will be the work plan of the Substance Misuse sub-group of the Implementation Group.

Quarterly reporting will track progress against outcomes and indicators with remedial action being taken by partners in areas where there is under-performance or blockages.

Outcomes

The public health outcomes framework contains a number of indicators which will reflect progress made in addressing drug misuse.

A performance dashboard has been developed to monitor the impact of this strategy, and include the following measures:

Outcomes and Indicators

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

- Increases in number of young people leaving treatment with reduced drug use or drug free
- Increase in number of young people leaving treatment with reduced risky behaviours
- Increase in proportion of adult opiate & crack users exiting treatment successfully without representing (Public Health Outcomes Framework)
- Increase in proportion of adult non-opiate and crack users exiting treatment successfully and not representing (Public Health Outcomes Framework)
- Decrease in number of burglary (dwellings)

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

Contact details

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

Public Health

Gateshead Council

Telephone:

Website:

Email:

Completion: September 2016

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Appendix B

How we will deliver: local response

Intrinsic to the success of this strategy is the associated communications and engagement work. Communication campaigns have been aligned to each of the priority areas which will utilise various forms of media, targeting different population groups and the various aspects of alcohol related use and abuse, as the local action plans develop. These campaigns will also seek to reflect and amplify national campaign messages where appropriate. These are outlined below:

Reduce demand **Prevention across life course**	Dry January Balance Campaigns LiveWell Gateshead
Reduce Supply	Minimum Unit Pricing Challenge 25 Endorsement of national campaigns (e.g. pre-Christmas, World Cup, Domestic Violence awareness)
Build Recovery / Recovery focussed treatment services	Training, clear, accessible referral pathways Promotion of support and services

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Links to strategic priorities

There are a number of strategic priorities that are driving forward this Strategy[Error! Bookmark not defined.], including:

- Reduce the overall alcohol consumption in the population
- Reduce the incidence of alcohol related illness, injuries and deaths
- Reduce the incidence of alcohol-related disorder, anti-social behaviour, violence and crime

The nationally produced Public Health Outcomes Framework[10] provides a model from which our outcomes are developed:

Domain 2: Health improvement

i. Reduction in alcohol-related admissions to hospital.
ii. Reduction in the people entering prison with substance dependence issues who are previously not known to community treatment.
iii. Increased take up of the NHS Health Check programme for those eligible, which now incorporates alcohol consumption levels

Domain 4: Healthcare public health and preventing premature mortality

I. Reduction in mortality from liver disease.

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[10] Department of Health (2013) Public Health Outcomes Framework https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency

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Gateshead Council

HEALTH AND WELLBEING BOARD
15th July 2016

TITLE OF REPORT: Live Well Gateshead evaluation

Purpose of the Report

1. To inform members of the Health & Wellbeing Board about the findings from the evaluation of Live Well Gateshead, ask for comments and endorsement of the recommendations outlined below for the re-modelling of Live Well Gateshead.

Background

2. Live Well Gateshead aims to improve health and wellbeing and reduce health inequalities through; improved service integration, promotion of healthy lifestyle behaviours and addressing the social determinants of health.

3. Commissioned in October 2014, it provides 1:1, group based and capacity building support for individuals, families, and communities.

4. An evaluation (July 2015-July 2016) was undertaken through Fuse (www.fuse.ac.uk) as part of an embedded researcher post by Mandy Cheetham from Teesside University.

5. Qualitative methods were used to collect data in 1:1 interviews with 25 wellness service users and 9 staff. 6 focus groups were conducted, 3 with LWG service users, and 3 with parents and Gateshead residents not using LWG services. The purpose of the focus groups was to identify potential barriers and facilitators to access.

6. Analysis of routine monitoring data was undertaken to understand patterns of referral, uptake, goal setting, and any reported changes.

7. Observations of training and group based sessions, and informal discussions added further information to contextualise the findings.

Findings

8. The findings suggest that the service is operating at many levels to bring physical, social, emotional, nutritional and educational benefits helping participants to:
   - Increase levels of physical activity
   - Access leisure/gym facilities
   - Eat healthily
   - Lose weight
   - Reduce alcohol consumption
   - Improve mental health and wellbeing
   - Learn new skills and build community cohesion.

9. Wider benefits include: reduced social isolation and stress, increased self-efficacy and confidence.

10. Participants identified that the following things help in making the wellness service successful:
    - Clear communications and marketing
    - Co-ordinated, referral pathways especially with GP input
    - Confidential, non-judgemental, holistic 1:1 support from trained coaches
    - Group-based sessions where peer support and friendships are encouraged
    - Understanding that change takes time
    - Opportunities to become volunteer buddies
    - Access to activities which are affordable and appropriate in terms of time, location, transport links, level.

11. In addition to the 1:1 service, the Community Capacity Building Team were valued for:
    - Developing and sustaining community groups
    - Inter-organisational communication
    - Developing networks
    - Promoting integration
    - Enabling groups to build stronger more cohesive communities, using local assets
    - A source of support, information, contacts, funding and practical advice to navigate systems
    - Providing the encouragement to make things happen.

12. Overall LWG is valued by individuals and communities, but further work is needed to develop the offer for families and ensure that LWG runs as an integrated whole. There was evidence of fragmentation, siloed activity, and poor communication between the elements.

13. Multiple KPIs, incomplete data recording and the complexity of the scorecard, impede the capacity to make sense of how the different parts of the service are actually operating. A review of the KPIs is underway and the findings are being used to inform the re-modelling of Live Well Gateshead.

14. **Recommendations for the re-modelling of Live Well Gateshead:**

Current practice

- Ensure initial contact and the assessment process for all users is smooth and efficient, in particular to provide assurances about confidentiality.

- Review efforts to target groups, including young people, carers, men and Black and Minority Ethnic communities.

- Use staff and service user feedback to inform practice. Celebrate successes.

Future developments

- Involve stakeholders in discussions about re-modelling LWG to learn from what is working well.
- Engage stakeholders to develop the LWG offer for families, building on existing examples of effective practice.
- Increase step up / step down options including volunteering and mentoring opportunities.
- Explore with stakeholders the possibilities and risks of co-locating staff in community hubs.
- Engage schools, children, teachers and parents in LWG, using evidence of what works.
- Senior leaders to work together to address fragmentation in the system and ensure co-ordinated, integrated systems and structures moving forward.

Data collection:

- Improve routine data collection to measure health gains and use this information to inform practice and drive up performance.
- Review and reduce the volume of Key Performance Indicators (KPIs) to enable meaningful judgements about performance. Commissioners to build in shared responsibility for KPIs.
- Identify an independent data lead to produce regular activity reports about LWG from the Data Collection and Recording System (DCRS).

Contact: Mandy Cheetham (0191) 4332736

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HEALTH AND WELLBEING BOARD
15th July 2016

TITLE OF REPORT: Primary Care Co-commissioning - Next Steps

Purpose of the Report

1. To seek the views of the Health & Wellbeing Board on the next steps for primary care co-commissioning.

2. A report from Newcastle Gateshead CCG is attached.

Recommendations

3. The Health and Wellbeing Board is asked to consider the report.

Contact: Jane Mulholland (0191) 2172982

Primary Care Co-commissioning - Next Steps

1. Aim

The aim of this paper is to brief members and seek views on the next steps for primary care co-commissioning.

2. Background

Primary care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. Co-commissioning aims to support the development of high quality integrated out-of-hospital services based around the needs of local people.

In November 2014, NHS England released 'Next steps towards primary care co-commissioning' offering CCGs the opportunity to take on additional responsibilities for the commissioning of primary care services. There were three levels that CCGs could assume from 1st April 2015:

- Level One: Greater CCG Involvement in NHS England decision making
- Level Two: Joint Decision Making (Joint Commissioning) by NHS England and CCGs
- Level Three: CCGs taking on delegated responsibilities from NHS England

Newcastle Gateshead CCG undertook a process by which member practices voted for their preferred option. The result of this vote was that the CCG would enter into Joint Decision Making with NHS England on 1st April 2015. Since then, the Joint Committee has been established and business is being conducted via that forum. A subsequent practice vote to move to level 3 was undertaken in October 2015. Member practices voted to remain at level 2.

The CCG Executive now seek to move to co-commissioning level 3 with a member practice vote by 20th September 2016 after a members meeting on 13th September. This will ensure sufficient time to engage member practices in the process.

3. Level 3 CCG Delegated Responsibilities

Under level 3 the role of the CCG will be to exercise the Delegated Functions which include;

- decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to:
  - Enhanced Services
  - Local Incentive Schemes including the design of such schemes
  - establishment of new GP practices, including branch surgeries and closure of GP practices

- the approval of practice mergers
- planning primary medical care services in the area, including carrying out needs assessments
- performance management of GP practices, including decisions and liaison with the CQC (but excluding decisions in relation to the performers list)
- management of the Delegated Funds
- Premises Costs Directions Functions (revenue)

Legally, NHS England retains the residual liability for the performance of primary medical care commissioning, including issuing contract breaches, as well as to exercise the Reserved Functions including;

- management of the performers list
- revalidation and appraisal process
- complaints management
- decisions regarding the Prime Minister's Challenge Fund
- Capital Expenditure Functions

4. Level 3 Benefits and Risks

Detailed SWOT from 2015 see Appendix 1.

Benefits for practices include;

- Enables CCGs to prioritise investment for acute, primary and community services
- Budget slippage will be retained for investment in primary care locally whereas at level 2 budget slippage is retained by NHSE to spend across the area or return as underspend
- Local knowledge and relationships;
    - support collaborative solutions to problems
    - enable more timely resolution of queries
- CCG roles and structures provide easier contact points and ongoing support for practices

Risks include;

- Any potential overspend and financial risks will be borne by the CCG
- Delegated functions are complex (see below), CCG skills and competencies will need to be developed
- The delegated functions mean that risks management will need to be enhanced.
- The CCG will be also responsible for delivering the CCG elements of the NHSE Assurance Process and CQC Process

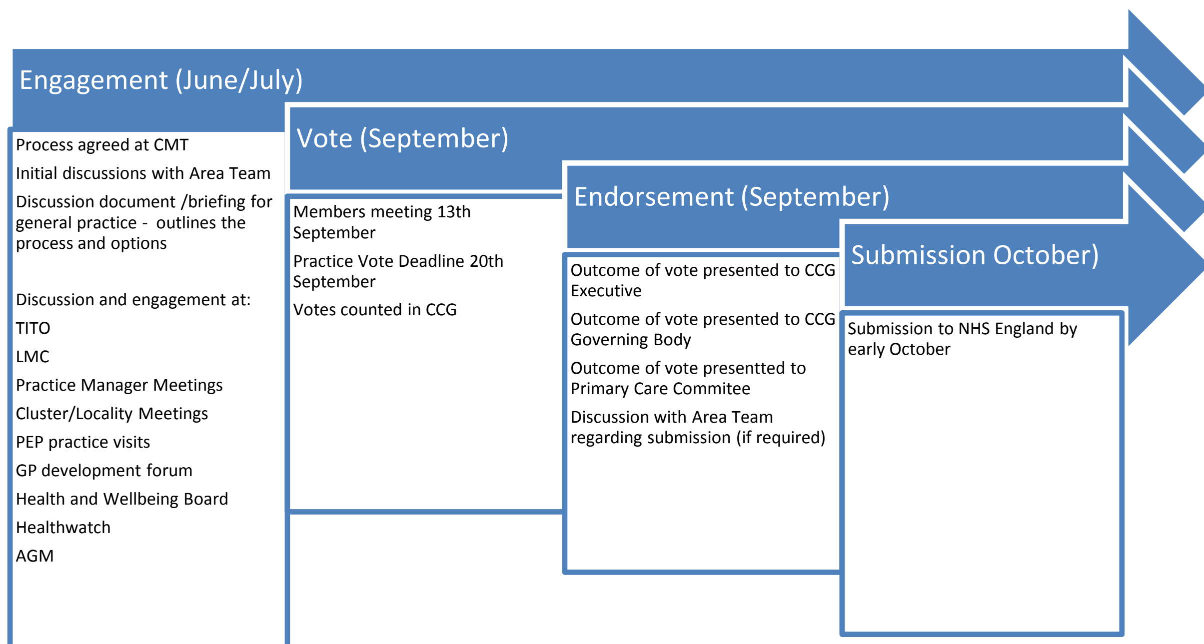
5. CCG process for decision making

In order to identify if a move to assume delegated responsibilities is supported by the member practices, it is proposed that a similar process be undertaken to the one used in 2014/15 and October 2015. Member practices will be invited to vote for their

preferred option for assuming commissioning responsibility for primary care. The vote will be operated as a one practice, one vote system. Member practices and the LMC will be engaged in the decision to move to level 3. The CCG will also engage Healthwatch in both Newcastle and Gateshead and the Health and Wellbeing boards in the process.

The Primary Care Commissioning Committee and Governing Body will endorse the decision of the CCG prior to submission. The timetable is very tight from the member vote in September to submission in early October (date awaited from NHSE) therefore the governance and ratification process could be problematic.

To ensure the CCG is ready to make a submission should the outcome of the vote be that the CCG pursues level 3 commissioning responsibility, the following timetable is proposed:



6. Delegated commissioning next steps

NHS England will publish the process for CCGs to apply to take on delegated arrangements in 2016/17 in due course. This is currently an annual process. It is anticipated that we will apply in October 2016 to take on responsibilities 1 April 2017.

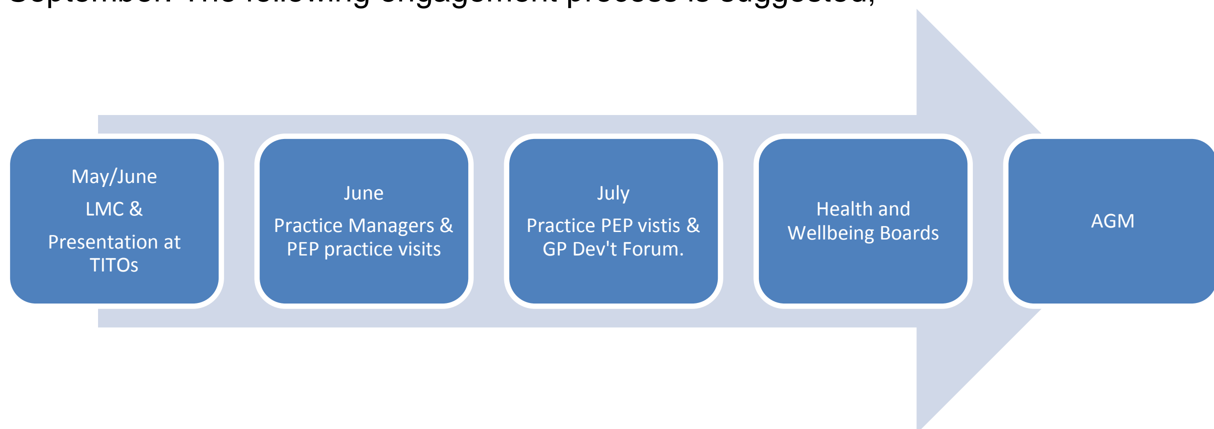
A summary of the key points in the existing approvals process can be found below:

The process currently outlined by NHSE is as follows:

- Apply to take on delegated responsibility from 1 April 2017
- Template and supporting information available – date awaited
- Submission deadline **October 2016** (likely to be early in the month) (to england.co-commissioning@nhs.net and to their local NHS England team)
- Regions will support CCGs to ensure the submissions meet requirements
- Regional panels will review proposals and make recommendations to a national panel on which proposals to take forward
- Primary Care Oversight Group (PCOG) will provide national moderation date awaited.
- PCOG will make recommendations to an Executive Scrutiny Group - date awaited
- CCGs will be notified of the outcome.

7. Engagement

The level of member engagement is important as this could impact on the outcome of the member practice vote. Member engagement and communication is key to ensuring member practice support the move. For this reason it is proposed that the vote be undertaken in September. There will be a member practice meeting regarding co-commissioning on 13th September resulting in a vote by 20th September. The following engagement process is suggested;



8. Stakeholder perspective

a) Practices – anecdotal mixed feedback from practices
b) LMC – fully support the move to level 3 and would like to see practice engagement
c) Healthwatch – no known views at this time
d) Health and Wellbeing Boards - no known views at this time
e) Area Team – strongly support the move to level 3 however the move is not mandatory

Appendix 1. Local SWOT

In 2014/15 the CCG developed a SWOT analysis for each of the options for co-commissioning.

Level 2 - Continuing with joint commissioning arrangements

Strength	Weakness
• Reduced potential for challenge re conflict of interests (clearer 'blue water') • Pooled budget 'soft £' • Reduced reporting requirements • Current arrangements working well – split between transformational and transactional • Not a barrier to making progress in certain areas • Current Area Team – skills and experience	Reduces CCG motivation to enact significant change – e.g. more passive about larger opportunities
Opportunity	**Threat**
Increased flexibility to select priority areas for local area	Resources are taken to support model 3 CCGs Area team may not be able to pick up where they are required to No clear owner

Level 3 – Move to delegated commissioning

Strength	Weakness
• Greater control of existing e.g. premises/IT • 'hard wired £' • Greater control of transformation (alignment) • Aligns with national direction of travel therefore allows for greater alignment	• More transactional • CCG skills and experience will need development • Other local CCGs not made any significant changes yet. • CCG capacity to deliver
Opportunity	**Threat**
• Opportunity to mould QoF to meet local commissioning intentions • CCG embracing wider opportunities which may not be immediately obvious	• Greater opportunity for challenge re conflict of interest • Additional performance management responsibility • More change for general practice is destabilising • Capacity required to carry out performance management • Limited available capacity within the CCG to deliver • Potential impact on existing stakeholder relationships- requires additional relationship management • Needs increase pace of market development; Requires CCG to mobilise primary care

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HEALTH AND WELLBEING BOARD
15 July 2016

TITLE OF REPORT: Draft 2016/17 Forward Plan & Meetings Schedule for the Health & Wellbeing Board

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Purpose of the Report

1. To seek the views of the Health & Wellbeing Board on an initial draft Forward Plan and meetings schedule to steer the work of the Board during 2016/17.

Background

2. The Health & Wellbeing Board is in its fourth year as a statutory Board. A draft Forward Plan has been developed (Appendix 1) to guide and shape the work of the Board during 2016/17. It reflects issues which have been identified by the Board to-date and relates to 5 key areas of focus:

   - strategy, policy development and commissioning intentions
   - transformation agenda, integration and ways of working
   - health and care service developments and reviews
   - performance management
   - assurance issues

3. Appendix 2 sets out an indicative timetable for these issues to come to the Board. It also sets out a list of potential items for consideration by the Board which have not yet been slotted in to the meetings schedule. This will be the subject of discussion with partners over the summer.

Proposal

4. To finalise the draft Forward Plan and meetings schedule for the HWB for 2016/17 following discussions and input from stakeholders. In particular, it is proposed to use the period until the next Board meeting after the summer recess to:

   - confirm the ‘big issues’ which should form the core of the Board’s business during 2016/17, when they should come to the Board during the course of the year and lead organisations;
   - identify any preparatory work that will need to be undertaken and/or arrangements put in place to facilitate this.

5. A final draft 2016/17 Forward Plan and supporting timetable will then be brought back to the Board for endorsement on 9th September.

Recommendations

6. The Health and Wellbeing Board is asked to consider an initial draft Forward Plan for 2016/17 and an associated meeting schedule (set out in Appendices 1 and 2 attached) and the proposed next steps to finalise this work.

Contact: John Costello (4332065)

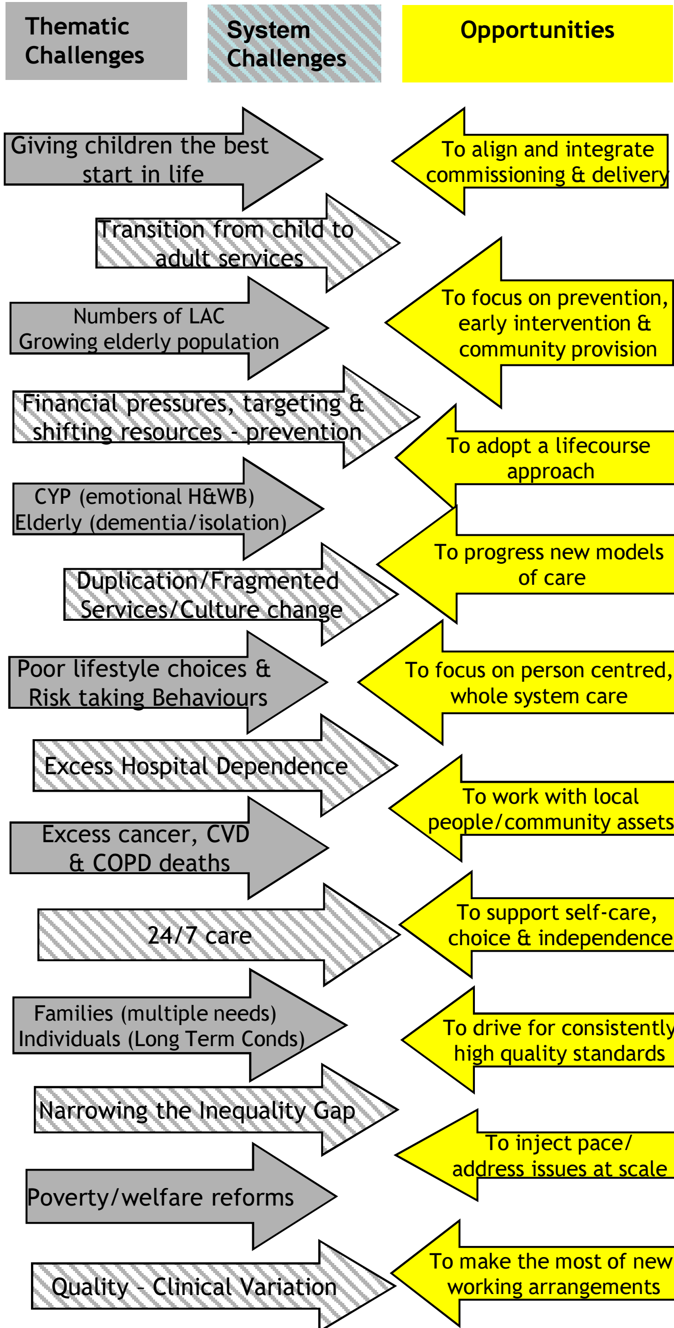
Gateshead Health and Wellbeing Board Forward Plan – 2016/17

Appendix 1

Aspirations for the Future

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

A healthy, inclusive and nurturing place for all where children have the best start in life; where older people are independent and part of community life; where people lead healthy lifestyles, with more people living longer; and where those who need help can get it easily with agencies working together.



Areas of Focus of HWB during 2016/17

Area	Focus
Strategy, Policy & Commissioning Intentions	Development of JSNA, including needs assessment of homeless, BME and refugees & asylum seekers Health & Wellbeing Strategy Refresh Development of a Health Inequalities Framework Commissioning Intentions for health & care (all age) Health & Care Strategic and Operational Plans Tobacco Control 10 Year Plan, Sexual Health Strategy
Transformation Agenda: Integration & Ways of Working	Responding to key challenges over next 5 years: Financial and demand pressures New Models of Care BCF Transition Transformation Enablers – workforce, technology, estates, involvement & engagement, system architecture (collaborative planning and working arrangements etc.)
Service Developments & Reviews	Community health, Mental health, Primary care, Urgent care services Children & Young People: prevention & early support Older Peoples Wellbeing / Management of LTCs Drug related deaths Place shaping and health / Licensing objectives Social Prescribing / Achieving More Together
Performance Management Framework	A Performance Management Framework encompassing: - Key health & wellbeing system Indicators - BCF monitoring - Inspections etc.
Assurance	DPH Annual Report Health Protection Assurance Annual Report HealthWatch Gateshead Annual Report & Priorities Safeguarding Annual Reports (Children & Adults) Learning Disability Joint Self-Assessment

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Gateshead Health & Wellbeing Board
Meeting Schedule and Draft Work Programme 2016/17

Meeting Date / Time	Report Title
9 September 2016 (10am -12noon)	***For Decision and/or Discussion:*** **Gateshead JNSA 2016, including a focus on:** - **Homeless** - **BME** - **Refugees & Asylum Seekers** **Gateshead Health & Wellbeing Strategy Refresh** **Learning Disability Partnership Board: 2016/17 Objectives** ***For Assurance:*** **Local Safeguarding Children Board Annual Report 2015/16** **Safeguarding Adults Board Annual Report 2015/16** ***Performance Management:*** *Items to be identified as required.*
21 October 2016 (10am -12noon)	***For Decision and/or Discussion:*** **Children & Young People – Prevention and Early Intervention** **Tobacco Alliance Needs Assessment Update** **Gateshead Council's Budget Proposals & NHS Budgetary Position** **Emerging Commissioning Intentions 2017-18 (children & adults)** **Community Health Services – mobilisation and transformation** **Gateshead Sexual Health Strategy** ***For Assurance:*** *Items to be identified as required.* ***Performance Management:*** *Items to be identified as required.*

Meeting Date / Time	Report Title
2 December 2016 (10am -12noon)	***For Decision and/or Discussion:*** **BME Health Needs Assessment** **Health & Wellbeing Strategy (Refresh)** **Director of Public Health Annual Report** **Drug Related Deaths: Review of Progress against 2016-17 Action Plan** **Mental Health Employment Integration Trailblazer – Update on Delivery** ***For Assurance:*** *Items to be identified as required.* ***Performance Management:*** **Performance Report for Health & Care System**
20 January 2017 (10am -12noon)	***For Decision and/or Discussion:*** **Tobacco Control 10 Year Action Plan** ***For Assurance:*** **Health Protection Assurance Annual Report 2015-16** ***Performance Management:*** *Items to be identified as required.*
3 March 2017 (10am -12noon)	***For Decision and/or Discussion:*** **Operational Plans for 2017-18** **Final Draft Commissioning Intentions 2017-18 (Children & Adults)** **Development of OSC Work Programmes for 2017-18: Emerging Themes** ***For Assurance:*** *Items to be identified as required.* ***Performance Management:*** *Items to be identified as required.*

Meeting Date / Time	Report Title
28 April 2017 (10am -12noon)	***For Decision and/or Discussion:*** **HWB Work Programme and Forward Plan for 2017-18** **Recommendations arising from the Care, Health & Wellbeing OSC review of the role of housing in improving health and wellbeing** **Sustainability & Transformation Plan – refresh of Plans for 2017-18** ***For Assurance:*** *Items to be identified as required.* ***Performance Management:*** *Items to be identified as required.*

Other Items:

Other items to be included within the meetings schedule for 2016/17 as required include:

- New Models of Care/Transformation of Care – Intermediate Care, Vanguards (Care Homes and Urgent Care), community health services, primary care, prevention and wellbeing etc. This is central to the health and social care integration agenda.

- Management of financial and demand pressures on the local health and care system (linked to work on new models of care etc.).

- Children & Young People's Agenda.

- Older Peoples Wellbeing / Management of Long Term Conditions.

- Social Prescribing in Gateshead / Achieving More Together / Community led approaches to health and wellbeing.

- Public Health Objectives in Licensing.

- Place Shaping for Health and Wellbeing (including a focus on the wider determinants of health).

- A Health Inequalities Framework for Gateshead.

- Transformation and Reconfiguration of Mental Health Inpatient and Community Services.

- CAMHS Transformation Plan: Progress Update.

- North East & Cumbria Learning Disability Transformation Plan: Progress Update.

- Personal Health Budgets: Progress update as required.

- BCF 2016/17: Transition planning and monitoring returns to NHSE.

- Ways of Working Across Local Health & Care System / Enablers:

    - Workforce
    - Technology: Digital Solutions
    - Estates
    - Involvement & Engagement
    - System Architecture (collaborative planning and working, payment systems, system leadership and governance)

HEALTH AND WELLBEING BOARD
15th July 2016

TITLE OF REPORT: HealthWatch Gateshead Annual Report 2015/16 and Priorities for 2016/17

Purpose of the Report

1. To seek the views of the Health & Wellbeing Board on HealthWatch Gateshead's Annual Report for 2015/16 and its priorities for 2016/17.

2. A report from HealthWatch Gateshead is attached.

Recommendations

3. The Health and Wellbeing Board is asked to consider the report

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Contact: Douglas Ball (0191) 477 0033

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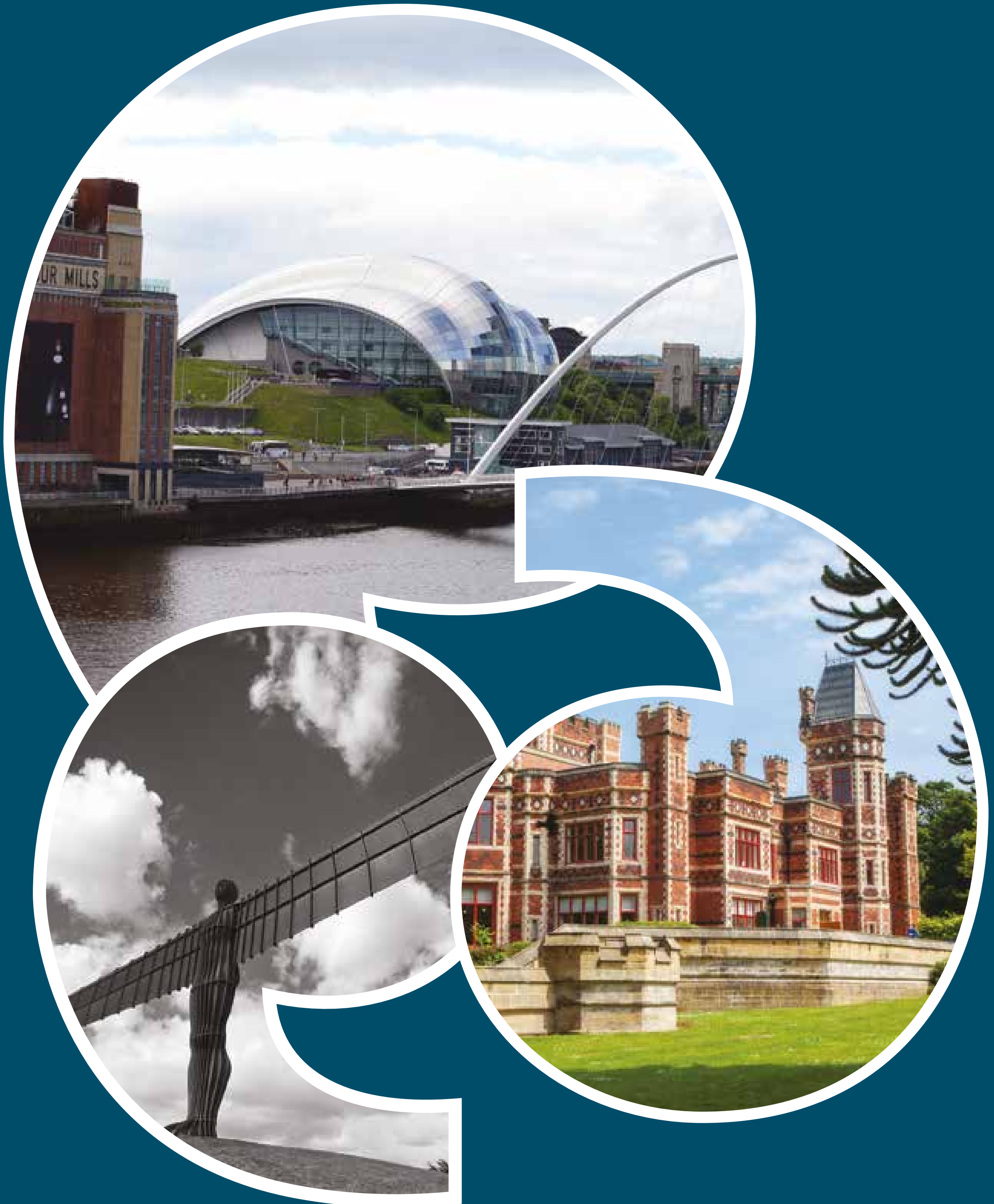
healthwatch Gateshead

Annual Report 2015/16



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Healthwatch Gateshead board meetings are held monthly at our offices in the Davidson Building, Swan Street, Gateshead. Two public meetings are held in May and October each year to provide the opportunity for residents to talk with board members and ask questions. For more information and enquiries, email info@healthwatchgateshead.co.uk

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Message from our Chair

Welcome to Healthwatch Gateshead. Our role is to represent the views of the residents of Gateshead to the commissioners and providers of health and social care. To carry out this function on your behalf we need to know your experiences good as well as bad, your cares, your issues and what improvements or changes you would like to see from the providers of the services you receive.

The board members of Healthwatch Gateshead are volunteers who give their time and expertise to their particular role which is to help Gateshead residents shape their health and social care delivery, influence the services they personally receive and hold services to account.

We work with health and social care service providers to improve the quality of their services and to help develop both local and national services. We encourage decision makers to capitalise on the desire of consumers to engage and work with people as partners for change.

The current board including myself, with one exception, all joined in the second half of last year. Our grateful thanks to the previous board members Sharon Stuart, Esther Ward, Marjorie Hunter, Hollie Pinder and the Development Officer Andrew Moore for their contribution to the management of the organisation. We are always interested in hearing from individuals who would like to help contribute to their local community.

This year, as last year, has seen significant changes in the manner in which health and social care will be both commissioned and delivered. The challenge for everyone is how to meet the increasing demand with limited resources, balancing the attributes of economies of scale which favours concentrating expertise in limited centres while at same time providing a locally based service.

There is both a need for openness from commissioners and service providers regarding the practical options available due to past decisions (good and bad) and a need for each of us to accept some self-responsibility to conserve the limited health and social care resources for those less able to look after themselves.

Healthwatch Gateshead costs about 86 pence per Gateshead resident to operate in 2015-2016, which funds five part time staff involved in the various activities identified in this annual report.

It is obviously easier to demonstrate our influence when for an individual we can show an outcome. It is always harder to demonstrate our influence when we are trying to influence policy.

Examples of where we have been successful include working with, but not for, the Queen Elizabeth Hospital and GP practices. We have been able to help them improve the quality of their services and their feedback shows the impact of our independent reviews.

Longer term is the importance of our feedback on your views on Gateshead Council's social care budget proposals, Deciding Together, Vanguard care home programme, the Sustainable Transformation Programme and the Commission for Health and Social Integration.

We will continue to develop ways to enable your views to be heard by us and review our approach to ensure that we represent your concerns in the most influential manner possible. Thank you to all those who have helped us shape the future of health and social care in Gateshead.

Douglas Ball

Chair, Healthwatch Gateshead

Who we are

Healthwatch Gateshead is the borough's consumer champion for health and social care, representing the voices of current and future users to decision makers.

It is one of 148 local Healthwatches across England which form a national network, and is a registered Community Interest Company.

As set out in the Health and Social Care Act of 2012, Healthwatch Gateshead has the following statutory activities:

- Promoting and supporting the involvement of local people in the commissioning, the provision and scrutiny of local care services.
- Enabling local people to monitor the standard of provision of local care services and whether and how local care services could and ought to be improved.
- Obtaining the views of local people regarding their need for, and experiences of, local care services and importantly making these views known.
- Making reports and recommendations about how local care services could or ought to be improved. These are directed to commissioners and providers of care services and people responsible for managing or scrutinising local care services and shared with Healthwatch England.
- Providing advice and information about access to local care services so choices can be made about local care services.
- Formulating views on the standard of provision and whether and how the local care services could and ought to be improved; and sharing these views with Healthwatch England.
- Making recommendations to Healthwatch England to advise the Care Quality Commission to conduct special reviews or investigations (or, where the circumstances justify doing so, making such recommendations direct to the CQC); and making recommendations to Healthwatch England to publish reports about particular issues.
- Providing Healthwatch England with the intelligence and insight it needs to enable it to perform effectively.

Healthwatch Gateshead's overarching aim is to improve local health and social care provision across the borough. As a statutory watchdog, our role is to ensure that local health and social care services and the local decision makers put the experiences of people at the heart of their care.

This will be achieved by:

- Reaching out to the residents and communities in Gateshead.
- Gathering evidence from what local people are telling us and working to improve local services.
- Providing comprehensive, accurate information and advice to the public to enable them to make effective choices and decisions when accessing local health and social care services.
- Representing Gateshead residents' views, concerns and needs to commissioners and providers of health and social care services.
- Seeking to influence the improvement, development, delivery and implementation of local health and social care services.
- Signposting appropriate services for individuals and representing them.

Your Healthwatch team

Philip Kerr
Manager

Philip is responsible for the operations and contract monitoring for Healthwatch Gateshead. He is committed to influencing and changing the health and social care services in Gateshead for everyone.

Kim Newton
Community Participation and Engagement Worker

Kim works with local voluntary groups and residents who want to engage with health and social care services. She was previously Gateshead LINk's engagement and involvement worker, so has a wealth of information and contacts. Kim lives in Gateshead with her husband and autistic son Daniel.

Carole Gourdie
Community Participation and Engagement Worker

Carole's role involves working with local voluntary groups and residents who want to engage on health and social care services. She has 24 years' experience of work in various roles in the voluntary community sector and most recently worked with Age UK Gateshead managing the Age UK North East regional 'Fit as a Fiddle' Big Lottery funded national health and wellbeing programme.

Victoria Clark
Signposting and Information Officer

Victoria is Healthwatch's Signposting and Information Officer and is responsible for communications and information. Victoria has worked in Gateshead all her working life and has many contacts in the voluntary and public sectors.

Nicola Winship
Administrator

Nicola is our Administrator and is responsible for providing essential administrative support to the team and our Board.

Karen Bunston
Volunteer Programme Manager

Karen is our newest team member, joining us as Volunteer Programme Manager. She is responsible for our volunteer programme, particularly Enter and View.

Our vision

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

Our priorities

We identified the following strategic priorities for 2014-16:

Strategic development

- Work proactively with Clinical Commissioning Groups, the local authority and all health and social care providers, other organisations and the general public to develop and maintain strong working relationships.
- Widen public access and involvement.
- Create an organisation which is representative of and influenced by the local population.

Operational development

- Develop our volunteer programme to establish volunteers who will engage with a range of communities across Gateshead.
- Implement reporting mechanisms which enable us to gather the views of a wide range of diverse communities.
- Build an effective evidence base so that we can influence local service delivery and development on behalf of local people.

Delivery

- Develop engagement with hard to reach groups.
- Develop a programme of innovative and creative engagement activities.
- Develop our local 'drop in' sessions so that we have an effective presence across the borough.
- Widen public access.

Giving people advice and information

Helping people get what they need from local health and social care services

During the year we have provided a wide range of advice and information to patients and carers, who have contacted us via email, telephone or our website - or met us at events and roadshows across the borough.

Signposting enquiries have ranged from alcohol dependency and eating disorder support services to patient group information to complaints and escalations.

Examples of signposting queries during the year include:

- A lady in her late 80s who, along with her husband, was seeking help with heavier household chores. We referred her to Gateshead Council's Adult Social Care Reablement Team service, Age UK and Happy to Help.
- A lady wanting help for her husband who is a hearing aid wearer and can't hear on the phone. We referred the couple to Action on Hearing Loss and Hearing Loss Support and to Adult Social Care for an assessment.
- A carer whose elderly father had been diagnosed with Alzheimer's and whose mother had failing health seeking support, whom we referred to the Alzheimer's Society, the Carers' Association and the dementia lead at their local GP practice.
- A wheelchair user seeking advice on where to get their chair fixed was advised to check it was under guarantee from the supplier first, but to then contact local Trading Standards if there was a dispute, or if purchased second hand to try Gateshead Shopmobility Scheme or supplier Peacocks.

Giving advice at the Party in the Park at Saltwell Park during Carers' Week.

- A caller concerned their neighbour may have undiagnosed dementia wondering what to do, who was recommended to call 999 if they feared immediate danger, to contact the neighbour's family if they were comfortable to do so, or to raise a safeguarding alert with Adult Social Care.
- A query from a member of the public seeking power of attorney for their mother who was referred to Age UK Gateshead and either a family solicitor or a local legal firm.

The Healthwatch Gateshead website has also been updated during the year and now has an A to Z list of services for all kinds of health and social care information, advice, complaints, care pathways, patient and support groups. There is also a section on frequently asked questions which is reviewed on a regular basis.

> "You are the first person I've spoken to that I actually feel I have been listened to. I feel better thank you."
>
> Mrs Marston, October 2015

Listening to people who use health and care services

Gathering experiences and understanding people's needs

During the year we have undertaken research projects and engagement activities to gather local people's experiences and expectations of health and social care services, recommended service improvements and identified best practice which could be adopted locally or nationally.

These include:

- A survey of patients' experiences of GP access and out of hours provision.
- A review of the discharge process at Queen Elizabeth Hospital.
- Informing residents of Gateshead Council's social care budget proposals and presenting residents' views to the council.
- Representing Gateshead residents' views on the 'Deciding Together' consultation regarding the future of specialist mental health services in Gateshead.
- Establishing asylum seekers and refugees' issues in accessing health and social care services.

Healthwatch Gateshead uses a variety of techniques to gather residents and patients' views.

We established patients' experience of GP access and out of hours provision, through surveys promoted via the Healthwatch website, e-newsletter, social media and at community engagement events. The report was submitted to all the practices that took part to help identify both good practice and any improvements that need to be put in place. The report was also used by a local MP as part of a parliamentary review of GP services.

We established patients' views of the Queen Elizabeth (QE) Hospital discharge process through a questionnaire specially developed in conjunction with QE. The QE has adopted the recommended improvements identified by Healthwatch Gateshead and we will revisit the QE to establish the impact of implementing these recommendations on patients' satisfaction.

We offer Gateshead residents a range of methods to raise any issue or concern directly with Healthwatch Gateshead via our website, telephone, letter or our Freepost 'Have your say' cards issued at community events such as the Party in the Park and other activities including 'Cuppa with a Copper'.

For more complicated consultations, we have held special events to inform Gateshead residents. In December 2015 to raise awareness of Gateshead Council's social care budget proposals, we held a special event and Gateshead Council provided a speaker to explain the proposals. The report was presented to Gateshead Council identifying residents' and carers' concerns and the disenfranchising nature of making their website the main mechanism to disseminate consultation documents.

We used our partnership and our resident contact database to publicise the 'Deciding Together' consultation on the provision of mental health services to Gateshead and to gather the views and issues from Gateshead residents. Healthwatch Gateshead sent a formal report identifying all the concerns and issues raised by Gateshead residents in response to the consultation. Our report was also presented to Gateshead Care, Health and Wellbeing Overview and Scrutiny Committee and sent to Newcastle Gateshead Clinical Commissioning Group to influence their decision on the provision of mental health services for Gateshead residents.

Health issues of asylum seekers and refugees in Newcastle and Gateshead

Efforts to engage with diverse groups and communities have included two events held in conjunction with Healthwatch Newcastle and the Regional Refugee Forum to discuss the health issues of asylum seekers and refugees.

This was a joint piece of work with Healthwatch Newcastle and the Regional Refugee Forum (RRF). The events were held with the RRF in June and October 2015 at Brunswick Methodist Church in central Newcastle.

The first event gave RRF members the opportunity to describe the unique and distinctive health and wellbeing issues affecting them. The second event brought together members of the refugee and asylum seeker communities with those responsible for planning and commissioning health and care services in Newcastle and Gateshead.

The joint report sent to commissioners and providers made several recommendations around the cultural stigma some communities have with mental illness, the need for staff training, language barriers, and the lack of information on healthy eating and free leisure activities.

What we've learned from visiting services

One of our key roles is to carry our Enter & View visits to providers of health and social care services to identify both good practice that can be shared with others and any issues service users feel concerned about.

Developing Enter & View is a key priority for Healthwatch Gateshead, and we carried out our first visit in March 2016.

The Teams Medical Practice was selected as it had been rated 'outstanding' in its latest CQC inspection and we wanted to share good practice examples of meaningful patient engagement. In addition, the practice wanted to use the findings of the visit to improve its services.

A team of authorised representatives comprising volunteers Christina Massey, Ann Atkinson and Kay Parker and staff members Victoria Clark and Karen Bunston carried out the visit, talking to patients and carers, health champions, clinical and non-clinical staff.

They found a number of ways in which patients could engage, including a patient forum, volunteer health champions, a walking group, involvement in staff recruitment and social media.

Suggestions, comments and complaints are included as agenda items at practice meetings, and staff reported being encouraged by partners to feedback both positive and negative information from patients to improve services.

Further improvements recommended to the practice in the Enter & View report included reporting the outcomes of patient engagement in a 'you said, we did' style of reporting, greater use of social media and involving patients in the production of the practice newsletter.

> "In the past year the Regional Refugee Forum North East has forged a stronger relationship with Healthwatch Gateshead which has enabled the voice of the refugee and asylum seeker community to be heard about their concerns on health issues, expecially challenges about accessing the right services. The relationship has also demonstrated how true partnership can actually lead to better outcomes."
>
> Herbert Dirahu,
> Regional Refugee Forum

How we have made a difference

Our reports and recommendations

We have published a number of reports following surveys, reviews and consultations involving patients and made a series of recommendations to providers for improvements to services.

These have included surveys on GP access and out of hours services, arrangements for the discharge of patients from hospital, and raising awareness of planned changes to the local social care budget and specialist mental health services.

Queen Elizabeth Hospital discharge review

Healthwatch Gateshead's Board commissioned a review into discharge arrangements at the Queen Elizabeth Hospital.

A paper questionnaire was completed by patients in 15 wards between August and October 2015 as part of the discharge process. The overall satisfaction rate was good, with 95% happy with their discharge.

The report to the hospital trust had no high areas of concern but contained several recommendations which the trust has agreed to action.

They include a review of the discharge process relating to the issue of medication, which had led to delayed discharge for more than a third of patients we surveyed, and promotion of the underused discharge lounge. Problems with transport for patients being discharged, including delays and the lack of suitable equipment to transfer patients with mobility issues into their homes, were also highlighted.

"Healthwatch Gateshead is a valued partner to the Quality and Safecare Team at the Queen Elizabeth Hospital, recently working with us to achieve valuable insights into our patients' view of our discharge process, and regularly giving important contributions to our committee meetings and patient experience project workshops. We highly regard the well-established external agency link afforded to us by Healthwatch, and look forward to continuing our joint working to improve patient experience."

Dr Nichola Stefanou
Head of Safecare, QE Gateshead

GP access and out of hours provision

Anecdotal reports from patients on problems with access to GPs and out of hours provision led to a four month survey of users of the borough's 31 GP practices and four branch surgeries by Healthwatch Gateshead.

The survey was promoted via our website, e-newsletter, social media and at community engagement events between April and August 2015.

It asked questions about experiences of booking appointments, out of hours provision, dignity and respect, continuity of care, patient information and prescription services.

Respondents reported a variety of positive and negative experiences in using GP services. Recommendations in our report to Gateshead Council's Care, Health and Wellbeing Overview and Scrutiny Committee included improved information on: ways to make appointments and out of hours services; the ability to make longer appointments; advance appointments with the same GP; patient forums.

Our report was also used by Blaydon MP Dave Anderson for his submission to the House of Commons Public Accounts Committee. It was specifically referred to by the committee chair Meg Hillier MP in the oral session on Access to GPs in England in January 2016.

Consultation on Gateshead Council's social care budget proposals

In October 2015 Gateshead Council put forward proposals for changes to the social care budget which would result in a reduction in care packages and an increased role for unpaid carers, including reassessing people with learning disabilities, reviewing support for people to live independently and a reduction in domiciliary care packages.

The authority said the service changes were a result of funding cuts which had led to a planned reduction in the workforce.

We expressed concern to the council during the eight week consultation period that the predominantly website-based consultation, with limited paper copies of proposals available, prevented individuals with sensory impairments or learning disabilities and older people without internet access from accessing the consultation documents and therefore being able to respond to the consultation.

We also highlighted the lack of impact statements - which made it very difficult for any reader to understand what the proposals would actually mean for them or for those that they provided care for. Subsequently Gateshead Council added additional information to their proposals.

We contacted key stakeholders in the Voluntary and Community Sector and individuals on our members' database to ensure that they were aware of the consultation.

Healthwatch Gateshead organised a consultation event at Gateshead Masonic Hall in December 2015 to make residents aware of the proposed reductions in services by Gateshead Council in their social care budget. The Council's Director for Social Care and Independent Living addressed the event.

Attendees had the opportunity to ask questions or gain clarity on any aspect of the proposals, and workshops enabled discussions with feedback fed into the council consultation as part of the Healthwatch Gateshead report which summarised the concerns raised by residents, carers and stakeholders.

The consultation event at Gateshead Masonic Hall

"Healthwatch Gateshead have been instrumental in supporting service users and family carers of Gateshead services to have a voice that truly matters. The ideas, issues and concerns that Healthwatch have raised on behalf of service users and carers has enabled Gateshead Council to be both respectful of and responsive to these when determining the future direction of services."

Keith Hogan, Service Manager
Social Care and Independent Living,
Gateshead Council

Deciding Together consultation on the future of specialist mental health services

Deciding Together was launched by NHS Newcastle Gateshead Clinical Commissioning Group (CCG) in November 2015 to gather feedback from residents, carers, mental health professionals and service providers about the business options determined by the CCG for the provision of mental health services in Gateshead.

The consultation raised significant concerns from Gateshead residents regarding the lack of any local option for Gateshead residents, the planned closure of mental health beds before the proposed community support programme was in place, and great difficulty for Gateshead residents being able to visit their relatives by public transport for two of the options.

Healthwatch Gateshead has represented the residents' concerns in a number of forums as well as producing a formal response which was submitted to the CCG.

Gateshead Council has raised similar concerns and used the independent published report of Healthwatch to support its concerns.

Involving local people in our work

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

All of our board members are volunteers. During 2015/16 we have invested in a Volunteer Programme Manager and a framework for volunteer involvement has been developed in line with national guidance, along with a 'volunteering toolkit' covering every aspect of volunteer involvement.

A series of outreach events held to promote volunteering and also the wider work of Healthwatch has led to the recruitment of four new volunteers.

> "I became involved as a volunteer for Healthwatch as I feel it is important to contribute towards improving health services and care provision in Gateshead which affect everyone. My first Enter & View was a little daunting but I was well briefed and well supported by the Healthwatch team and I look forward to continuing to make a worthwhile contribution to a very important project."
>
> Ann Atkinson – Volunteer

Working with other organisations

Healthwatch Gateshead works in partnership with both voluntary organisations and statutory bodies to bring about improvements to health and social care services – an approach which reduces duplication of effort and provides greater value for money in an era of austerity.

Patient organisations contact us for help with issues raised by their members, including consultations on changes to services. An example of this was Action On Hearing Loss informing us that there were issues within GP practices being able to interact with individuals with hearing loss, or who are deaf with BSL as their first language. We presented the information to the Primary Care Joint Committee of the Clinical Commissioning Group for their consideration.

We share information with the Care Quality Commission (CQC) to assist with its inspections. For example Healthwatch Gateshead promoted a listening and engagement event held by CQC in September 2015 as part of their inspection of Gateshead Health NHS Foundation Trust and provided anonymous patient experiences regarding services received from the Queen Elizabeth Hospital to feed into their inspection process. We also provided input to, and publicised the CQC inspection of, the North East Ambulance Service NHS Foundation Trust in April 2016.

All of our reports and recommendations are shared with Healthwatch England.

Part of our role is to review the Quality Accounts for trusts who provide services to residents. We attend Gateshead's Care, Health and Wellbeing Overview and Scrutiny Committee reviews of the Quality Accounts for the following trusts: Northumberland & Tyne and Wear NHS Foundation Trust; Gateshead Health Foundation Trust and South Tyneside NHS Foundation Trust. We are invited to hear the trust's presentations and share Gateshead Healthwatch's views on the respective Quality Accounts at the meetings.

Teams Medical Practice is an example of a provider keen to work with us to improve services to patients. Our recommendations for improvements to their already impressive patient engagement activity after the Enter & View visit in March 2016 were positively received.

Strategic partnerships that we regular input to, ensuring that the voice and opinions of local people are taken into account when decisions are being made about health and social care services, include:

- Primary Care Joint Commissioning
- Gateshead Safeguarding Adults Board
- Local Engagement Board
- Health and Wellbeing Board
- Health and Wellbeing Overview & Scrutiny Committee
- Gateshead Patient User Carer Public Involvement Group
- Gateshead Smokefree Tobacco Alliance
- Gateshead Care Home Vanguard
- North East Commission for Health & Social Care Integration
- Joint Integrated Care Programme Board
- Achieving More Together
- Gateshead Voluntary Sector Advisory Group
- Gateshead and Newcastle Joint Overview and Scrutiny Committee
- Northumberland Tyne and Wear NHS Foundation Trust

"Healthwatch Gateshead carried out an Enter & View of our practice (Teams Medical Practice) at the end of March 2016. The practice, staff and patients all found it to be a very positive experience and have already implemented some of the feedback received by the Enter & View team. The practice has worked with Healthwatch Gateshead very positively over the last couple of years and hopes to continue to do so in the future."

Sue Jennings, Practice Manager

Our plans for next year

Future priorities

One of our key strategic priorities for 2016/17 is to convert Healthwatch Gateshead into an independent self-governing body able to deliver the Healthwatch contract for Gateshead Council independently of Carers Federation.

The board in June 2016 consisted of three new members and one founder member, and was actively recruiting new members. A senior strategic manager had been recruited to manage the contract, develop the services and support the board to deliver its strategic priorities.

We will continue to:

- Participate whenever possible in consultation events run by health and social care commissioners and providers.
- Work closely with the Care Quality Commission to assist in their inspections and provide detailed information received from Gateshead residents.
- Work with the Commission for Health and Social Care Integration in the North East to try and ensure that any future service design is resident orientated, rather than institution based.
- Work with the Integrated Care Programme Board to develop a sustainable transformation plan which is more patient based than institution based.
- Promote and support Gateshead Council's 10 year tobacco reduction programme.

The Board will also be considering how we can support:

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

Our people

Decision making

Our Board is made up of local people who live or work in Gateshead who want to help further our work. Each member has a keen interest, understanding or specialist skills in the health and social care sector.

The Board is responsible for making sure Healthwatch meets its statutory obligations and it sets our strategic objectives.

Our Board meetings are held at our offices in the Davidson Building, Swan Street, Gateshead. The dates of meetings for the remainder of 2016 are: July 25th; August 24th; September 27th; October 25th; November 28th and December 20th. There are two public meetings held in May and October each year to provide the opportunity for the residents to talk with board members and ask questions.

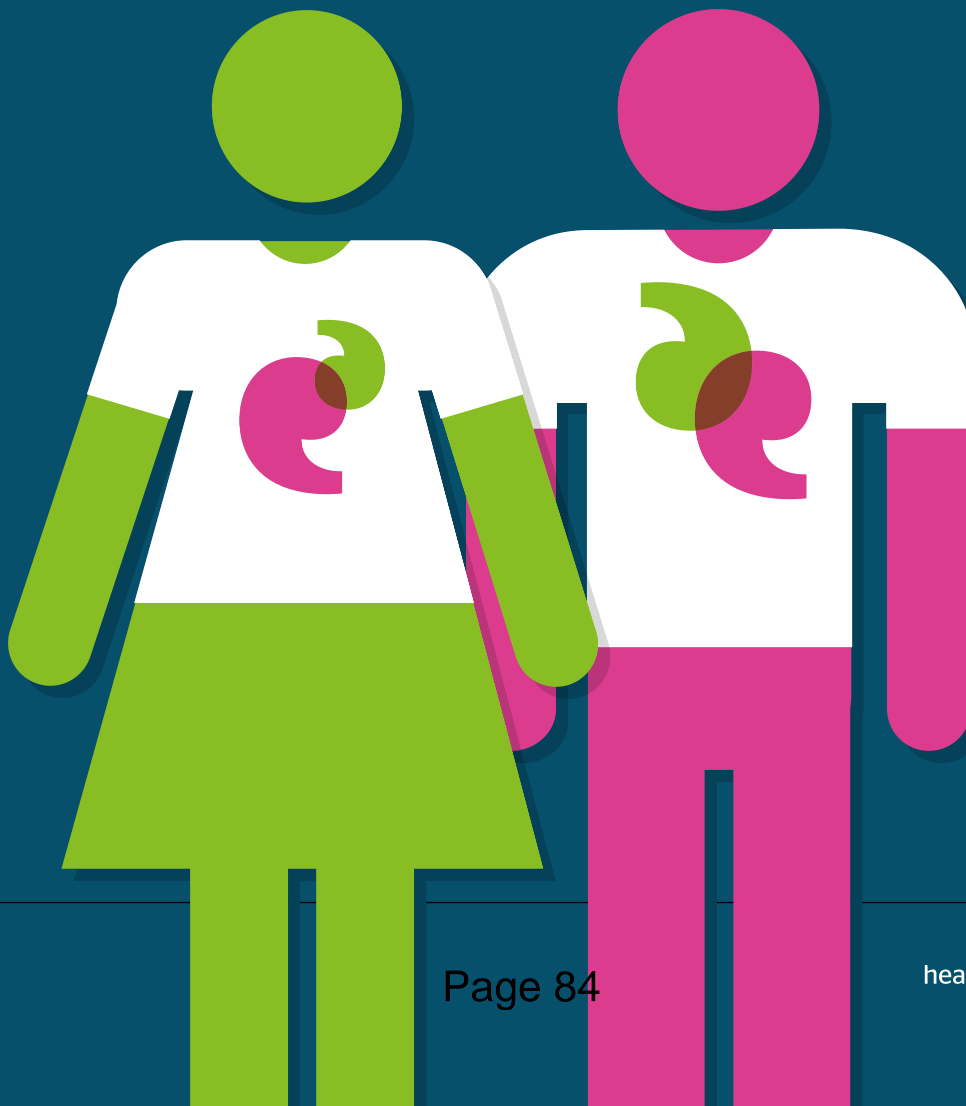
Policies and procedures are published on our website as they are developed and agreed.

How we involve the public and volunteers

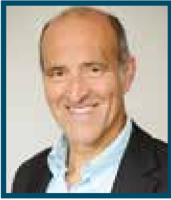
We have introduced two public meetings each year to enable residents to ask questions and talk to the board about their concerns and issues.

We invite members of the public through a range of media to contact us with their problems and issues. We are planning to create a partnership with the Youth Council to capture their views on health and social care and involve young people in the volunteering activities of Healthwatch.

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



Board members

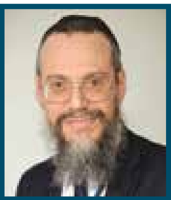


Douglas Ball - Chair

Douglas is a local resident and brings to the Board of Healthwatch a breadth of skills and experience in both the statutory, voluntary and community sectors. He has been an active volunteer in Gateshead, successfully supporting the development of local charities on their Boards as a member and also as Chair. Douglas has a good knowledge and understanding of local health and social care issues that affect both local residents and service providers.

Kay Parker

Kay has significant previous work experience as a social worker and specialised in mental health services. Since retiring Kay has set up and facilitated various mental health support groups and been active in many related steering and working groups including personalisation and independent living. Kay has been a Board member since the beginning and her specialist area of skills are older people, volunteering, mental health and equality. Kay lives and volunteers in Gateshead.



Michael Glickman

Michael has been a resident of Gateshead for 28 years, is a teacher and an educational consultant and has taught in both private and local authority schools. He has also worked for a local authority developing services for children, particularly within the minority communities. Michael has considerable experience in the health sector in a voluntary capacity. He has been a Trustee and Co-ordinator of a local community first response service for 25 years and has developed close links with voluntary and statutory services. He was elected Governor of the North East Ambulance Service, when it became a foundation trust, and is currently Lead Governor.

Janet Gauld

Janet has lived in Gateshead for over 20 years. She was an Executive Board member and Director of Operations in a national safeguarding organisation and a senior management consultant undertaking work across public services including the NHS. With extensive knowledge of corporate governance and a strong commitment to protecting vulnerable people, she brings with her commitment to and enthusiasm for improving health services for the people of Gateshead.

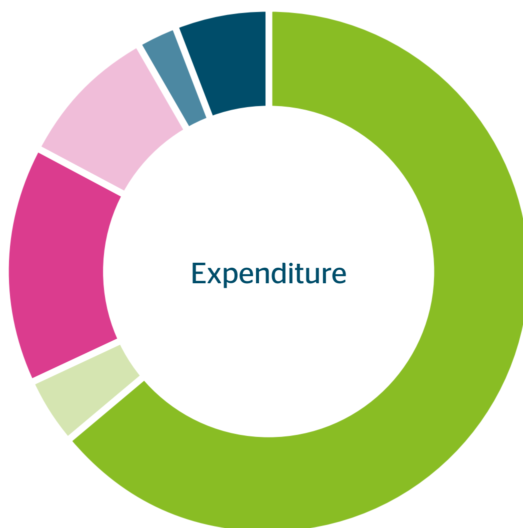
Our finances

Income

Funding from Gateshead Council	£150,000
Adjusted carried forward 2014/15 (inc pre-planned for year)	£57,545
Total Income	**£207,545**

Expenditure

Management and staff salaries	£110,120
Training and other expenses	£7,269
Operational costs	£24,997
Marketing and publicity	£15,555
Outreach activities	£3,979
Long term care project (redirected)	£10,000
Total expenditure	**£171,920**
Balance carried forward	**£35,625**



Expenditure

- Management and staff salaries
- Training and other expenses
- Operational costs
- Marketing and publicity
- Outreach activities
- Long term care project (redirected)

healthwatch Gateshead

Please note on publication of this report copies are automatically sent to:

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Gateshead Council Health and Well Being Board

Gateshead Council's Care, Health and Wellbeing Overview and Scrutiny Committee

If you require your own copy please contact us:

Healthwatch Gateshead
Davidson Building, Swan Street, Gateshead, NE8 1BG

Tel: 0191 477 0033 or 0300 123 4008
Email: info@healthwatchgateshead.co.uk
Web: www.healthwatchgateshead.co.uk
Freephone: 0808 801 0382

Facebook: facebook.com/gatesheadhealthwatch
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Gateshead Council

HEALTH AND WELLBEING BOARD

15 July 2016

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

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Purpose of the Report

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

Background

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

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

Update

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

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

Overview of Current performance

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

Public Health

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

8. The definition for LW4 Reduce Excess weight in 4-5 year and 10-11 olds has been revised, using residential postcodes rather than school attended. This has still resulted in the required target being surpassed for 2014/15 of 24%. It reduced from 24.4% in 2013/14 to 23.1% on 2014/15. Gateshead is now considered to not be significantly different to the England average of 21.9%. The change in definition did not have any impact on 10-11 year olds and has not changed since the previous report.

9. Gateshead's rate of alcohol admissions per 100,000 for 14/15 has been revised since the previous report. Based on the final data Gateshead's rate of alcohol admissions per 100,000 has reduced from 956.0 per 100,000 in 13/14 to 927 per 100,000 in 14/15. However, as a result of the revision this has now missed the required target of 924 per 100,000 that was set for 14/15. Gateshead is considered significantly worse than both the current England average of 641 per 100,000 and the North East average of 830 per 100,000.

10. Healthy Life Expectancy at Birth for males has increased from 57.5 years to 58.4 years for 2014/15. Despite this increase Gateshead missed the target of 60.3 years. Gateshead is currently significantly worse than the England rate of 64.0 years but is considered similar to the North East figure of 59.8 years. Healthy life expectancy for females remains the same at 59.4 years with Gateshead significantly worse than the England average of 64.0 years but is considered similar to the North East average of 59.8 years.

11. Indicator LW15 Gap in employment rate for those with a learning disability is 64.4% for 2014/15, slightly higher than the North East gap of 64.0% but lower than the England gap of 66.9%. Indicator LW17 Gap in employment for those in contact with secondary mental health services is 68.5% for 2014/15, higher than the North East gap of 63.6% and the England gap of 66.1%. These are newly reported indicators.

12. LW18 Excess under 75 mortality rates in adults with serious mental health illness is also a newly reported indicator. For 2013/14 the Gateshead ratio was 408.2, this is lower than the North East ratio of 428.7 but higher than the England ratio of 351.8. Significance is not calculated for this indicator by Public Health England.

13. Indicators LL4, LW2, LW19, LW22, LW23 and PG20 have not changed since the previous report

Gateshead Better Care Fund Plan:

14. Challenging targets were set and performance is mixed for 2015/16.

15. Particular issues include permanent admissions of older people to residential or nursing care. For April 2015 to March 2016, there were 433 permanent admissions compared to a plan of 314 as reported under the BCF definition. This represents 1,126.9 admissions per 100,000. This target is challenging as there is an ageing population that faces high levels of health inequality. Of the 433 admissions, 55% were aged 85 years or more and 48% concerned patients with dementia.

16. Older people still at home 91 days after hospital discharge. Performance for 2015/16 was under plan with 85.6% against a planned 88.7%. Performance is based on those that were discharged from hospital during October to December and followed up 91 days later during January – March. The final outcome for 2015/16 however shows an improvement on 2014/15 levels.

17. Non-elective admissions – early activity pressures were the subject of a deep dive which was shared with the provider and will form the basis of discussions going forward. Improvements in Non Elective activity were experienced in the latter half of the year due to the impact of ambulatory care activity where revised reporting arrangements were implemented to reflect the changes in the clinical pathway. The final year end position was therefore broadly in line with the planned level of Non-Elective activity due to this change to reporting.

18. For delayed transfers of care, there was a substantial increase in delays during Q4 2015/16, which led to non- achievement of the final year-end target. Further work has been implemented to understand reasons for the delays and to enable close monitoring of delays in this area.

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

Newcastle Gateshead CCG Strategic Indicators

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

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

22. Progress against the national indicators is detailed in appendix 1. Key areas which are currently off track and the associated mitigating actions are as follows:

- Securing additional years of life for the people of England with treatable mental and physical health conditions (OA1) - The priority diseases areas to close the life expectancy gap in Gateshead include Cancer, CVD, Gastrointestinal mortality and Respiratory conditions. The CCG continue to work with Public Health and the LA to embed early identification and intervention with a specific focus on those at increased risk including Health checks programmes, cancer profiles for practices and targeting work, case finding atrial fibrillation and the practice engagement plan (PEP) programmes for disease prevalence, as well as a review of the diagnostic pathways.

- Particular focus is ongoing to tackle the care for people with LTCs with both physical and mental health components, with the aim of improving the score from the GP patient survey in this area which showed a decrease in 2013/14 (OA 2). There has been some improvement, however, not to the required amount.

- Work continues in reducing the time people spend in hospital avoidably (OA 3) by further implementation of the Better Care Fund (BCF) programmes of work which include 11 BCF schemes.

- OA 4 is linked to the BCF work programme and national metric to support older people to live independently (see BCF section).

- On-going work pathway redesign to encourage care closer to home and promote a positive experience with care provision by our providers of community services and General Practice continues to improve OA 6.

- The Healthcare Acquired Infection Partnership across Newcastle, Gateshead and Northumberland continues to closely monitor trends and to develop action plans in conjunction with commissioner and provider organisations which links to OA7.

Gateshead CCG Quality Premium 2014/15

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

24. The 2015/16 quality premium is based on a set of measures that cover a combination of national and local priorities as detailed in appendix 1. Areas which are currently at risk are as follows:

- Reducing potential years of life lost through causes considered amendable to healthcare – also OA1 as detailed above

- Delivery of the Quality Premium indicators is linked to achievement of key NHS constitution standards. A summary of performance against a number of the key constitution standards is outlined below.

NHS Constitution

25. The NHS constitution establishes the principles and values of the NHS and sets out the rights for patients and the public including the rights patients have to access services.

    Key constitution indicators have been outlined in appendix 1 and the risks at the end of 2015/16 were as follows:

- A&E 4 hour waiting times at both Newcastle Hospitals and Gateshead Health were not achieved for 2015/16 due to pressures experienced in quarters 3 and 4. Gateshead Health performance has shown significant improvements into 2016/17 and the FT continues to implement recovery actions around flow and accelerated discharge.

- NEAS Cat A red 1 response times were not achieved for 2015/16 with 68% achievement at year end compared to the required standard of 75%. A recovery action plan is in place for 2016/17.

- Diagnostics has been a national pressure and through 2015/16 we have experienced pressures at both NUTH and Gateshead Health. Gateshead Health has since recovered from November 2015, however pressures at NUTH in MRI and sleep studies have put CCG performance at risk. Recovery actions at NUTH are expected to show improvements by Q2 2016/17.

Children's Strategic Outcome Indicators

26. Children in Gateshead are achieving well academically. Performance against the strategic indicators remains strong with a significant improvement in children achieving a good level of development at age 5, continuing the improving trend over the last 3 years. Gateshead Primary Schools have continued to perform strongly, attainment at key stage 2 in the reading test, writing teacher assessment and mathematics test, the percentage of children attaining Level 4 and above was 82%, a 2% increase from the previous year of 80%. Although educational attainment at secondary level showed a slight decrease of 0.4% this year (academic year 2014/15) Gateshead has been consistently higher than the national average (in terms of 5+ A*to C with English and maths) over recent years. This has continued again this year, however, the gap has closed slightly. This is mainly due to the maths results being disappointing. Gateshead's results are also above the north east average.

27. Overall performance for children's social care remains strong although we witnessed increasing demand for services. Numbers of children subject to a child protection plan or children who are looked after increased during 2015/16. At the end of the year there were 273 children subject to a child protection plan. The rate per 10K is also higher than the same period at the previous year end and remains higher than the national average (42.9) and the regional average (59.5), (CIN census 2014/15).

28. We also experienced a slight increase in the number of children who became looked after, at a rate of 85.8 per 10,000. This year's figure is above the regional average of 82 children per 10,000 and it is also higher than the national average of 60 per 10,000 which has remained relatively stable since 2013. However qualitative indicators such as the children subject to a plan for a second or subsequent time and the percentage of looked after children remaining in the same placement continue to show good performance. At 11.8%, children subject to a child protection plan for a second or subsequent time is below the national, regional and statistical neighbour average, which suggests robust practice in Gateshead and appropriate levels of support being offered for children who require child protection.

Adult Social Care Outcome Indicators

29. Please also see the Better Care Fund section.

30. Performance is variable. Targets for service users receiving self- directed support and service users and carers using direct payments have been met. The proportion of carers receiving self-directed support has improved but missed the target slightly. Clients in receipt of Direct Payments have improved on 2014/15 performance of 19.1% to 21.1% for 2015/16 (the 2014/15 North East average was 24.1% and the England average was 26.3%). 17.2% of carers received direct payments, significantly below the 2014/15 North East and England averages for this indicator (48.1% and 66.9% respectively).

31. The target was achieved for the number of adults with learning disabilities in paid employment with a significant improvement on 2014/15 performance of 7.7% to 10.3% in 2015/16. However, the target for adults with learning disabilities living in their own home which was 76.5% has not been achieved with performance of 75.1% being reached. This is an improvement compared to 2014/15 outturn of 73.0%.

32. The target for the proportion of adults with secondary mental health services living independently has been not met and remains below national and regional averages. Work has been initiated to share information between Gateshead Council and NTW Mental Health Trust which should enable a more joined up approach in this area.

Recommendations

33. The Health and Wellbeing Board is asked to consider current performance and comment on any amendments required for future reports.

Contact: Ann Day, Gateshead Council **Tel:** 433 3484

Appendix 1

Gateshead Local Authority Public Health Strategic Indicators (Compared to England Value)

Significantly better than the England Average (green circle)
Not significantly different to the England Average (amber circle)
Significantly worse than the England Average (red circle)
North East Average (blue diamond)

Indicator	Data Period	Count	Gateshead Value	N/E Average	England Average	England Worst	England Range	England Best
LL4. Decrease the Percentage of People who are Dissatisfied with Life (%)	2014/15	-	6.3	6.1	4.8	8.7		2.8
LW2. Prevention of ill Health: Prenatal Outcomes (% of mothers smoking at time of delivery)	2014/15	344	15.1	18.0	11.4	27.2		2.1
LW4. Reduce Excess Weight in 4-5 and 10-11 year olds (4-5 yo) (%)	2014/15	455	23.1	23.7	21.9	27.4		14.9
LW4. Reduce Excess Weight in 4-5 and 10-11 year olds (10-11 yo) (%)	2014/15	629	34.0	35.9	33.2	43.2		21.5
LW13. Stabilise the Rate of Hospital Admissions, per 100,000 for Alcohol Related Harm	2014/15	1820	927	830	641	1223		379
LW15. Gap in employment rate between those with a learning disability and overall employment rate (% point)	2014/15	-	**64.4**	64.0	66.9	79.8		44.0
LW16. Equalities Objective - Hospital Admissions for self-harm, rate per 100,000 (10-24 yo)	2014/15	179	531.3	477.7	398.8	1388.4		105.2
LW17. Gap in employment rate for those in contact with secondary mental health services and overall employment rate (% point)	2014/15	-	**68.5**	63.6	66.1	77.5		54.2
LW18. Excess U75 mortality rate in adults with serious mental illness (Indirectly Standardised Ratio)	2013/14	-	408.2	428.7	351.8	587.7		135.4
LW19. Reduce Mortality From Causes Considered Preventable (Rate per 100,000)	2012-14	1334	234.1	224.9	182.7	317.5		128.6
LW20. Healthy Life Expectancy at Birth (Male) (Years)	2012-14	-	58.4	59.7	63.4	55.0		70.5
LW21. Healthy Life Expectancy at Birth (Female) (Years)	2012-14	-	59.4	59.8	64.0	54.4		72.2
LW22. Gap in Life Expectancy at Birth Between each Local Authority and England (Male) (Years	2012-14	-	-1.7	-1.5	0.0	-4.8		3.8
LW23. Gap in Life Expectancy at Birth Between each Local Authority and England (Female) (Years)	2012-14	-	-2.0	-1.5	0.0	-3.4		3.5

PG20. Reduce the % of children in low income families (formerly children in poverty)	2013	8195	**20.5**	22.2	18.0	35.5		5.9

Gateshead Better Care Fund National Metrics

Indicator	CCG / Provider / LA	Latest Data Period	Month Actual	Actual to Date	Target to Date	2015/16 Target	Risk to Year End
Permanent admissions of older people (65+) to residential and nursing care homes, per 100,000 population	Gateshead Local Authority	April – Mar 2015/16	1144.4	1144.4	817.2	817.2	**Risk**
Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Gateshead Local Authority	April – Mar 2015/16	85.6%	85.6%	88.7%	88.7%	**Risk**
Estimated diagnosis rate for people with dementia (All Ages)	Gateshead Local Authority	2015/16 Q4	69.2%	69.2%	69.0%	69.0%	**No current risk**
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) NHS and Social Care Attributed delays	Gateshead Local Authority	2015/16 Q4	1554	4146	3330	3330	**Risk**
Non-Elective Admissions (average per month)	Gateshead Local Authority	2015/16 Q4	6772	6772	6204	25,693	**Risk**
Patient Experience Measure: Patients with a LTC who have had enough support from local services or organisations answering yes definitely	Gateshead Local Authority	Jan - Sept 14	40.0%	40.0%	46.0%	46.0%	**Risk**

Newcastle Gateshead CCG Quality Premium 2015/16

Indicator	CCG / Provider / LA	Latest Data Period	Month Actual	Actual to Date	Target to Date	2015/16 Target	Risk to Year End
Potential years of life lost through causes considered amenable to healthcare and including addressing locally agreed priorities for decreased premature mortality	NHS Gateshead CCG	2014	-	2606.9	-	2151.3	Risk
Delayed transfers of Care - NHS attributed	NHS Newcastle Gateshead CCG	March 2016	867	7209	Reduction compared to 2014/15	Reduction compared to 2014/15	No current risk
Reduction of Severe Mental Health Illness (SMI) patients who smoke	NHS Newcastle Gateshead CCG	March 2016	41.1%	41.1%	42.0%	42.0%	No current risk
Childhood Asthma - increase in the proportion of annual reviews which result in a management plan	NHS Newcastle Gateshead CCG	March 2016	-	65.8%	10%	10%	No current risk
Young Carers	NHS Newcastle Gateshead CCG	March 2016	-	409	68	68	No current risk
Antibiotic prescribing in Primary and Secondary Care	NHS Newcastle Gateshead CCG	March 2016	Part A 1.2 Part B 7.7%	Part A 1.2 Part B 7.7%	-	1.3 11.3%	No current risk

Newcastle Gateshead CCG Strategic Indicators- Outcome Ambitions

Indicator	CCG / Provider / LA	Latest Data Period	Month Actual	Actual to Date	Target to Date	2015/16 Target	Risk to Year End
OA1: Potential years of life lost through causes considered amenable to healthcare and including addressing locally agreed priorities for decreased premature mortality	NHS Gateshead CCG	2014	-	2606.9	2151.3	2151.3	Risk
OA2: Improving the health related quality of life for people with one or more long term conditions. Average score (in the GP patient Survey) for people with Long Term Condition.	NHS Newcastle Gateshead CCG	Jul 14 to Mar 15	-	0.711	-	0.718	Risk
OA3: Reducing avoidable emergency admissions	Newcastle Gateshead CCG	March 2016	177.1	2803.8	Reduction compared to 2014/15	Reduction compared to 2014/15	Risk
OA4 Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Gateshead Local Authority	March 2016	85.6%	81.6%	88.7%	88.7%	Risk
OA5: Patient experience of hospital care	-	-	-	-	-	-	No current risk
OA6: Patient experience of GP out-of-hours services	NHS Newcastle Gateshead CCG	Jul 14 to Mar 15	66.9	66.9	67.1	67.1	Risk
OA7: Health Care Associated Infections - C.Difficile	NHS Newcastle Gateshead CCG	March 2016	13	199	60	142	Risk
% people who access psychological therapies (IAPT)	Newcastle Gateshead CCG	March-16 *provisional data	-	18.1%	3.8%	15.0%	No current risk
People accessing IAPT moving to recovery	Newcastle Gateshead CCG	March 2016	**51.4%**	**47.31%**	50.0%	50.0%	Risk
Estimated diagnosis rate for people with dementia	NHS Gateshead	Mar 2016	**68.5%**	**67.0%**	67.0%	67.0%	No current

Indicator	CCG / Provider / LA	Latest Data Period	Month Actual	Actual to Date	Target to Date	2015/16 Target	Risk to Year End
(65+)	CCG						risk

NHS Constitution

Indicator	CCG / Provider / LA	Latest Data Period	Month Actual	Actual to Date	Target to Date	2015/16 Target	Risk to Year End
18 Week Referral to Treatment (Incomplete Pathways)	NHS Newcastle Gateshead CCG	March 2016	93.8%	93.8%	92.0%	92.0%	No current risk
RTT 52 weeks for treatment	NHS Newcastle Gateshead CCG	March 2016	0	0	0	0	No current risk
A&E Under 4 Hour Waits	NHS Newcastle Gateshead CCG	March 2016	90.7%	93.8%	95.0%	95.0%	Risk
Over 12 hour trolley waits	GHNT	March 2016	0	0	0	0	No current risk
	NuTH	March 2016	0	0	0	0	No current risk
Urgent Suspected Cancer GP Referrals seen within 2 Weeks of Referral	NHS Newcastle Gateshead CCG	March 2016	95.7%	94.6%	93.0%	93.0%	No current risk
Red Category 1 Ambulance Calls with < 8 Minute Response Time	Newcastle Gateshead CCG	March 2016	71.6%	77.5%	75%	75%	Risk
	NEAS		61.5%	68%			
< 6 weeks for the 15 diagnostics tests	NHS Newcastle Gateshead CCG	March 2016	0.65%	0.65%	1.0%	1.0%	No current Risk
	GHNT	March	0.24%	0.24%	1.0%	1.0%	No current

Indicator	CCG / Provider / LA	Latest Data Period	Month Actual	Actual to Date	Target to Date	2015/16 Target	Risk to Year End
		2016					Risk
	NuTH	March 2016	1%	1%	1.0%	1.0%	Risk

Children's Strategic Outcome Indicators

Indicator Description	Previous Year End 2014/15	Performance end March 2016	Year End Target	Traffic Light	Trend (Compared to same period last year)
F02 - Readiness for school: Children achieving a good level of development at age 5 (Early Year Foundation Stage scores) – New Definition	57%	**63.7%**	59%	Met Target	↑
F04 -Educational attainment primary (% pupils achieving level 4 in Reading, Writing and Maths at Key Stage 2) Increase the % of children attaining the expected standard at the end of KS2 (*New - used from summer 2016)*	80% (academic year 2013/14)	**82%**	82%	Met Target	↑
F05 -Achievement of 5 or more A*- C grades at GCSE or equivalent including English and Maths (*final year 2016 with 2017 first year of the new 1-9 grade*)	58.5%	**58.1%**	59%	Not Met Target	↓
Rate of children's services referrals per 10,000 (cumulative indicator)	436.9	**519.7**	450	Not Met Target	↓
F08 - Number of Children with a Child Protection Plan per 10,000	64.2 per 10,000 (234 CYP)	**68.1 per 10,000 (273CYP)**	62 per 10,000	Not Met Target	↓
Children who are subject to a second or subsequent child protection plan	11.3%	**11.8%**	Less than 15%	Met Target	↓
Number of looked after children per 10,000	84.8 per 10,000 (341cyp)	**86 per 10,000 (344 CYP)**	Less than 84.9 per 10,000	Not Met Target	↓

Indicator Description	Previous Year End 2014/15	Performance end March 2016	Year End Target	Traffic Light	Trend (Compared to same period last year)
F10 - % of Looked After Children living continuously in the same placement for 2 years	78.8%	**86%**	78%	Met Target	↑

Adult Social Care Strategic Outcome Indicators

Indicator Description	Previous Year End 2014/15	Performance end March 2016	Year End Target	Traffic Light	Trend (Compared to same period last year)
ASCOF 1C (part 1A) Proportion of Clients receiving self-directed support	82.3%	**90.7%**	86.0%	Met Target	↑
ASCOF 1C (part 1B) Carers receiving self-directed support	86.3%	**89.7%**	90.0%	Not Met Target	↑
ASCOF 1C (part 2A) Proportion of clients receiving direct payments	19.1%	**21.1%**	20.0%	Met Target	↑
ASCOF 1C (part 2B) Proportion of carers receiving direct payments	12.1%	**17.2%**	16.0%	Met Target	↑
ASCOF 1F Proportion of adults with secondary mental health services in paid employment	3.8%	**4.2%** (April – Dec 2015)	4.0%	Met Target	↑
ASCOF 1H Proportion of adults with secondary mental health services living independently	38.6%	**33.4%** (April – Dec 2015)	45.0%	Not Met Target	↓

Indicator Description	Previous Year End 2014/15	Performance end March 2016	Year End Target	Traffic Light	Trend (Compared to same period last year)
CP06a (ASCOF 1E) Proportion of adults with learning disabilities in paid employment	7.7%	**10.3%**	8.0%	Met Target	↑
CP06b (ASCOF 1G) Proportion of adults with learning disabilities living in their own home or family	73.0%	**75.1%**	76.5%	Not Met Target	↑