Gateshead Council

Public Document Pack

HEALTH AND WELLBEING BOARD AGENDA

Friday, 26 February 2016 at 10.00 am in the Whickham Room - Civic Centre

From the Chief Executive, Jane Robinson

Item	Business
1.	**Apologies for Absence**
2.	**Minutes** (Pages 1 - 12) Minutes of the Meeting held on 15 January 2016 and Action List are attached for approval.
3.	**Declarations of Interest** Members of the Board to declare an interest in any particular agenda item.
	Items for Discussion
4.	**Fulfilling Lives - Addressing Multiple and Complex Needs** (Pages 13 - 60) Presentation on the Programme (Fulfilling Lives) by Sir Paul Ennals and Neil MacKenzie
5.	**Older Peoples Strategy & Action Plan** (Pages 61 - 72) Presentation by Margaret Barrett and Craig Bankhead
6.	**Vanguard Care Home Programme - Draft Value Proposition** (Pages 73 - 74) Report presented by Caroline Kavanagh, Newcastle Gateshead CCG
7.	**Development of OSC Work Programme for 2016/17** (Pages 75 - 80) Report of Strategic Director Corporate Services and Governance, To Follow
	Performance Management Items
8.	**BCF Quarter 3 Return to NHS England** (Pages 81 - 94)
	Items for Information
9.	**Updates from Board Members**
10.	**Schedule of Meetings 2016/2017** All Meetings will be held at Gateshead Civic Centre at 10am Friday 10 June 2016 Friday 15 July 2016 Friday 9 September 2016

Friday 21 October 2016
Friday 2 December 2016
Friday 20 January 2017
Friday 3 March 2017
Friday 28 April 2017

Contact: Sonia Stewart; email; soniastewart@gateshead.gov.uk, Tel: 0191 433 3045,
Date: Thursday, 18 February 2016

GATESHEAD METROPOLITAN BOROUGH COUNCIL

HEALTH AND WELLBEING BOARD MEETING

Friday, 15 January 2016

PRESENT:	Councillor L Caffrey (Chair)
	Councillors: H Hughes, C Donovan, M Graham, M Henry, F Hindle, I Blake, J Duncan, I Renwick, B Westwood, D Ball and M Dornan
IN ATTENDANCE:	P Walker, A Dunn, A Jobling, J Costello, S Jamieson, Councillors: S Green, M Hood, M Charlton
OBSERVERS:	Councillor J Beall, Stockton Council, Peter Kelly DPH Stockton

HW1 APOLOGIES FOR ABSENCE

Apologies were received from Mike Robson, Councillor M McNestry, Alison Elliott, Alison Smith and Mark Adams.

Update from Chair on MPs Select Committee
The Chair updated the Board on a request from a local MP regarding any information on GP Out of Hours Access. This was provided to the MP and it was mentioned at a Select Committee. Professor Maureen Baker said it was a national problem around barriers to access and unreasonable barriers to becoming a GP.

It was also noted that on Monday 18 January there is to be a debate on financial issues in Acute Trusts.

HW2 MINUTES

The minutes of the last meeting held on 4 December 2015 were agreed as a correct record.

Matters Arising

There were no matters arising.

Action List

There was 1 new item on the Action List which was listed on today’s agenda.

HW3 DECLARATIONS OF INTEREST

There were no declarations of interest received.

HW4 NHS PLANNING GUIDANCE 2016/17 TO 2020/21

Mark Dornan provided the Board with an update on the CCG plans based on NHS Planning Guidance.

The CCG have to produce a sustainability and transformation 5 year plan and also have to produce a 1 year plan and update the Better Care Fund.

The 2016/17 Operational Plan will include some key 'must dos' which are to

- Reduce excess deaths by increasing the level of consultant cover and diagnostic services available in hospitals at weekends.
- Improving access to out of hours care by achieving better integration and redesign of 111, minor injury units, urgent care centres and GP out of hours services to enhance the patient offer and flows into hospital; and
- Improving access to primary care at weekends and evening where patients need it by increasing the capacity and resilience of primary care over the next few years.

The 3 gaps identified are straight from the NHS Forward View which is very positive.

Health and Wellbeing Gap– closed by earlier identification / management of long term conditions, greater personalisation of care and further investment in public health.

Care and Quality Gap – delivered by introducing new models of care – 5 North East Vanguards with expected savings of £22 billion.

Finance and Efficiency Gap – annual efficiency targets with proposed additional £8 billion NHS funding.

It was noted that provider efficiency is over half of the block of saving which is going to be a huge challenge.

The next stages are to develop a clear overall shared vision and plan for the public and patients of Newcastle and Gateshead. Accountable officers across the Newcastle and Gateshead health and social care system have already met to discuss how this work can be collectively taken forward.

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

Working together with senior colleagues across the system developing the STP.

The plans will be submitted in June and will run from October 2016 – 2021. The plans will need to be referenced when submitting funding bids in the future.

RESOLVED - That the information in the plan be noted.

HW5 HEALTH AND WELLBEING STRATEGY REFRESH (SCOPING REPORT)

The Board were presented with a report providing a draft copy of the Health and Wellbeing Strategy refresh. It was suggested at a previous meeting that this be brought to the Board because of the links with the CCG Plans.

The Health and Wellbeing Board still have a statutory duty to produce plans.

It is felt that the issues and ambitions within plan are still relevant to be taken forward into the new plan.

It was suggested that a Board Development Session be arranged to take this plan forward.

It was noted that there is a regional event on 7 April on the development of Health and Wellbeing Strategies and it was suggested that a Board development event take place after this event.

RESOLVED - That a Health and Wellbeing Board development event be arranged for a time after 7 April.

HW6 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2014/15

Carole Wood presented her report to the Board. It has been to the Council's Cabinet and will be presented formally at full Council in February. The focus of the report was health inequalities with a particular focus on health in childhood, including health in schools. Carole has looked back at the Marmot Review and the report from Due North. The Marmot Principles were linked into the Health and Wellbeing Strategy.

They were – Giving Children the Best Start in Life, Trying to improve prosperity by getting people into better jobs. Getting Children Ready for School and ready to learn. The report has looked at deprivation as an issue in Gateshead. As part of the Council plan improving prosperity, jobs and wealth are a priority.

In terms of a general overview of health it is improving slowly but still worse than the National Average on a number of indicators.

The Healthy Schools Programme will continue in 2016 and schools are being asked to contribute to the scheme.

Carole advised that we now have a more explicit strategy to tackle health inequalities and this aims to support people to manage the self care agenda.

RESOLVED - that the recommendation in the report be agreed.

HW7 HEALTH PROTECTION UPDATE

A report was submitted to the Board to provide an update on current Health Protection Issues.

Cancer screening is slightly down on the previous year in relation to cervical screening, however the update is similar to the North East and higher than England.

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

Excess winter deaths is creating some cause for concern, which is a national issue. Currently it can't be explained why this has happened.

There is an emerging concern with regards to the low level of uptake in regard to flu vaccinations. In terms of the Health Services, the Trust in particular has done really well with the uptake, however, there has been a struggle in the Local Authority in terms of uptake.

There appears to be a greater focus at the moment in relation to TB and how we are responding to newly arrived immigrants.

Sexual health in terms of STI rates in Gateshead are lower than the National Average but we are continuing to monitor trends and performance carefully.

RESOLVED - That the information in the report be noted.

HW8 ROLE OF HOUSING PROVIDERS IN PROMOTING HEALTH AND WELLBEING : HOUSING CONDITIONS

The Committee received a report in relation to the impact of Housing Conditions on Promoting Health and Wellbeing. The current make up of housing stock in Gateshead and the prevalence of certain 'hazards' to occupier's health and wellbeing was documented in a report produced for the Council by the Building Research Establishment (BRE) Stock Condition Projection Model for Gateshead in 2013.

The concept of 'Category 1 Hazards' were introduced by the Housing Act 2004 and their existence in a property means that the standard of the property falls below the legal minimum standard for housing.

The private rented sector has the highest proportion of non-decent homes.

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

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

More than 1200 rented homes have been included within designated 'Selective Landlord Licensing' areas, with associated checks on 'fit and proper' status of landlords and property inspections having ensured that standards have been driven up in some of the lowest demand areas of the borough.

A further 900 homes have been homes have been improved to this standards outside of these areas following intervention by the Council.

RESOLVED - That the information in the report be noted and taken into consideration.

HW9 ACHIEVING MORE TOGETHER PROGRAMME

The Board were advised of an event which is currently in the process of being organised with input from Cormac Russell, who is an internationally-linked expert facilitator on developing asset based ways of working. He has worked with a range of NHS and local authority partners in the UK to help them develop their collective thinking with regard to principles and approaches.

The exact nature of the session is still under discussion, it is likely that several sessions will be held with different stakeholder groups. One 'Master Class' event for system leaders is being proposed, this would include Health and Wellbeing Board members, along with key partners such as representatives from Gateshead Strategic Partnership.

The Board were asked to note the dates in the diary. The Board were also asked to note the scope for further collaboration with Newcastle Health and Wellbeing Board to progress this approach.

RESOLVED – That the information be noted.

HW10 MENTAL HEALTH EMPLOYMENT TRAILBLAZER PILOT: DEVELOPMENT OF MODEL

The Board received an update report on the Mental Health Employment

Trailblazer Pilot.

This scheme was first brought to the Health and Wellbeing board in January 2015, however, there has been a delay in the funding which has resulted in the project start being delayed as it was dependent on match funding; however, everything is now in place and it is expected work will commence in late January. The project is being led by Northumberland County Council and is 1 of 4 pilots across the country.

The aim of the project is to try and embed employment support through existing IAPT services. People will be referred to the project by Job Centre Staff and there will be a team based across the North East. There will be a control group who will be given intensive one to one employment support.

It was noted that at the previous meeting the voluntary sector indicated that they would like to be involved and where possible offer support. It would be useful if they could be included where appropriate on a steering or operational group. The Board were advised that it was Northumberland Council who were leading the project

RESOLVED - That the Board note progress and receive a further update in 6 months.

HW11 PERFORMANCE REPORT FOR THE HEALTH AND CARE SYSTEM

A report was presented to highlight some areas of performance which it was felt represented cross-cutting themes. The areas have been discussed within each agency, however, if the Board felt that there could be different indicators, or some indicators added or removed, this could be considered provided the information is available.

It was noted that people with severe Mental Health problems die 15 year earlier, it was queried whether this could be reported. It was also queried whether a measure could be included on fuel poverty.

RESOLVED - That the information in the report be noted and potential additional measures be considered.

HW12 UPDATES FROM BOARD MEMBERS

Newcastle Gateshead CCG

The Allocations for NHS Funding have awarded a growth position of 3.6% which is good news, it was felt that this was because of Gateshead's CCG merge with Newcastle.

HW13 ANY OTHER BUSINESS

The Director of Public Health advised the Board that a funding pot was available

from the Council and CCG for social isolation and loneliness. There will be a one off round of funding. This is a bidding opportunity for the voluntary sector.

Copies of all reports and appendices referred to in these minutes are available online and in the minute file. Please note access restrictions apply for exempt business as defined by the Access to Information Act.

Chair…………………………..

**FIEL
D_F
ORM
ATTE
D_N
UMB
ER
FIEL
D_F
ORM
ATTE
D_N
UMB
ER
FIEL
D_F
ORM
ATTE
D_N
UMB
ER
FIEL
D_F
ORM
ATTE
D_N
UMB
ER**

This page is intentionally left blank

Item 2b

GATESHEAD HEALTH AND WELLBEING BOARD
ACTION LIST

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Matters Arising from 15th January 2016 meeting of the HWB			
Health & Wellbeing Strategy	That a Health and Wellbeing Board development session be arranged for a time after the 7th April regional workshop	John Costello	To be arranged
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
Tobacco Control 10 Year Plan	A plan to be brought to the Board within the next 6 months.	Alice Wiseman	To feed into the Board's Forward Plan

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Matters Arising from 11th September 2015 meeting of the HWB			
Personal Health Budgets	Personal health budgets to be examined in the context of social prescribing as part of a planned workshop due to take place in November. A further update report on Personal Health budgets to be brought back to the Board in April 2016.	Alice Wiseman/ Gail Bravant Julia Young/Gail Bravant	Workshop completed. Report on social prescribing to be brought to 22nd April Board meeting, Included within 2015/16 Forward Plan of HWB
Homeless Health: Deep-dive exercise	NTW also to be involved in this piece of work going forward. The findings of the further research work to be brought back to the Board early in the New Year.	Lisa Philliskirk	Being progressed. Included within 2015/16 Forward Plan of HWB.
Communications Strategy	Communications leads to meet to discuss arrangements for taking forward the strategy and to develop an initial communications plan for the Board for the six month period to 31 March 2016. Bring back the Plan to the board for endorsement.	Lee Hansom	Being progressed.

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
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	To be brought to the 22nd April Board meeting. Logged for inclusion within the Forward Plan of HWB
Matters Arising from 17th July 2015 meeting of the HWB			
HWB Forward Plan	Timings to be identified for outstanding items to come to the Board linked to the Forward Plan.	All Partners	Being progressed
Matters Arising from 5th June 2015 meeting of the HWB			
Older Peoples Wellbeing – Addressing Social Isolation	A scoping report setting out work that is already ongoing and identifying gaps to be brought back to a future meeting of the HWB	Alice Wiseman	Included within 2015/16 Forward Plan for HWB
Matters Arising from 24th April 2015 meeting of the HWB			
Place shaping for health and wellbeing	That a Stakeholder workshop be arranged on place shaping for health and wellbeing.	Carole Wood/Paul Dowling	Included within 2015/16 Forward Plan for HWB

This page is intentionally left blank

FULFILLING LIVES
Newcastle Gateshead

Year 1 Review and Evaluation Findings

Purpose

The purpose of this brief report and presentation is to:

- Update Gateshead Health and Wellbeing Board on the progress and Year 1 evaluation findings of the Fulfilling Lives Newcastle Gateshead Programme.
- Secure continued support for the principles of the programme and commitment to joint working

Recommendations

Gateshead Health and Wellbeing Board:

- Continue to support the principles and work in partnership with Fulfilling Lives towards improving outcomes for people with multiple and complex needs and 'ingrained inequality'
- Explore the potential of the Navigator model to improve access to and effective use of services across health and wellbeing services
- Supply information which helps further demonstrate costs of the client group and potential budget savings that can be gained
  Commit to using the learning from Fulfilling Lives in commissioning decisions to develop services which cut across traditional boundaries and better meet the needs of the whole person.

About Fulfilling Lives Newcastle Gateshead

The Fulfilling Lives Programme is seeking to help people with complex needs to better manage their lives, by ensuring that services are more tailored and better connected to each other. The focus of the programme is on those people who often spiral around the system(s), are excluded from the support they need and experience a combination of at least three of the following four problems; homelessness, re-offending, problematic substance misuse and mental ill health. The programme is managed by a partnership of three voluntary sector agencies (Changing Lives, Mental Health Concern and Oasis Aquila Way). It is overseen by a strategic group involving Gateshead and Newcastle Councils, the local hospital and mental health trusts, probation and NHS England. Gateshead colleagues – especially Alice Wiseman and Michael Laing – have provided important support and help to the programme.

Our goal is to improve and better coordinate services to support people across Newcastle and Gateshead living with multiple and complex needs seeing people for the potential they have, rather than for their problems.

The programme receives £5.2m from the Big Lottery, over 8 years. The longevity of the programme and level of funding allows real opportunity to make a serious impact upon the lives of people with complex needs living in and between Newcastle and Gateshead. This means that beyond supporting the individual, one of the main aims of Fulfilling Lives is to learn through the programme, and through that learning evoke a change to the system that will allow us all to work more effectively with people with multiple and complex needs.

Fundamental to this learning is the engagement of service users in the delivery of the programme and finding ways of improvement from a service user perspective.

How it works

We offer a combination of Service Navigators to tackle individual need and System Brokers who address systems blockages. The System Brokers identify where the current system may prevent service users from transforming their lives and then work with the Service Navigators to evidence the real issues facing our client group.

We have established Experts by Experience, Operational and Strategic reference groups. These groups are committed to understanding and changing the way services respond, are commissioned and delivered, based on evidence of the real issues.

Our vision

Our hope is that as the system changes it will become better coordinated and easier to navigate for people with complex needs. The result will be a diminishing demand for Service Navigators and less cost to society. By removing barriers and blockages to support the help required to negotiate a complex system will lessen, and this will enable our programme to focus on the provision of a sustainable peer support network reaching those that are the 'hardest to reach'.

Client outcomes after year one

- Fulfilling Lives worked with 137 clients in Year 1. Of those 15 clients progressed from needing intensive support to requiring limited navigation. There has been a high retention rate with 11% of clients disengaging.
- 60% of clients presented with all four needs, 31% with three out of four needs and only 9% with two needs. At time of referral 72% of clients are homeless, 97% have a substance misuse or alcohol problem, 94% have mental health needs and 86% are repeat offenders.
- On average after six months of engagement clients are recording positive changes across all areas of the New Directions Team Assessment, or Chaos Index. This means that on average after six months clients have moved from being at immediate risk of loss of accommodation to living in short term or temporary accommodation; drug or alcohol use has moved from recurrent use of alcohol or drug abuse to some use of alcohol or drug abuse; non-compliant with routine activities or reasonable requests to usually complies with reasonable requests; definite risk of abuse or exploitation from other individuals or society to minor concerns about risk of abuse or exploitation; and definite indicators of deliberate self-harm or risk of suicide to minor concerns about self-harm and suicide risk.

Executive summary attached.

Neil McKenzie (to 31.3.16) / Lindsay Henderson (from 1.4.16)
Programme Manager
17.2.16

Contact 07903962835
neil.mackenzie@fulfillinglives-ng.org.uk / Lindsay.henderson@fulfillinglives-ng.org.uk
www.fulfillinglives-ng.org.uk

CHANGING LIVES

FULFILLING
LIVES
Newcastle & Gateshead

Year One Evaluation Report: Understanding Multiple Complex Needs in Newcastle and Gateshead

Written by: Sophie Boobis

CHANGING LIVES

TABLE OF CONTENTS

1 Introduction **2**

About this report 2

About Fulfilling Lives Newcastle Gateshead 2

Context 3

2 Understanding the client group **5**

About this section 5

Why is it important to understand this client group? 5

Support Needs 5

Profile 11

Conclusions 18

3 Understanding the system **19**

Why is it important to understand the system? 19

System mapping methodology 18

The system mapped 20

Map 1: The service users system 21

Map 2: The frontline workers and service managers system 22

Referral Sources 24

4 Costs **26**

Cost to the system 26

Case studies 26

5 Fulfilling Lives Newcastle and Gateshead Outcomes **30**

About this section 30

Client Outcomes 30

6 Conclusion **36**

Recommendations 36

Evaluation next steps 37

References **38**

1. Introduction

1.1 About this report

At this stage in the Fulfilling Lives programme it is important that we establish a baseline of what we know about the multiple complex needs client group and the system they interact with. This report aims to provide more information in answer to the following questions:

1. Who are the multiple complex needs client group?
2. What is the multiple complex needs system?

From this process of identifying emerging themes from this initial evidence it is anticipated that this report will be used as a touchstone to initiate and stimulate discussion for system changers looking to improve outcomes for those with multiple complex needs through the planning, commissioning or delivery of services.

This report forms part of a much larger body of evidence that will be produced from the Fulfilling Lives programme; both locally and nationally. Evidence across all twelve Fulfilling Lives programmes is being analysed and reported on by CFE Research and QA Research. Their evidence is produced independent of the individual projects and will look at common trends and evidence at the national level. At a local level separate evidence reports will be produced for the individual pilots and specific aspects of the Fulfilling Lives programme assessing impact and, where appropriate, cost effectiveness. Further economic analysis is being undertaken in partnership with Resolving Chaos, lead partner of the Lambeth, Lewisham and Southwark Fulfilling Lives programme. This will be examining whether there are archetypal client groups within multiple complex needs and looking at the consequential cost implications. Ongoing research and evidence building will be taking place throughout the programmes lifetime as themes emerge, both through operational activity and through consultation with service users.

1.2 About Fulfilling Lives Newcastle Gateshead

What is Fulfilling Lives Newcastle Gateshead?

The Fulfilling Lives Programme is seeking to help people with complex needs to better manage their lives, by ensuring that services are more tailored and better connected to each other. The focus of the programme is on those people who often spiral around the system(s), are excluded from the support they need and experience a combination of at least three of the following four problems; homelessness; re-offending; problematic substance misuse and mental ill health.

Our goal is to improve and better coordinate services to support people across Newcastle and Gateshead living with multiple and complex needs – to see people for the potential they have, rather than for their problems.

The longevity of the programme and level of funding allows real opportunity to make a serious impact upon the lives of people with complex needs living in and between Newcastle and

Gateshead. This means that beyond supporting the individual, one of the main aims of Fulfilling Lives is to learn through the programme, and through that learning evoke a change to the system that will allow us all to work more effectively for people with multiple and complex needs.

Fundamental to this learning is the engagement of service users in the delivery of the programme and finding ways of improvement from a service user perspective.

How it works

We offer a combination of Service Navigators to tackle individual need and System Brokers who address systems blockages. The System Brokers identify where the current system may prevent service users from transforming their lives and then work with the Service Navigators to evidence the real issues facing our client group.

We have established Experts by Experience, Operational and Strategic reference groups. These groups are committed to understanding and changing the way services respond, are commissioned and are delivered, based on evidence of the real issues.

Our vision

Our hope is that as the system changes it will become better coordinated and easier to navigate for people with complex needs. The result will be a diminishing demand for Service Navigators and less cost to society. By removing barriers and blockages to support then the help required to negotiate a complex system will lessen, and this will enable our programme to focus on the provision of a sustainable peer support network reaching those that are the 'hardest to reach'.

1.3 Context

The situation affecting both the support offered and the system surrounding multiple complex needs does not exist in isolation, both in how it interconnects with wider health and social care policies and budget and geographically in Newcastle and Gateshead. Consideration needs to be given to the wider political context and how that may impact on provision and causing a block to change at a local level.

Austerity measures issued by central government have massive implications on all sectors involved with supporting multiple complex needs. In times of restricted and reduced funding and a constant awareness of financial implication, increasing support for the multiple complex needs community is not an easy endeavour. Services, both statutory and voluntary sector, are being stretched to provide delivery of support in an unprecedented manner.

Attempting system change within this context will be a challenge but is in no way impossible.

Equally awareness needs to be given to the differences between Newcastle and Gateshead in terms of their local economies, geography and infrastructure. Whilst this programme looks to join working up between the two Local Authorities, and other partners, and whilst some services work across the boundaries, others are deeply constrained by their geographical

limits. The idea of a “one size fits all” model may not always be appropriate or may require give and/or take.

Fulfilling Lives in Newcastle and Gateshead exists as one of twelve Big Lottery funded programmes working with multiple complex needs across England. The Making Every Adult Matter (MEAM) coalition is running a number of multiple complex needs programmes. Lankelly Chase and NPC have both recently produced literature around the multiple complex needs client group and system change for that community. This is a client group for whom a greater awareness is being pushed at a national level. Research and evidence beyond this programme will be forthcoming and we should be aware of how this programme relates to other ongoing work and how we can both be influenced, and influence this activity.

2. Understanding the Client Group

2.1 About this section

The purpose of this section is to help understand who we are talking about when we refer to people with multiple complex needs, what are the issues they are presenting with and are we seeing any trends that suggest archetypal client groups.

This section uses the data from the first year of the Fulfilling Lives programme. The statistical analysis was conducted using data from 130 clients who are, or who have been, engaged with the Newcastle and Gateshead Fulfilling Lives programme.

2.2 Why is it important to understand this client group?

The idea of multiple complex needs is not new within the world of health and social care. However, as Rankin and Regan highlighted, a lack of tangible definition of what multiple complex needs means has an impact on care provided: “there is uncertainty about the term” (Rankin and Regan, 2004). This uncertainty is a problem as it presents a barrier in providing both support and solutions in supporting those with multiple complex needs.

The Lankelly Chase Foundation’s “Hard Edges” report was the first attempt to provide a statistical profile to the multiple complex needs client group. This study concluded that “People affected…are predominantly white men, aged 25-44, with long term histories of economic and social marginalisation”. They also highlighted other defining factors such as childhood trauma, low levels of educational attainment and early interaction with the criminal justice system.

This report was an important step in helping to understand this client group. However as the report itself states, it is not without imperfections; women are suspected to be underrepresented as they may be more likely to appear in other datasets than the ones used for the study; the report also does not use mental health as a criterion for defining severe and multiple disadvantage.

Our findings do interplay with those found by the Hard Edges report, supported by the MEAM coalition (“Individuals with multiple needs: the case for a national focus”) and the year one evaluation of the aggregated data from all Fulfilling Lives programmes (CFE –“Fulfilling Lives: Supporting people with multiple needs”). However there are also differences within our cohort that will be highlighted and explored further in the following sections.

2.3 Support Needs

Definition of Multiple Complex Needs

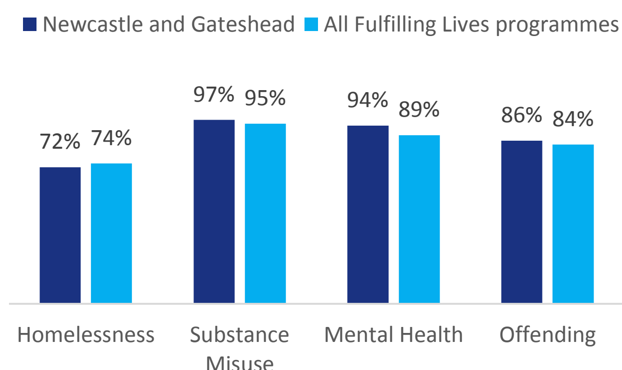
For the purpose of this programme the Big Lottery Fund have defined multiple complex needs as someone having two or more of homelessness, mental health problems, substance or alcohol misuse problems and history of offending. Further definition is also given as to what is meant by homeless in the context of all the Fulfilling Lives projects:

> *"Homeless includes those who are statutorily homeless, sleep rough, single homeless people living in hostels, shelters or temporary supported accommodation, and hidden homeless households including those living in overcrowded conditions or temporarily sharing with family and friends."*

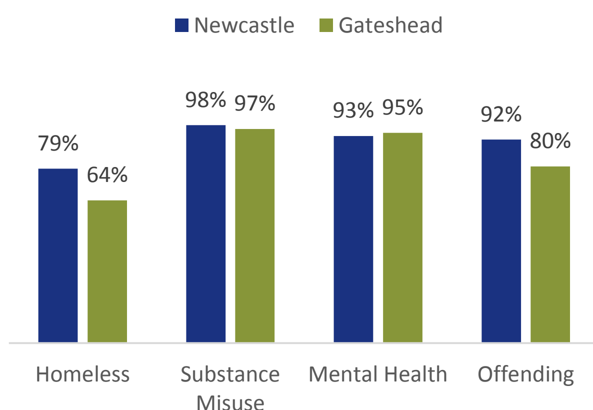
As Lankelly Chase Foundation state, these four categories are "strongly resonant" with service providers' definition of multiple complex needs and that there is "broad consensus [that]… identified this set of experiences as the crucial set of (negative) interactions in their lives." (Bramley, G. et al *2015*). However it is also important to maintain awareness that these are not the only problems that build up the complexity of someone with multiple complex needs; at its broadest definition multiple complex needs can be considered as "interconnected needs that span medical and social issues" (Rankin and Regan *2004*). Whilst the focus of support from this project is around the four main domains, the wider issues and support needs that individuals may have are not forgotten and form an integral part of holistic support offered. This section looks to examine further what some of these additional support needs are and over the lifetime of the project how they can help develop our understanding of how to best help those with multiple complex needs.

Presenting Needs

At the point of referral into the programme 60% of our clients present with all four needs, and 31% with three out of the four needs. The remaining 9% presented with two needs. The breakdown of presenting needs shows that our cohort broadly correlates with the profile being seen across the other Fulfilling Lives programmes.



62% of those presenting with three needs present with the combination of substance misuse problems, mental health issues and repeat offending. Of those presenting with all four needs 72% are male and 28% are female (this is explored further in the Gender and Age section below). When looking at the breakdown by Local Authority it should be highlighted that there is an even split with exactly 50% from Newcastle and 50% from Gateshead. From the Fulfilling Lives caseload there is a higher prevalence of individuals with four needs in Newcastle than in Gateshead with 34% of all clients have four needs and are from Newcastle, and 25% have four needs and are from Gateshead. This is driven primarily by the proportion of Newcastle based clients who are housed in supported accommodation, which is explored

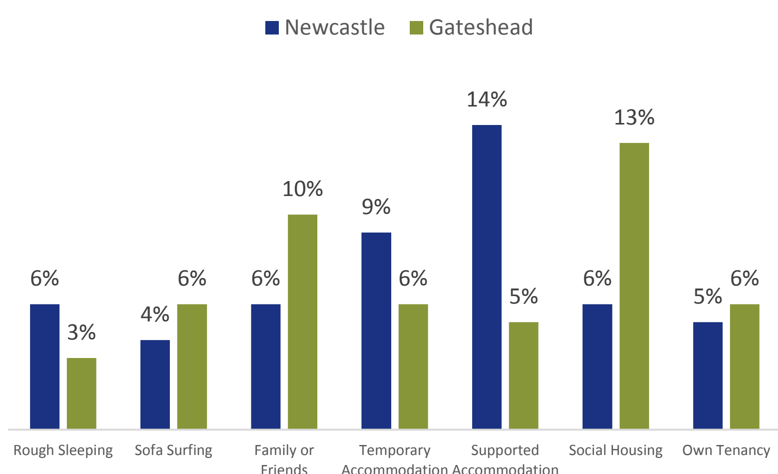


further in the housing section of this report. The full breakdown of support needs between the two areas shows a more even split between Newcastle and Gateshead.

Housing

The breakdown of specific housing situations initially shows a not unexpected picture. 83% of those who were homeless at point of engagement with the programme have all four needs; whilst only 6% of those with three needs are street homeless or sofa surfing. This is a strong indicator that those who are at the most extreme end of secure housing are most at risk of being in crisis and struggling with multiple problems.

Of those housed in temporary accommodation 89% present as having all four needs. As with street homelessness and sofa surfing this indicates that the environment that these properties present is perpetuating the problems around multiple complex needs and is not necessarily providing conducive and supportive surroundings for this client group. This is a particularly pertinent thought when looking at the housing situation of the clients when split between Newcastle and Gateshead.



Whilst Newcastle shows a greater percentage of rough sleepers this isn't unexpected as the larger size, geography and affluence of Newcastle city centre is more likely to attract rough sleepers. Conversely the more spread out and rural geography of Gateshead suggests that rough sleepers may be both less attracted to the city centre and less visible in more rural areas. What is quite notable is the differences between the numbers of individuals housed in temporary and supported accommodation in Newcastle and Social Housing in Gateshead. One explanation for this is that there is significantly higher number of bed spaces in temporary and supported accommodations in Newcastle than in Gateshead and therefore there is greater option for this type of housing. Additionally being housed in supported accommodation should not necessarily be seen as a negative given the importance of the care provided and needed by these services. However an overreliance on these services may be masking a lack of progression into independent accommodation. Certainly given that

3 in 10 individuals with all four needs are street homeless or sofa surfing

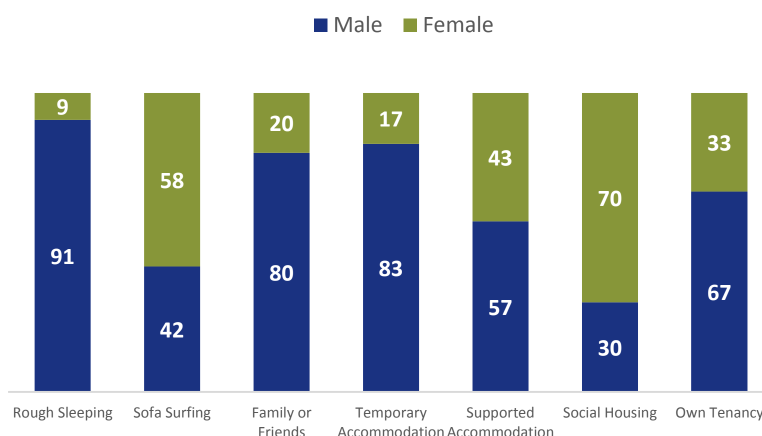
89% of those housed in temporary accommodation have all four needs there is a strong suggestion that having 9% and 6% of individuals housed in temporary accommodation respectively is not a helpful situation.

Of interest is the proportion of individuals who are reliant on family or friends for accommodation. This is occurring in both Local Authorities although with a higher prevalence in Gateshead. This raises concerns around the stress that this is putting on clients' social support networks who may be acting as informal carers but who may also be unintentionally hiding clients from accessing the support they need. Reliance on family and friends is not a long term solution to housing issues and there are questions around what assistance, if any, exists for those family and friends who are supporting individuals with multiple complex needs.

There is a comparatively large difference between the numbers housed in social housing in Newcastle against in Gateshead. In part this could be explained by the higher number of temporary and supported accommodation units in Newcastle which may alleviate the need to house individuals in supported accommodation. However it does warrant further investigation as to why so few of this cohort have access to social housing in Newcastle.

Housing and Gender

When housing situation is broken down by gender some significant patterns start to emerge. Most striking is the dominance of men in the rough sleeper category, although this corresponds with the anecdotal understanding that men are more likely to find themselves sleeping on the streets. That more women are sofa surfing again adds substance to the idea that women are more likely to be able to find a bed for the night although the safety for the women of these arrangements is not clear.



Particularly of note is the difference between the proportion of men and women in both temporary accomodation and social housing and the question should be asked as to whether there is a connection between the two. It should be noted that, as demonstrated by the number rough sleeping, men are more likely to be in need of temporary accomodation and there are more male temporary bed spaces which may indicate a supply and demand cycle which could explain the disparity in male and female usage of temporary accomodation with the multiple complex needs client group. However the social housing percentages give a worrying indication that males with multiple complex needs are not being supported by Local Authority housing provision. Given how highly vulnerable this group present as, regardless of

gender, this should be highlighted and investigated further to assess whether there is a gap in service provision for men with multiple complex needs.

As discussed in the System Mapping exercises there is reservation around temporary accommodation from both male and female service users as being places where they are open to abuse and where it is very difficult to maintain recovery. There is evidence here indicating importance of secure, stable and safe housing to this client group.

Offending

86% of the Fulfilling Lives cohort are reported as having offending behaviour and/or engagement with the criminal justice system. This is more common amongst the male clients, with 90% of male service users having offending behaviour, against 77% of females.

Northumbria Probation services, both the National Probation Service (NPS) and Northumbria Community Rehabilitation Company (CRC), contribute the highest number of referrals into the Fulfilling Lives programme, with 16% of all accepted referrals coming from either NPS or the CRC. CRC contribute the highest proportion of clients – 12% of accepted referrals - the highest of any single referrer.

Over half of clients presenting with a pattern of offending behaviour present with all four needs, with 54% of the cohort presenting as such. The next most common combination of needs is offending behaviour in combination with substance misuse problems and mental health needs, with 39% presenting with these three needs. 57% of those with offending behaviour were also homeless at point of engagement with Fulfilling Lives.

100% of those presenting with offending behaviour also have either substance misuse or alcohol problems, or mental health needs. This is significant as it is a higher proportion than the already high percentage across the general prison population which is estimated at over 90%[1]. Separated this equates to 95% with mental health needs and 98% with substance misuse or alcohol problems, with figures remaining the same for both genders.

Whilst engaged with the Fulfilling Lives programme 24 clients have been sentenced or recalled to custody. Of those 24, ten currently remain incarcerated but of those that have been released eight served sentences of less than a month, with two serving sentences of less than a week; three served sentences of less than two months; and one served a sentence of less than four months. Only one client served a sentence of greater than 12 months.

Six clients have served multiple custodial sentences within the last 12 month period, all of which were under 12 weeks in length, with the average sentence being less than four weeks. This lends credence to the supposition that this client group represent a significant strain on the criminal justice system in that they are committing low level crimes that hold short

[1] The Bradley Report, Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system, April 2009

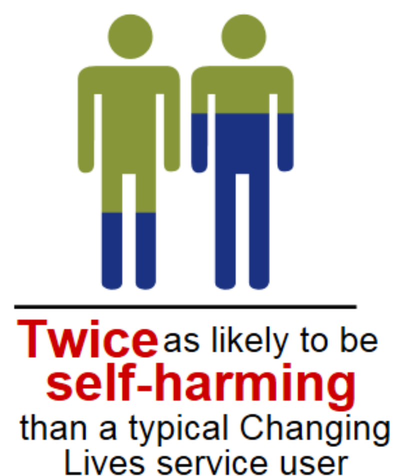
custodial sentences, but are cycling through repeat offences and associated criminal justice process. In light of the recent changes prison release and all prisoners, no matter how short the sentence, having to have a 12 month period under supervison in the community the financial implication to the criminal justice system must be considered when looking into this client group. More importantly, however, the repeat offending behaviour strongly suggests that the rehabilitive element of a custodial sentence is not achieiving success with this client group. This should be considered particularly in relation to the high levels of mental health needs amongst those in this cohort.

Self-harming and risk of vulnerability

Unsurprisingly this is a client group who present as extremely vulnerable. 89% of all our client population are assessed as being at least at a medium risk of vulnerability with 46% considered to be at a high risk. If looking at vulnerability by gender, females have a higher percentage of at least a medium risk of vulnerability, with 94% at risk against 86% of males. Looking solely at the high risk category the divide becomes more notable with 57% of females against 38% of men.

In this context vulnerability is described as being at risk of both physical, emotional, sexual and financial exploitation. This vulnerability is also cyclical so even those who are a high risk to others are themselves at a high risk of exploitation.

It is also important to look at this in comparison to the wider population of service users who are not necessarily suffering from multiple complex needs but are in need of service provision. A comparison with the wider Changing Lives[2] client group across all services in Newcastle and Gateshead shows 51% to be at least at medium risk of vulnerability with 28% considered to be at high risk. This is a notable difference between the wider service user group and those with multiple complex needs and is an important aspect of this client group that should be highlighted when thinking about improved methods of providing support. It should not be denied that these are individuals who often present as demanding, chaotic and disruptive and who are challenging to work with. But an increased awareness amongst services of this underlying vulnerability should be a priority in promoting a change in attitude towards individuals with multiple complex needs.



Additionally this is a group that is extremely prone to self-harming behaviour. 29% of the client group are at a high risk of self-harming and 64% with at least a medium risk of self-

[2] This data was collected from all Changing Lives services across Newcastle and Gateshead including temporary and supported accommodation, outreach, drug and alcohol services, sex working services, women's services employability services. This data was selected for two reasons, firstly this wider cohort of Changing Lives services were considered to be a comparable client group to the Fulfilling Lives clients, encountering similar problems to the Fulfilling Lives cohort but not always on such a complex scale e.g. housing only, or substance misuse only. Secondly a pragmatic decision was made based on the time and resource available for this report. Going forward wider datasets will be looked to be included to enhance this comparison.

harming. Only 5% of the cohort is considered to be at no risk of self-harming. The wider Changing Lives data shows that 28% of the client group are at least at a medium risk of self-harming. It is estimated that 4% of people in the UK are self-harming[3]. This means that individuals with multiple complex needs are 16 times more likely to be self-harming than the average adult.

When looked at by gender there is a somewhat surprising picture. There is a higher percentage of males who show at least a medium risk of suicide, with 52% males against 46% females. The higher proportion of males at risk of suicide is not unexpected given that suicide as an issue in the wider population is something that particularly prevalent amongst males. However the split between female and male is perhaps closer than expected. For the general population males are three and a half times more likely to commit suicide than women. Whilst the figures related to the Fulfilling Lives clients concern risk of suicide as opposed to actual attempts the smaller difference in the male and female experience is notable.

For risk of self-harming again there is a higher percentage of males at least at medium risk than women, with 59% female against 64% male. This is somewhat unexpected as anecdotal awareness would suggest that females are more likely to be self-harming than men. When looking specifically at those with a high risk of self-harming this becomes more balanced, with 31% of women to 30% of men. However the overall higher percentage for men does suggest that this is counter to the typical trend for this type of behaviour and is potentially something indicative of this client profile.

According to MIND the definition of self-harm is “when you hurt yourself as a way of dealing with very difficult feelings, old memories, or overwhelming situations and experiences”. Understanding the motivation for self-harming behavior and having the skills to be able to offer support should be an integral element of any systemic change. Whilst self-harm is not considered to be a “need” in the context of multiple complex needs it should be viewed as a strong indicator of significant and potentially traumatic underlying factors.

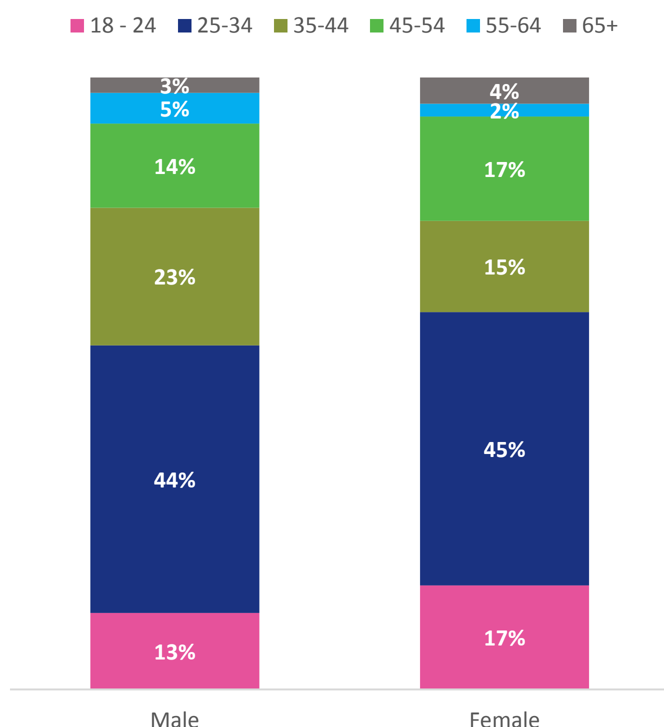
2.4 Profile

Gender and Age

In common with the Hard Edges report and the Fulfilling Lives aggregated demographics (across all twelve pilot sites) the biggest proportion of individuals are male and aged between 25 – 44: with 34% of all our accepted clients falling into this profile. However we have seen less of a gender divide than is suggested by the Lankelly Chase report with a much more equal split of 63% male to 37% female. In part this may be due to the groundwork done by the programme in reaching out to specific female services, and in having a dedicated women’s services as part of the wider partnership. However it should be noted that there has been little difficulty in maintaining this gender ratio which suggests this is a solid representation of the gender profile of multiple complex needs in Newcastle and Gateshead.

[3] Self-poisoning and self-injury in adults, Clinical Medicine, 2002

Whilst it would be too early to draw concrete conclusions as to why we are seeing a more even gender split there are certain questions that we can begin to pose and investigate further throughout the programme's lifetime. Certainly there is a question around whether typical data is capturing the expected information, in that the systems are geared around the most visible clients, who historically are male. There is potential that women are unrepresented in typical datasets because they are more hidden from the standard services and therefore the information they collect. However given the prevalence of women in our client group there is emerging evidence that suggests defining multiple complex needs as a typically male problem may be presumptuous. Also in agreement with the Hard Edges report is that this client group predominately falls into the 25 – 34 year old category, with 44% of our cohort within this age range. This is true for both male and female clients with 44% of all male clients and 45% of all female clients. There is also a relatively even split between clients in the 18 – 24 range with 13% male and 17% female clients in this range.



The 35 – 44 age range sees an interesting diversion between genders. Whilst 23% of males are between the ages of 35 – 44, only 15% of females are. There are a number of assumptions that could be made as to why this change happens; there is a good possibility that the system is working for women of this age and therefore they are less likely to fall into multiple complex needs. This could be because of the women's increased vulnerability or pregnancy and child caring which would give them priority housing and associated wrap around support and therefore increased chances of stability and recovery. However there is also the possibility that women in this age range are an entrenched hidden population and are not accessing any support despite need.

From the number of females presenting with multiple complex needs between 18 – 34 it is apparent that this is a problem that presents for women and therefore the drop off after the age of 34 warrants further investigation to ensure that this is not a vulnerable population who are alienated from services.

Case Study: Susan. Older People	
Background	Susan was referred to Fulfilling Lives in November 2014 from Age UK Newcastle. She was a 71 year old female with alcohol problems, suspected mental health issues (although no diagnosis) and issues with shop lifting. She was housed in an extra care housing scheme with care available although independent living expected.

	Susan has poor mobility and falls approximately three times a week due to her drinking. When this happens an ambulance is called, either to take her to hospital or to help her back to bed. She suffers regular injuries due to falling including cracked ribs and head injuries. She is doubly incontinent. Susan has significant memory problems but it is unclear if this is due to her drinking or due to mental health problems. She does not eat meals and is very underweight and malnourished. Susan is very isolated. She has no contact with any family and has no visitors or Next of Kin. Susan denies having an alcohol problem, despite daily drinking and recently having her stomach pumped following the consumption of two shop lifted bottles of vodka. She has been assessed as having mental
Working with Fulfilling Lives	The Service Navigator's main priorities when engaging with Susan were around supporting her with her alcohol problems, and helping her to access mental health support. Despite a number of challenges the Service Navigator was successful in supporting Susan to a mental health assessment test, via her GP, despite the fact that social services had closed her case due to assessing her as having mental capacity. Following the assessment a Multi-Disciplinary Team meeting was held and attended by Susan, the Service Navigator, the assessing Psychiatrist, Day Centre Nurse, her GP and Care Home staff. Social services did not attend as they had closed Susan's case. The psychiatrist disagreed strongly with social services' assessment of Susan's capacity and stated that in her opinion she did not have capacity and was not suited to independent living. Those at the MDT agreed to challenge social services' decision on Susan's capacity. Social Services carried out a new capacity assessment and agreed that Susan did not have capacity, and that they should be supporting her further. In August 2015 Susan was moved to a 24 hour supported residential care home which is significantly more appropriate for her needs. Susan has settled in well to her new accommodations. She has reduced her drinking to two units a day, which is administered by care home staff. Since moving to the new home she has not had any falls, attends A&E and has stopped vomiting on a daily basis. Her incontinence issues have stopped and she is able to use the toilet. She was given a diagnosis of Korsokoffs Syndrome following an MRI scan. She is eating regularly and engaged with a dietician. She engages with all social activities and her loneliness has reduced significantly. Susan has told her Service Navigator that she "loves it". Due to the successful relocation of Susan, and the support she is now receiving, Fulfilling Lives is no longer needed in Susan's care and she has been successfully moved to "move-on" status.
Learning and actions	Despite the fact that the support and services existed to help Susan, poor communication, lack of cohesive working and misunderstandings meant that Susan was not accessing any of this support. The Service Navigator was able to bring the relevant services together, to open up the right channels of communication and help facilitate bringing the support to Susan. As a result she is now happily homed and looked after, and her significant costs to the emergency services have now gone.

Ethnicity

Only 5% of clients are Black, Asian and Minority Ethnic (BAME). The Newcastle and Gateshead area is a predominantly ethnically white area (90% at the 2011 census) and thus it is expected

that the majority of clients would not be BAME. However it is strongly suspected that this figure is not representative of the multiple complex needs presence in certain BME groups. Whilst this assumption is currently based on anecdotal evidence there are indications that the stigma associated with complex needs and the lack of ethnically aware services prevents individuals from seeking help. Further research needs to be done to investigate the veracity of this assumption.

Lesbian, Gay, Bisexual and Transgender (LGBT)

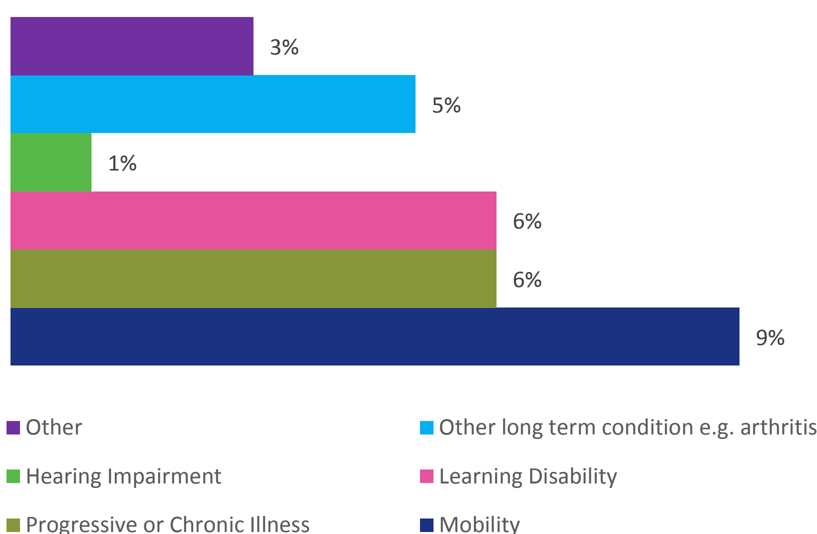
The 2011 Census data for Newcastle and Gateshead states that 1.7% of people identify as either LGBT. Our cohort has over double this proportion with 3.9% identifying as LGBT. This is a conservative estimate as there is an incomplete dataset relating to this category; given the sensitivity of the question for certain clients and the level of chaos it is not always appropriate for this information to be sought immediately. There is a higher proportion of individuals identifying as LGBT amongst the younger populations than there is in those over 65 and this should be considered. However, nationally 2% of the 18 – 54 population identify as LGBT and so the Fulfilling Lives data is still showing a higher percentage.

Whilst this should be taken with the knowledge that this relates to a small sample of individuals and it is too early to assess as an emerging trend this is something that should continue to be observed to see if it does develop into a significant pattern.

Disability and long term health

Excluding those who solely have a mental health diagnosis (as this group are discussed separately) 25% of the cohort have either a disability or long term health condition.

This is much higher than the proportion for the average Newcastle and Gateshead population which has 10% of the population with disability, and of this population 78% are over 65 (2011 census). Given that the majority of the Fulfilling Lives client group fall within an 18 – 54 age range this strongly implies that disabled individuals are disproportionately represented within the multiple complex needs group. Again this is supported by the evidence found in the Hard Edges report which reported a higher than average occurrence of disability or long term illness.



The most common disability need related to mobility with 9% of the cohort presenting with these issues. This is followed by chronic or progressive illnesses, which comprise 6% of the client group. Chronic

Obstructive Pulmonary Disorder (COPD) and Epilepsy are the most prevalent amongst these illnesses.

6% of the client group have diagnosed learning disabilities (including autism and autism spectrum disorder). However further exploration is required to establish the scale of undiagnosed learning disabilities as it is anecdotally reported.

This is only an initial exploration of this client group's health needs beyond mental health needs and is one that requires further examination in detail. The Homeless Link Homeless Health Audit that was conducted by both Newcastle and Gateshead Council's should provide a strong base to further this investigation.

Case Study: Learning Difficulties.	
Background	Tom was referred to Fulfilling Lives by Advocacy Centre North. He is a 22 year old male with significant learning difficulties. He is a regular user of alcohol and is depend on alcohol on a daily basis. He has a previous history of self-harm and suicide attempts. He suffers from depression and uses alcohol further to cope with declines in his mental health. Tom lives in learning disability supported accommodation. Due to some errors with his benefits and mistakes relating to direct debits Tom had significant debts that he was not handling. Tom often finds it difficult to engage with services due to his distrust of strangers and dislike of, and inability to cope in, groups. Tom is a vulnerable young man due to various factors, not least his immediate family. His mother is supportive but also contributes to his drinking habits and suffers severe learning disabilities herself. His brother and cousin have been known to attack Tom quite severely on more than one occasion and his family do not attempt to protect him from this.
Working with Fulfilling Lives	Tom was housed in supported accommodation when Fulfilling Lives became involved. He was supported by workers within the accommodation project, and an additional learning disability service who were supporting his three times a week. Tom disclosed to his Service Navigator that he was not getting on with the staff from the additional support agency and that they had repeatedly ignored his request for female only workers. In addition during the time that Tom was working with Fulfilling Lives he was attacked on two occasions by members of his family. Safeguarding incidents were reported and a plan to manage his family problems were drawn up by Social Services, Fulfilling Lives and the accommodation project. Work was done to help sort out Tom's benefits and debts and a repayment programme was put in place. Tom has maintained this and continues to engage with this package. Following discussions with Tom on what support he would like it was agreed that he would no longer receive support from the additional service but would instead have a more enhanced care package provided by the supported accommodation. This streamlined the number of services engaged with Tom making delivery more efficient and suiting Tom's needs. Whilst efforts to reduce Tom's drinking have not been successful, Tom is now happy with the support he is received and is engaging with it. His financial problems have been resolved and the risk from others has been managed. Due to the severity of Tom's learning disabilities he is unlikely ever to maintain independent living however the situation Tom is currently in is very positive for him.

Learning	There are number of key learning points that can be taken from working with Tom. Firstly is a recognition that not all clients are going to be able to move into independent living, some will always require a level of support. This needs to be considered when looking at changing how the system works and ensuring that provision will always remain for this cohort of the client group. Secondly the importance of choice in providing support. Whilst Tom was accessing support that was there to help him, he was not happy with his worker and as a consequence wasn't engaging with the service. In asking him what care package he wanted a simple solution was able to be enacted. It may sound like a simple message to learn but for this client group sometimes the element of choice is taken from them.

Education

At least 25% of the Fulfilling Lives case load have no qualifications and a further 12% have significant literacy problems. Only 5% have achieved A Level or equivalent qualifications. This lends itself to the Lankelly Chase supposition that multiple complex needs typically presents in those from low socio-economic backgrounds. The low level of education attainment also suggests that there may be indicators that lend itself to early-intervention work.

The dominance of those from low socio-economic areas also hints that poverty may be a key contributing factor in multiple complex needs. The longevity of the Fulfilling Lives programme allows for us to build the evidence base in order to answer that question.

Children in care

37% of all female clients have a child who is no longer in their custody, 14% of male clients are in the same position. The damaging impact on the children of being removed from the custody of their parent should not be discounted, but equally the effect of losing children on the mother, or father, should also be highlighted and to be considered as something to explore. In particular for those whose children have been permanently removed from their care there is a question around this on the implications for their motivating factors. This is predominantly of note for the female client group, of which 38% of those with children have had them permanently removed from their care, a further 14% are in temporary foster care. This is very different to the situation for the male clients, who for 62% of those with children, the child, or children, are living with the mother.

The impact of having a child permanently removed from care, or even temporarily removed from care in the context of this client groups wider support needs is something that warrants further attention. Particular attention should be given to what, if any, support services provide for women in this specific situation.

Asylum Seekers

Whilst constituting a small number of the overall caseload, asylum seekers are becoming a disproportionate presence in our cohort and in light of the global refugee crisis one that is perhaps particularly pertinent.

This is a group that present as particularly chaotic but also especially vulnerable in no small part due to their ineligibility for housing or benefit support. This traps them in a cycle of rough

sleeping or sofa surfing and given they are reliant entirely on a £15 hardship payment a week places them in a very precarious situation in terms of being able to legally provide themselves with food and shelter.

As a consequence this particular group have a disproportionate cost impact on both the criminal justice system and emergency health care with no resolution until a final decision is made on their immigration or asylum status. This is not a healthy situation for either the individual or for the services providing the safety net.

Whilst recognition must be given to the statutory limitations of supporting this group, acknowledgement must also be made that these individuals do exist within the region, that they are trapped in chaos and need and are in extremely unsettled and uncertain situations.

Case Study: Ali. No Recourse to Public Funds.	
Background	Ali was referred to the programme in September 2014 and has been engaging for a year. He was referred to Fulfilling Lives twice, both by the West End Refugee Service (WERS), and by The Hubbub, a community based support group for asylum seekers and refugees. Ali is a failed asylum seeker from Iran, currently appealing the decision on his immigration, who has no recourse to public funds. His immediate presenting needs at the time of his referral were homelessness, substance misuse problems and offending behaviour. Iranian asylum seekers refused leave to remain in the UK, are in a particularly difficult position as immigration do not help or support them to return to Iran due to risk of imprisonment or torture on return, but equally they are not entitled to support. As a result Ali is street homeless, has no public housing options, no benefits or income options, and no support for his mental or physical health. Due to a serious offence Ali is required to sign in at a police station weekly. He is also required to regularly present at immigration in North Shields. He is given no support or funding for travel. Ali has had previous leave to remain and work in the UK before this decision was overturned. At the time he maintained a stable lifestyle and was employed managing a pizza takeaway. During this period Ali was abstinent for over two years, and successfully retained accommodation with no support from the DWP.
Working with Fulfilling Lives	Ali's Service Navigator has been supporting him with engaging with immigration services, including legal services, engaging with probation, helping him maintain safety on the streets and supporting him accessing community services such as food banks. There is limited support that Ali is entitled to. On the occasions that Ali has managed to secure temporary and short term accommodation (typically sofa surfing) his Service Navigator has observed significant improvements in his general wellbeing and motivation. He also demonstrates improvement with his substance use, moving to a much lower dose of methadone. However this deteriorates rapidly as soon as he returns to rough sleeping. Ali is currently working with Freedom from Torture and the Medical Foundation to provide evidence for a new asylum claim. However this a difficult process due to limited legal aid resource and much of the expenditure requirement being on the client, including travel to Liverpool. Observations from Ali's Service Navigator have highlighted the complexity of the system for asylum seekers with no recourse to public fund. He has highlighted that there seems to be a pattern of third sector and community organisations are providing the only, and often limited, support.

Learning and actions	Learning from working with Ali and further beneficiaries with no recourse to public funds, has been that accommodation is a critical need that cannot be met for these individuals. Without accommodation there is a marked deterioration in physical and mental health, an increase in offending behaviour and increase in substance misuse. As a result Fulfilling Lives are now working with Your Homes Newcastle, WERS, Action Foundation, Changing Lives and Advocacy Centre North to explore the potential of supporting these individuals by opening up hard to let social housing to them, and working collectively to provide wrap around support.

2.7 Conclusions

As with other similar analyses the most common demographic profile is males aged between 25 – 44. However this client profile is not as dominant as it is in other studies. The implication is that this client group is already overrepresented in services, therefore providing a more visible sample, and a question needs to be asked is this because services and support are modelled around their needs or because they are genuinely the group with the highest needs.

Almost two thirds (62%) of the women are between 18 – 34 whilst the 35 – 44 profile has a significant drop off. It is not clear what is causing this drop off in women after the age of 35 and whether they don't exist as part of this client profile or whether they're too hidden to access support.

Whilst veterans are represented in the client group they aren't overly represented (2%). This suggests that there is no indication that they are more likely to have multiple complex needs than any other profile. Equally it was expected that care leavers would have a dominant profile within this group but as with veterans, whilst they're represented they aren't overly represented (3%). The inference of this is that whilst these groups may be more likely to have needs they are no more likely to have complex needs.

However certain marginalised populations are over represented; those with disabilities, LGBT communities and those with low educational levels. This is potentially indicative of how the wider support for these specific profiles interacts with the multiple complex needs system. For example are veteran support services more likely to be interacting with existing multiple complex needs services than disability support services thereby enabling smoother interaction and therefore faster support.

3. Understanding the System

3.1 Why is it important to understand the system?

In a well-functioning and efficient system service users are well aware of the pathways through, and ways to access required support. Equally organisations and services work effectively together with good communication and understanding of how to help service user's move through the system.

The multiple complex needs system is large and complicated, with multiple sectors interacting in a range of ways. Equally, due to commissioning cycles, it is also a regularly changing system. None of these things are conducive to effective systemic working and whilst it is not in doubt that certain parts of the system work well and are providing support for service users it is also clear that the system does not work as efficiently as it could. The purpose of understanding the system now gives an opportunity to show where there are gaps or blockages, areas for improved integration or access and understanding how those that use the system actually find it.

By taking the time to understand what the system is like now it enables us to have a strong baseline from which to build ideas for changing the system for the better. It also allows for a more considered and methodological approach to system change.

3.2 System mapping methodology

System mapping is not an inventory of services but a more dynamic representation attempting to demonstrate the flow and movement through systems, and how services interconnect.

These maps were created to capture the perceptions of those using the system and thus are a depiction of their view of the system not the system as a perfect entity. These maps were completed over a series of workshops with different users of the system; service users, frontline workers and service managers. The maps from each group were then amalgamated to make one map per system user type.

The process of this system mapping was kept at a deliberately high level – allowing those completing the maps to define what they felt was the appropriate level of detail to draw out as per their understanding of the system.

Those in the workshops were asked to draw what they felt was the system for those with multiple complex needs and how they see the different elements connect to each other. They were also asked to annotate the maps to provide a commentary on how they see elements of the system interacting.

Whilst these maps do demonstrate the version of the system that exists for those creating the maps they are not intended to be an accurate description of reality but a basis for discussion.

It should be reiterated that these are sample understandings of the system by the individuals completing the maps. They are not intended to be illustrative of all existing services and support that are available to this client group.

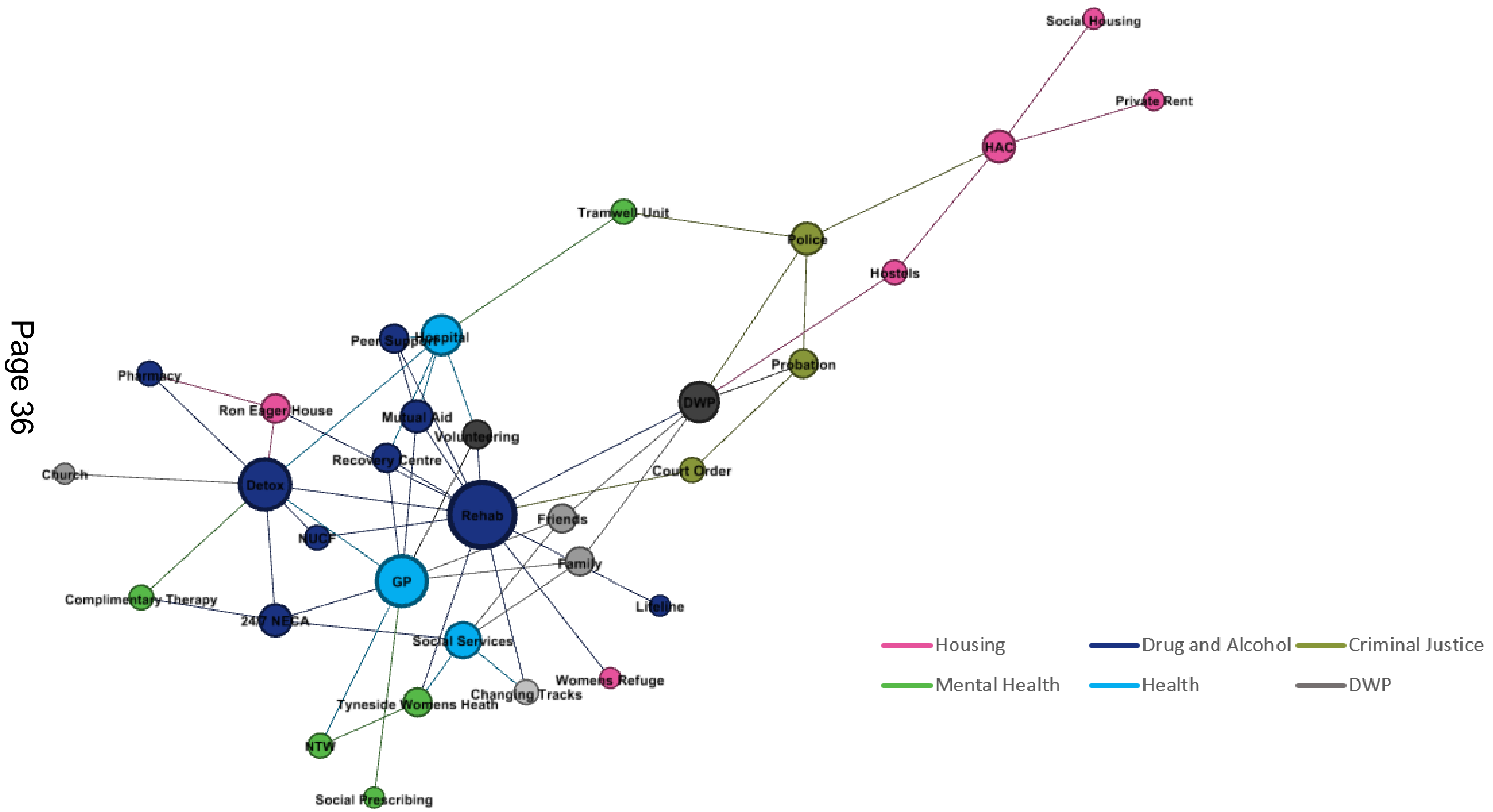
Going forward this method is intended to be used to help illustrate the client journeys of Fulfilling Lives clients and to combine these with more directory or pathway maps to assess how they compare.

3.3 The system mapped

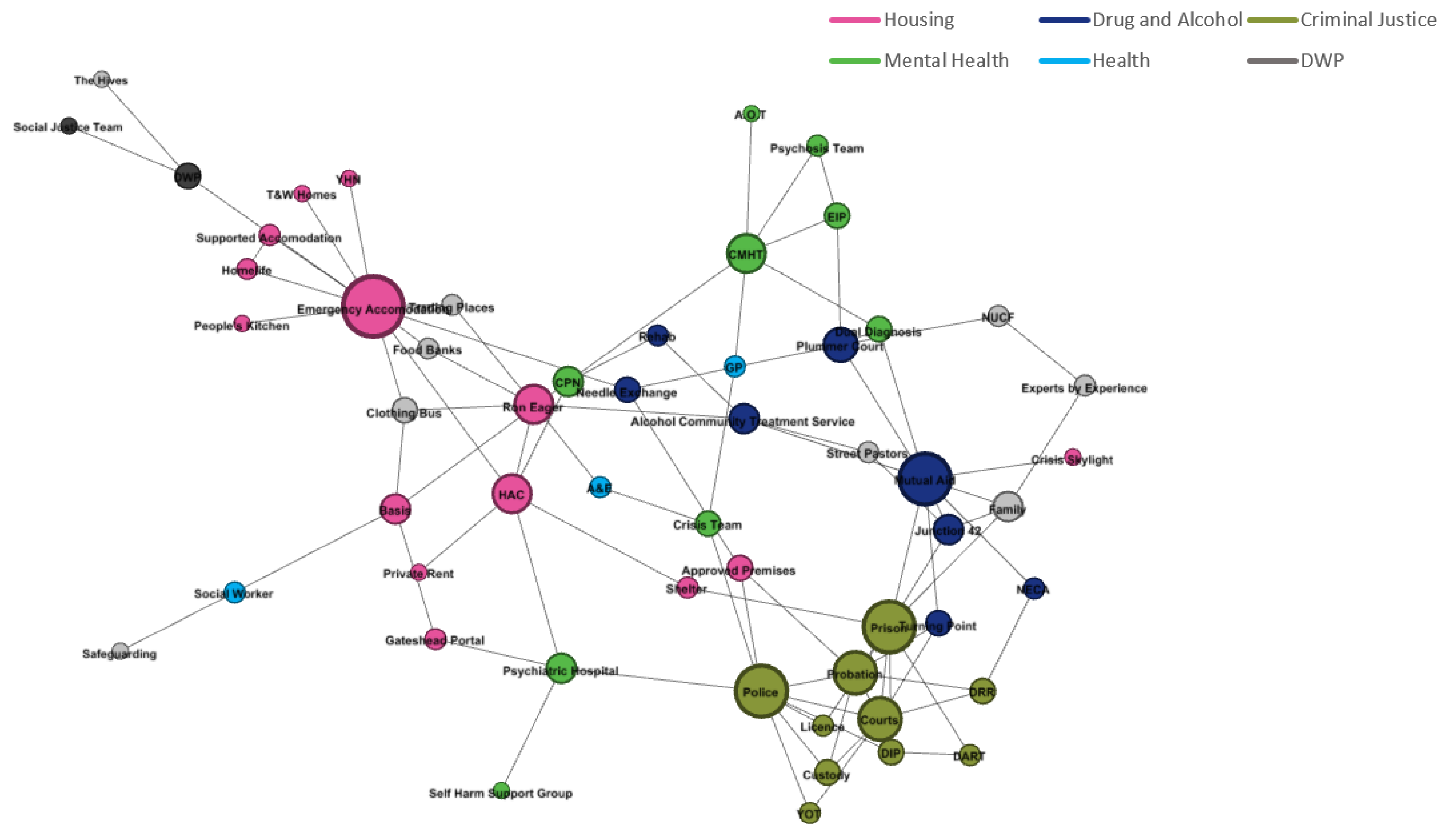
The maps below are created from the maps created in the workshops. These maps only include the service mentioned and the links between, the commentary and annotations around the services are used to inform the interpretation of the maps.

The maps are coded by service type i.e. Housing, Mental Health, Drug and Alcohol, Criminal Justice, DWP and any other. The size of the service relates to the number of other services linking in to it as perceived by the creators of the maps.

Map 1: The service users system



- Map 2: The frontline workers and service managers system



As both maps above demonstrate, and this is not unexpected, this is a complicated system combining multiple different sectors and with no clear pathway through. There is no obvious entry point or clearly navigable route. This is not necessarily a bad thing. A lot of the complication in the above maps comes from the number of services that are available and needed by those with multiple complex needs. However if there is no understanding of the choice and provision then this is not encouraging for effective working.

Understandably service providers have a much more detailed understanding of the system than service users. However as service providers clearly have a much better grasp of the details of the systems, service users become reliant on their workers to guide them through. This creates the potential for a massive variation in support provided as service users are dependent on the knowledge of their workers. Equally this dependence could lead to service users being un-empowered in their own care leading to a lack of ownership towards their own recovery and support. An example of this shown in the maps above are the differences in how mental health services are depicted; in the service users' maps, aside from a small number of specific services, mental health services are depicted purely as NTW. In the service providers' map mental health services are broken down in a much more specific manner. Service users see one entity that they need to gain access to, not the multitude of different services available.

Despite being integral elements of the system as perceived by both service users and service providers, housing services are typically perceived in a negative light. Hostels are not seen as positive places despite being one of the most critical points on the journey. Both male and female service users commented that hostels are seen as intimidating and violent places, where they are open to abuse and that the levels of drug and alcohol use means maintaining recovery in hostels is very difficult. Local Authority housing services are also perceived as a blockage within the system by both service users and service providers. Both groups highlighted that a lack of understanding towards the client needs means that support provided is often not satisfactory or helpful.

Service users particularly highlighted smaller community-based provision as being integral to the system. Equally faith based services are seen as critical on service users' maps but are not present on service providers'. The inference here is that there is a gap between service providers' understanding of holistic support and service users. Service users highlight a system that includes community-based provision as integral whilst service providers focus on the professional system.

Female service users highlighted that the specific system for women is poor with very few services tailored to them. Dedicated women's services such as refuges, GAP, and Tyneside Women's Health are viewed highly by female service users. Additionally the female service users in particular emphasised that they are often afraid to disclose their full problems to provision e.g. GPs for fear of losing their children. If this is a consistent blockage in helping women access support for their problems then action should be taken to help lessen these fears.

Over the workshops no one had a fully positive view of the system. Whilst certain elements were seen as positive, or certain links between services were seen as positive, the system as a whole is not considered healthy.

Echoing through all the maps is a key problem with communication. Both because the number of services involved is so vast that communication between provision is chaotic and inconsistent, because service users are often afraid to fully communicate their problems, and because of the variation in frontline workers knowledge creating a sense of mistrust. At a strategic level of communication, service providers feel that a lack of unified thinking with commissioning sits over the whole system as a barrier.

For service users, fear is another problem – fear of specific services e.g. hostels, fear of rejection and incompetence, or fear of the repercussions of asking for help. The services that were viewed most positively were small, informal community organisations or the services that support you when you have no choice e.g. probation.

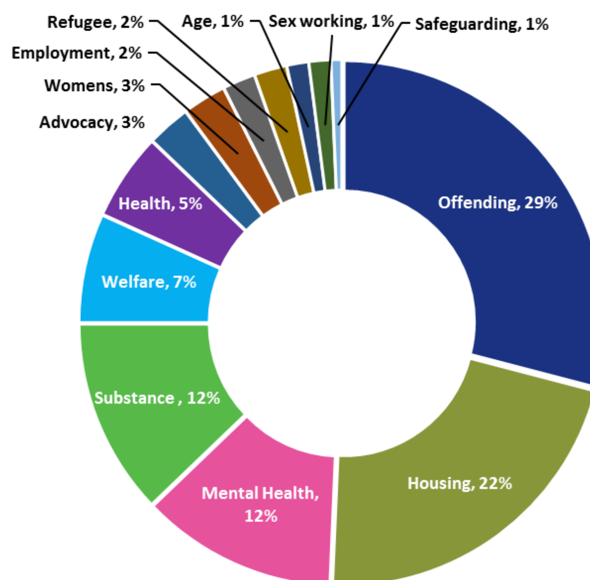
3.4. Referral sources

A strong indicator of the system that this client group is engaged with or visible to, are the referral sources of clients into the Fulfilling Lives programme. Referrals are open to any service, support agency or community organisation and have been received from a diverse range. There have been 74 different referral sources overall, and 56 when looking at appropriate and accepted referrals only.

The highest number of accepted referrals have been received from Northumbria Community Rehabilitation Company (CRC) with 27 accepted referrals, or 18% of overall accepted referrals. This is followed by Basis@366 (a drop in service for people in housing crisis) and the National Probation Service (NPS) making up 7% and 6% of accepted referrals respectively.

When grouping the referral sources by thematic areas an interesting picture emerges highlighting the diversity of services this client group interacts with. The referral sources for Fulfilling Lives can be divided into 13 broad categories of services or support agencies based on their primary function: advocacy; age; health; housing; mental health; offending; refugee; safeguarding; sex work; skills and employability; substance misuse; welfare (including Job Centre Plus); and women.

Of these categories the highest number of referrals, 29%, were received from services related to offending and/or the criminal justice system. Housing services provided the next highest percentage, with 22% of referrals received from these sources. The next two highest categories were mental health services and substance misuse or alcohol services with 12% of referral sources respectively. It’s worth noting that the four main categories of definition for this client group in terms of support needs are the four main areas of referral sources. Interestingly, however, the two lowest in terms of percentage of clients with related support needs (offending and housing) comprise the two areas from which the highest proportion of referrals have been received – over 50% combined.



It is not totally transparent as to why this may be but it may be a consequence of the fact that those with those two needs are more likely to be in crisis e.g. those with housing, alongside mental health and substance misuse problems, are more likely to be present as having multiple and complex needs then an individual with stable housing. Likewise with offending behaviour.

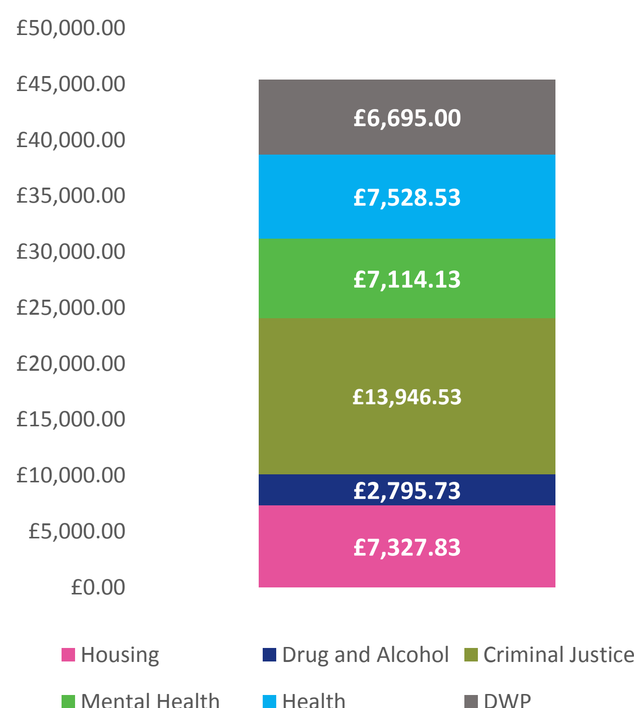
A key take away from examining the referral sources is the breadth and diversity of support that this client group encounters, and this echoes what was produced during the system mapping process. It also highlights the need to expand awareness of this client group from beyond the traditional four siloes of mental health, substance misuse, housing and offending that they are typically associated with.

4. Costs

4.1 Cost to the system

The Hard Edges report estimated the average cost of an individual with Multiple and Complex Needs to be around £19,000 a year (Bramley, G et al. (2015)). Based on the initial findings from the Fulfilling Lives programme this would appear to be a low estimate as our costings are more in line with those found in the Evaluation of the MEAM Pilots (Battrick et al. (2014)).

The Hard Edges report does provide an estimated benchmark of £4600 per the average adult for the same range of services and this is the comparator used in this report.



The costings utilised here were calculated using the average cost to services from the 32 clients who have been engaged with the programme since September 2014. Due to the limitations of the data available these costings are estimated on the low side. Where service usage was uncertain the conservative estimate was utilised. Using this information it can be estimated that an individual with Multiple Needs costs, on average, around **£45,000 per year.** Using the benchmark of £4600 our estimate suggests that an individual with multiple complex needs costs nearly 10 times as much as the average adult.

The Hard Edges report estimates that on average each Local Authority has 1,470 cases of multiple complex needs per year. Based on this assessment we can estimate that across Newcastle and Gateshead multiple complex needs is costing the area approximately **£133 million per year**.

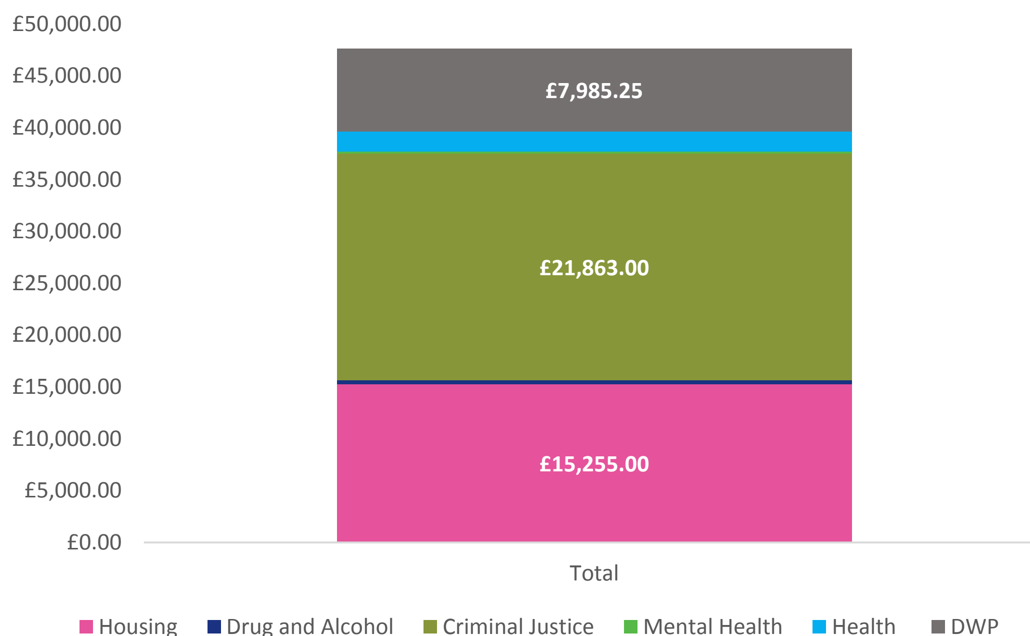
4.2 Case Studies

The following case studies examine the costings of three clients in relation to their engagement with the Fulfilling Lives programme. Detailed costing analysis will be contained in the economic analysis led by Resolving Chaos.

- **21 year old with low capacity for long term planning**
- **Binge drinks and uses legal highs**
- **Self-harms and has attempted suicide on multiple occasions**
- **Has no specific mental health diagnosis despite previous engagement with Early Intervention in Psychosis team.**
- **Is regularly evicted due to anti-social behaviour. Cycles through various temporary and supported accommodation.**

Mark began working with Fulfilling Lives in October 2014. Between October 2015 and June 2015 he was evicted four times from different temporary and supported accommodations. These were for anti-social behaviour, alleged assault and breach of licence. He is on a waiting list for non-psychosis mental health diagnosis but his care is currently with his GP. He is not any medication and has no dedicated mental health support. As a result of his binge drinking he has damaged his liver but this has not prevented his drinking. Mark is disengaged with services to a varying degree and when he does attend does not always communicate well. He's considered to be very immature for his age and does not have good capacity or judgement.

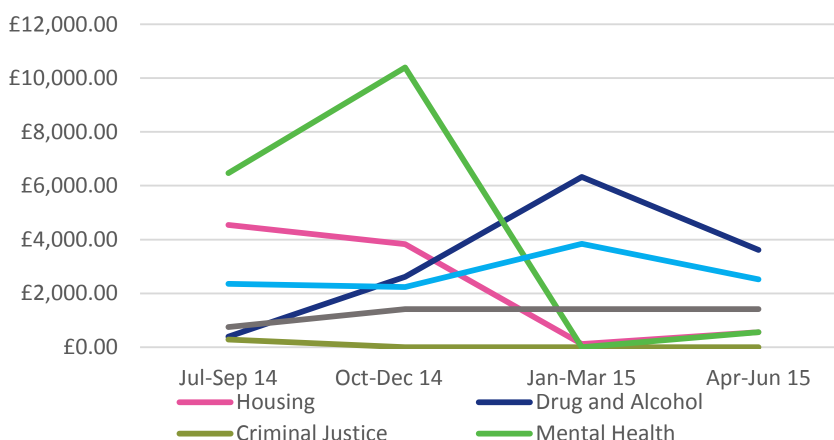
From October 2014 – June 2015 it is estimated that Mark has cost approximately **£47,600**. The below chart shows the breakdown of his costs across the different sectors. His significant Criminal Justice costs partially relate to a Crown Court case.



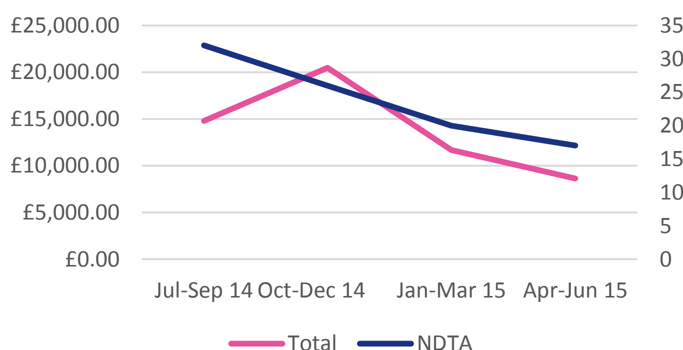
- **25 years old care leaver**
- **Heroin user**
- **Sex working**
- **Self-harming and suicidal**
- **Bouncing between rough sleeping, sofa surfing, temporary accommodation and mental health facilities**

Grace began working with Fulfilling Lives in August 2014. She presented as extremely chaotic with a particularly high reliance on mental health services. Her housing situation was unstable and she was prone to move regularly between rough sleeping, sofa surfing or staying with friends and temporary accommodation. She had regular stays in mental health facilities due to self-harming and suicidal behaviour. During her engagement with Fulfilling Lives it became apparent that accessing rehab was a key motivator for Grace. Due to previous failed attempts at rehab, paid for by Gateshead Local Authority, Grace was not eligible for funded rehab. Fulfilling Lives, supported by a contribution from Grace, funded a rehab place in Glasgow.

From July 2014 – June 2015 it is estimated that Grace has cost approximately **£55,500**. The below chart shows the change in spend during her time engaged with Fulfilling Lives:



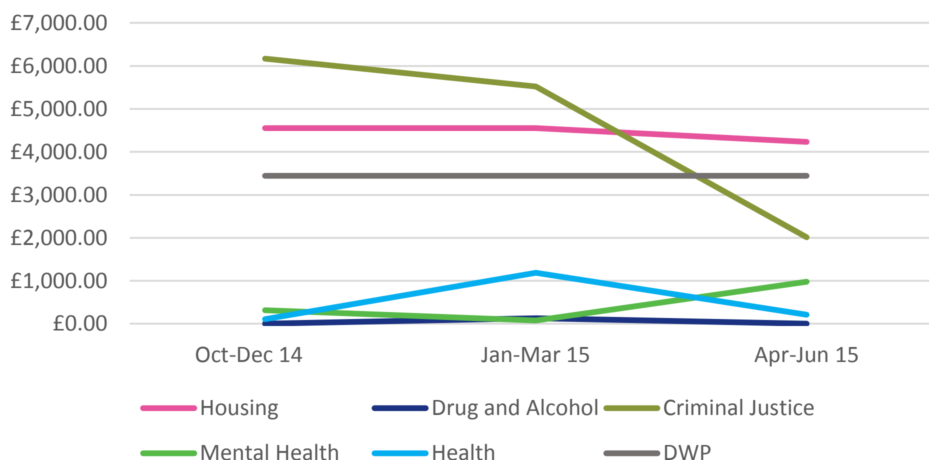
New Directions Team Assessments (Chaos Index) are used by the programme to assess levels of chaos. The below chart charts Grace's NDT score against her costings:



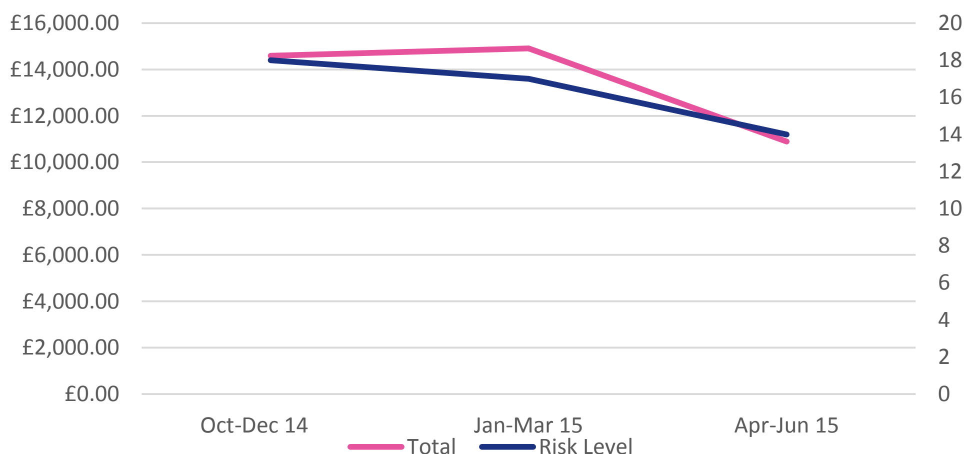
- **24 year old victim of emotional, physical and sexual abuse**
- **Regular binge drinker**
- **Has a diagnosis of Emotional Unstable Personality Disorder**
- **Self-harming and suicidal**
- **Has been in and out of prison since she was a teenager**
- **Has been a resident in supported accommodation for three years**

Sarah began working with Fulfilling Lives in September 2014. She is well known to local services but has exceeded the two year maximum stay in her accommodation. Despite threats of eviction she has not engaged with housing support or changed her behaviour within the accommodation. She has disengaged from mental health services but is often found in crisis particularly when under the influence. Sarah is difficult to engage and dislikes change. She responded well to regular appointments with her Service Navigator who managed to engage her with a Personality Disorder Hub worker.

From October 2014 – June 2015 it is estimated that Sarah has cost approximately **£40,300**. The below chart shows the change in spend during her time engaged with Fulfilling Lives:



Sarah presents as a high risk individual, particularly to herself. The below chart maps Sarah's risk levels against her costs:



5. Fulfilling Lives Newcastle and Gateshead Outcomes

5.1. About this section

The following section examines some of the initial outcomes emerging from the first year of the Fulfilling Lives programme delivery.

This part of the programme relates primarily to the work that the Service Navigators do in supporting individual clients in engaging, navigating and understanding the system around them and the support they can access. Fulfilling Lives does not provide a service in itself, but links clients with existing support or services that they are currently unable to either engage with or access. When relating this to outcomes this means that any changes relate also to the work of direct services.

5.2. Client outcomes

Client retention

Of the 130 clients who have been engaged with the programme there has been a notable success in the retention rate of clients with only 11% of clients disengaging. Disengaged for Fulfilling Lives constitutes not engaging at all with the programme for three months or more. Due to the chaotic nature of this client group, and given a lack of engagement is a key criteria for acceptance into the programme this should be recognised. As the programme progresses this proportion of disengaged clients should be assessed further and if this percentage remains low investigation should be done as to why this success is being seen.

New Directions Team Assessment; Chaos Index

All clients in the Fulfilling Lives programme are assessed using the New Directions Team Assessment (NDTA), or Chaos Index. This is a tool developed by South West London and St George's Mental Health Trust as a way of assessing people with chaotic lives who would be appropriate for their services. The tool requires the individual to be scored on 10 different criteria relating to engagement with services; intentional self-harm; unintentional self-harm; risk to others; risk from others; stress and anxiety; social effectiveness; alcohol/drug abuse; impulse control; and housing. A high score indicates high levels of chaos, with the highest score being 48.

The average overall score of clients at point of referral into the Fulfilling Lives programme is 30. Two clients have a high score of 44, and a further eight clients have scores of 40 or above. The most common score amongst accepted clients is 35, with 12 clients scoring this at their initial assessment.

The average related statement for each of the individual criteria are:

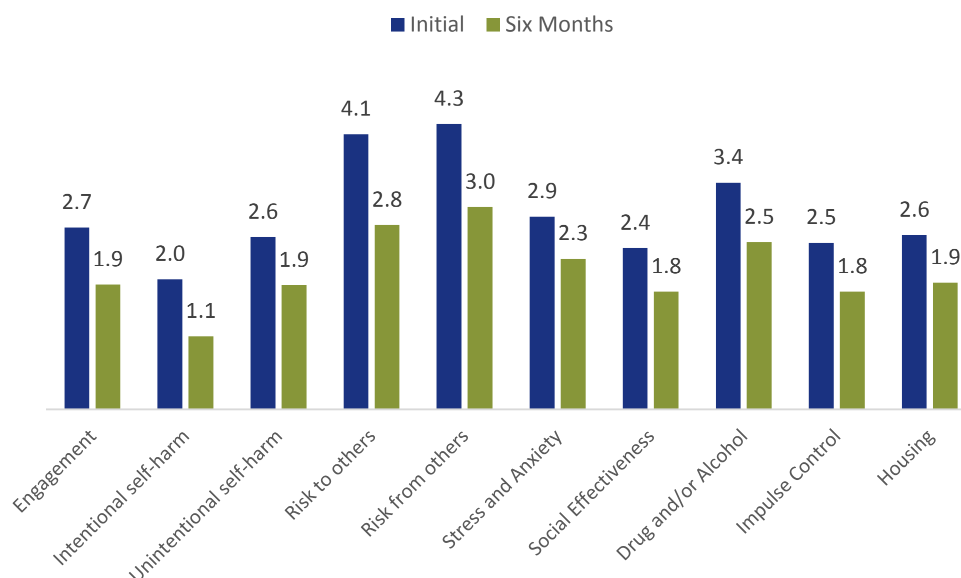
- Non-compliant with routine activities or reasonable requests; does not follow daily routine, though may keep some appointments
- Definite indicators of risk of deliberate self-harm or suicide attempt

- High risk to physical safety as a result of self-neglect, unsafe behaviour or inability to maintain a safe environment
- Risk to physical safety of others as a result of dangerous behaviour or offending/criminal behaviour
- Definite risk of abuse or exploitation from other individuals or society
- Obvious reactiveness; very limited problem solving in response to stress; becomes hostile and aggressive to others
- Uses only minimal social skills, cannot engage in give-and-take of instrumental or social conversations; limited response to social cues; inappropriate
- Recurrent use of alcohol or abuse of drugs which causes significant effect on functioning; aggressive behaviour to others
- Impulsive acts which are fairly often and/or of moderate severity
- Immediate risk of loss of accommodation; living in short-term / temporary
- accommodation; high housing support needs

Based on the 104 clients who have had six months of involvement with the Fulfilling Lives programme, on average NDTA scores have reduced from 30 at initial assessment, to 21 at the six month point. Furthermore, of the 27 clients who have been involved with Fulfilling Lives for 12 months, average NDTA scores have reduced from 29 at initial assessment, to 21 at the six month point and have remained at 21 at the 12 month point. It is encouraging to see that the NDTA score is maintaining its reduction following a further six months.

In comparison with the statements listed above, the average related statement for each criterion for the reduced score are:

- Follows through some of the time with daily routines or other activities; usually complies with reasonable requests; is minimally involved in tenancy/treatment
- Minor concerns about risk of deliberate self-harm or suicide attempt
- Definite indicators of unintentional risk to physical safety
- Minor antisocial behaviour
- Minor concerns about risk of abuse or exploitation from other individuals or society
- Moderately reactive to stress; needs support in order to cope
- Marginal social skills, sometimes creates interpersonal friction; sometimes inappropriate
- Some use of alcohol or abuse of drugs with some effect on functioning; sometimes inappropriate to others
- Some temper outbursts/aggressive behaviour; moderate severity; at least one episode of behaviour that is dangerous or threatening
- Living in short-term / temporary accommodation; medium to high housing support needs



The biggest average reductions are seen in the two risk criteria; risk from others and risk to others with both seeing an average reduction of 1.3. However of particularly note for this client group is the change in engagement levels, with clients at the start of the Fulfilling Lives programme very much dis-engaged from services and support, a mandatory criteria to be accepted onto the programme, to starting to interact with the service and support network around them.

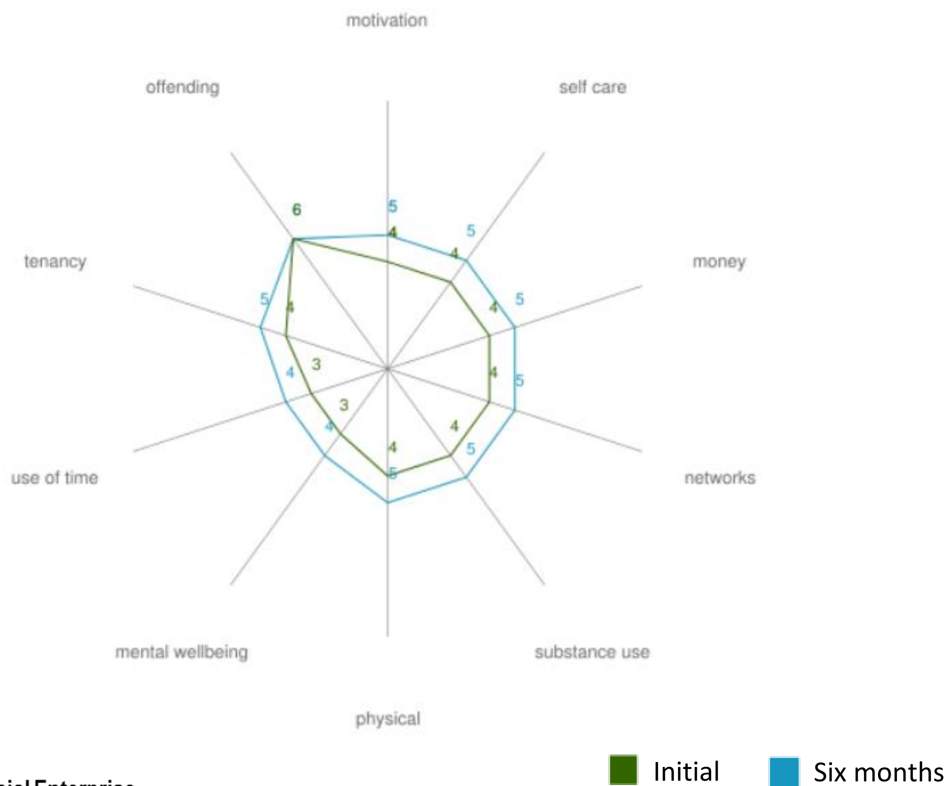
Not all clients have seen a positive progression. Of the 104 clients measured at the six month point, 14 have seen an increase in their NDTA score, whilst a further 10 have seen no change. One explanation for this is that Fulfilling Lives will accept some clients who are on the cusp of crisis but are not yet fully in chaos, although shortly after involvement the tenuous support in place collapses and therefore there crisis levels increase. However this is not the case for all clients who's scores have either maintained or increased and recognition must be given that for some clients six months is not a sufficient length of time for change or improvements to occur.

Encouragingly, of the 21 clients who have been engaged for 12 months, there were four who had an increase in NDTA score at the six month point. For all of these clients there has been a reduction between their scores at six months, and their scores at a year. Thus whilst for two of these clients, there scores still remain higher than at initial engagement there are positive signs of progression.

Homeless Outcomes Star

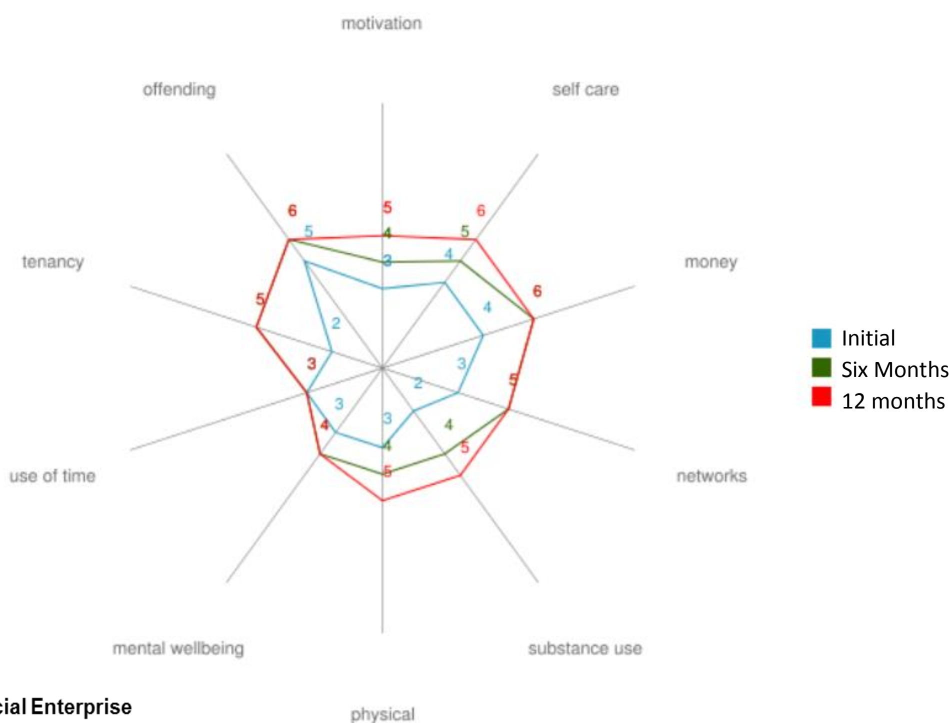
A comparatively smaller, but equally positive change has been seen across the Homeless Outcomes Star data at the initial and then six month sampling points. It is worth noting that the initial sampling point may show higher scores than expected. This is because Outcomes Stars can be completed up to three months into engagement with the programme and

therefore clients are potentially at a slightly more stable point then when they were first referred.



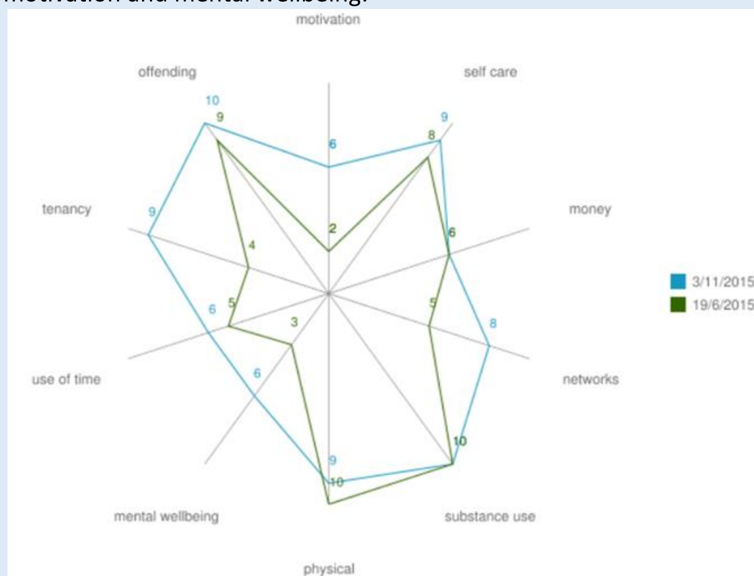
© Triangle Consulting Social Enterprise

Whilst there is typically only an increase of one point on the Outcomes scale this is still a positive sign, particularly as this is recorded at a six month sampling point. Encouragingly, as with the NDTA scores, for the smaller sample of clients who have reached the twelve month mark and therefore have a third sampling point in their Outcomes Score, this increase is either maintained or furthered.



© Triangle Consulting Social Enterprise

Case Study: Meaningful Activity	
Background	Janet was referred to Fulfilling Lives from Northumbria CRC in January 2015. She is a 59 year old woman, who has severe anxiety issues and suffers regular panic attacks. As such she rarely leaves the house. At the time of referral Janet was at risk of eviction due to non-payment of rent. She was self-harming regularly and has attempted suicide historically. Janet had received a 24 month suspended sentence order in November 2014.
Key engagement milestones	At the start of engagement Janet was very reluctant to work with her Service Navigator and was lacking in any motivation. She was of the belief that she was unable to change or improve her situation. Despite her lack of engagement the Service Navigator remained in contact with Janet. The following details Janet's journey, interspersed with quotes from Janet. After disclosing that she had a love of animals, the Service Navigator suggested Equine Therapy through Stepney Bank stables. Janet showed immediate interest and agreed to attend to attend a taster session. *"It was a simple chance conversation which led to [Service Navigator] suggesting a visit to Stepney Bank stables. Well I've tried more therapists than I can shake a stick and although talking is good, I don't particularly remember any lightbulb moments. To be fair, at least half the time my brain wasn't in any fit state to even recall what was said."* Following this initial session Janet stated that she had thoroughly enjoyed it. She had learnt breathing techniques and felt she had achieved something that "no- one else has been able to offer in over 30 years". Janet felt very comfortable and confident around the horses. *"I met a beautiful horse called Lara. She has a pink nose and adorable freckles. Animals are easy to be with, they don't expect you to be happy and chatty, you don't have to be upbeat and if I'm crying, Riff and Dino [dogs] still sort of get as close as they possibly can to me and I feel comforted."* Janet confirmed that she wanted to attend a second session and that she would make her own way to and from the stables. *"The sun is shining and I'm actually looking forward to Stepney Bank today!"* Since this point Janet has continued to engage with the stables and is coming to the end of her initial block of sessions. She has found great success in the therapeutic element of the activities. *"This therapy is different to anything I've done before. I've been to lots of counsellors and what nots [sic] and it's always been the same, talking about my past, the bad things that have happened to me and things that have happened that has had [sic] an adverse effect on me…I've told all this to [equine therapist] and she has somehow managed to make me feel not so pathetic and small."* Janet is reluctant for these sessions to end and has begun discussions with the stable manager around volunteering opportunities. *"What I am sure of is that this therapy has been the best I've ever had. It's been practical in giving me the tools to try and help myself survive."*

Outcomes	The below star maps Janet's outcome star results since she started engaging with the programme and shows the significant progress she has made particularly in relation to motivation and mental wellbeing:  From Fulfilling Lives initial engagement with Janet there has now been marked improvement. Her rent payments are now up to date and her housing is secure and she is participating in meaningful activity. The hope is that her experience at Stepney Banks stables will form the foundation for Janet to address her underlying mental health problems and reduce her anxiety.

6. Conclusion

The review of the data provided over the first year of the Fulfilling Lives programme presents a useful baseline for discussion going forward. It certainly has highlighted why there is so much difficulty in defining multiple complex needs given that at this stage there is little by way of definitive profiles emerging. Conversely to other similar reviews we have not found this to be a predominately male problem but something that occurs in both genders. Equally whilst there is a dominant age profile of 25 to 44, we have seen multiple complex needs occurring through the age spectrum from 18 to 72. It is apparent that further investigation needs to be done to further understand in detail elements of this client profile including disability and childhood factors.

What is common to the profile is their level of risk and vulnerability. In particular the high levels of self-harming are of notable concern. Putting this high risk to self in alignment with the extremely complex and chaotic system that emerges through the system mapping exercises the importance of improving outcomes for this client group becomes self-evident.

Individuals with multiple complex needs do not form a particularly large population group but they are disproportionately costly to the area. For those that are entrenched in a long term cycle of multiple service use, disengagement and poor outcomes the estimated cost of £45,000 a year can quickly add up over a lifetime. An efficient and effective system geared around supporting these individuals should be able to stem off the long term cycle before individuals become entrenched.

This report should be used as a baseline in sparking discussion and understanding this client group and their system. Those involved in this system from across the spectrum, including statutory sector, voluntary sector and service users, should be involved in finding solutions to these problems.

6.1 Recommendations

The following are the first recommendations that have emerged from the evidence as available to date. Some of the emerging trends require further investigation in order to provide sufficient evidence and are therefore not included here.

- A key theme that is apparent both in existing literature, and through the system mapping exercise is a lack of shared understanding across all services as to what multiple complex needs means and the informed care that individuals with these needs should be offered. In order to broach these differences across the service delivery, and to help improve communication about this client group, sector wide training would be an appropriate first step.

- The separation between the professionalised system as perceived by service providers and a system which has smaller community provision as perceived by service users should be recognised. This is not necessarily a problematic issue given that service users are entitled to space and support where they are not defined by their complex needs.

However if service users respond well to small community provision and these services and support are providing invaluable care then the question needs to be asked as to what is the potential learning for existing services.

- The differing needs for men and women should be recognised and the question asked as to whether support is predominately aimed at men and that women suffer from a lack of dedicated provision. In particular work needs to be done around supporting mothers with understanding the implications and processes for both them, and their child, if the child has been taken into child protective services.

- Greater investigation needs to be done into the disability profile of this client group and understanding the causality between this and multiple complex needs.

- Greater investigation needs to be done into the physical health needs amongst this client group, including access to non-emergency services such as GP and Dentists.

6.2 Evaluation next steps

Following this report there is a multitude of ongoing activity related to evidencing and evaluating both the multiple complex needs client group and the Fulfilling Lives activity.

Leading from information arising in this analysis, further and more detailed analysis is to be conducted around some of the emerging evidence related to disability profiles, socio-economic status, childhood trauma and the role of poverty as an overriding factor.

Further economic analysis looking at the multiple complex needs is currently underway, in partnership with Resolving Chaos. In addition cost analysis of Fulfilling Lives activity will be produced when specific activities or pilots are complete. These will be available throughout the programme lifetime.

Looking forward, more evaluation work will be done in collaboration with peer researchers and service users in order to provide a more closed loop analysis.

References

Adamson, Lamb, Moreton, Robinson and Howe, (2015), *Fulfilling Lives: Supporting people with multiple needs; Evaluation Report: Year 1*, CFE Research

Barclay and Pettitt (2014), *An Interim Evaluation of the Making Every Adult Matter (MEAM) Coalition*, Calouste Gulbenkian Foundation

Battrick, Cook, Edwards and Moselle (2014), *Evaluation of the MEAM Pilots – Update on our findings*, FTI Consulting LLP

Bradley and Department of Health (DoH), (2009), *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system,* Department of Health publications

Bramley and Fitzpatrick with Edwards, Ford, Johnson, Sosenko and Watkins, (2015), *Hard Edges: Mapping Severe and Multiple Disadvantage*, The Lankelly Chase Foundation

Bretherton and Pleace, (2015), *Housing First in England: An Evaluation of Nine Services*, University of York: Centre for Housing Policy

Calouste Gulbenkian Foundation and MEAM, (2015), *Individuals with multiple needs: the case for a national focus*, Calouste Gulbenkian Foundation: Author

Chapman, (2004), *System Failure: Why governments must learn to think differently; Second Edition*¸ Demos

Curtis, (2014), *Unit Costs of Health & Social Care*, Personal Social Services Research Unit

Department for Work and Pensions (DWP), (2011), *Annual Report and Accounts 2010 – 2011*

Harries, Wharton and Abercrombie, (2015), *Systems Change: A guide to what it is and how to do it*, NPC

Hargreaves, (2010), *Evaluating System Change: A Planning Guide*, Mathematica Policy Research, Inc.

Horrocks and House, (2002), *Self Poisoning and Self Injury in Adults,* Clinical Medicine Nov-Dec;2(6): 509-12

Hough, (2014), *Changing Systems for People with Multiple Needs: Learning from the literature*, New Economic Foundation

http://www.mind.org.uk/information-support/types-of-mental-health-problems/self-harm/#.Vfp_y9RwaoA, Accessed: September 2015

Ministry of Justice (MOJ), (2013), *Probation Trust Unit Costs Financial Year 2012 – 2013*

Mcneil and Hunter, (2015), *Breaking Boundaries: Towards a "Troubled Lives" programme for people facing multiple and complex needs*, Institute of Public Policy Research (IPPR)

Rankin and Regan, (2004), *Meeting Complex Needs: The Future of Social Care*, Institute of Public Policy Research (IPPR) and Turning Point

Rosengard, Laing, Ridley and Hunter, (2007), *A Literature Review on Multiple and Complex Needs*, Scottish Executive Social Research

Seddon, (2013), *Systems failure and systems thinking*, March: http://www.nesta.org.uk/blogs/systemic_innovation_a_discussion_series/systems_failure_and_systems_thinking

Shelter, (2012), *Immediate costs to government of loss of home*, Shelter: Author

United Way Peel Region, (2014), *Mapping the Mental Health System in Peel Region: Challenges and Opportunities*, Prepared by Taylor Newberry Consulting for United Way of Peel Region, Mississauga, ON: Author.

Whitehead, Stockdale and Razzu (2003) *The Economic and Social Costs of Anti-Social Behaviour: A Review*, London school of Economics

CHANGING LIVES

This page is intentionally left blank

Year 1 Review and Evaluation Findings

What is Fulfilling Lives?

- Big Lottery funded programme aiming to better support people with multiple and complex needs and work in partnership to effect system change
- £5.5m over 8 years working across Gateshead & Newcastle
- Multiple & complex needs defined as having a combination of:
  - Addiction
  - Poor mental health
  - Homelessness
  - Offending history
  - AND ineffective contact with services
- Core partnership: Changing Lives, Oasis Aquila Housing, Mental Health Concern
- Delivery partners: Blue Stone Consortium:
  - Tyneside & Northumberland Mind, Age UK Newcastle, Tyneside Women's Health, Advocacy Centre North

OUR KEY PRINCIPLES

For our clients:

- A whole person approach
- Stickability
- Asset based approach
- No signposting

For the system

- A whole system & preventative approach
- Try new things
- Reflective learning and development
- Listening and collaboration
- Sharing evidence and learning from the programme at a regional and national level

OUR CLIENTS SO FAR

- Most likely to be **white**, **male**, aged **25 – 34**
- Second most common profile is **white, females**, aged **25 - 34**
- **Fear** is a de-motivating factor for service users
- **16 times** more likely to be **self-harming** than an average adult
- At least **25%** have **no educational qualifications**
- **37%** of female clients have a **child no longer in their custody**
- **95%** of offenders have **mental health needs** and **98%** have **substance misuse problems**
- **Men** are much more likely to present with **all four needs**

OUTCOMES IN YEAR 1

- After 6 months of engagement the average NDTA score has **reduced by 9 points** from 29 to 20
- Current active caseload of **115 clients**
- **15** beneficiaries have progressed to **move-on support**
- Only **7** beneficiaries currently **disengaged**

On average, after six months of engagement:

Beneficiaries have moved from being at **immediate risk of loss of accommodation** to **living in short term or temporary accommodation**

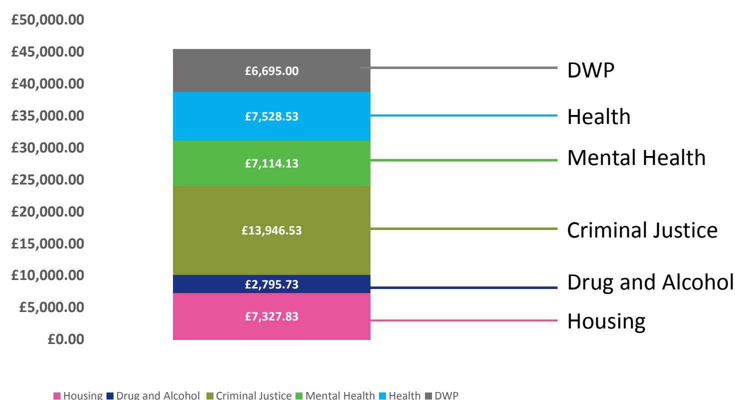
Beneficiaries drug or alcohol use has moved from **recurrent use of alcohol or drug abuse** to **some use of alcohol or drug abuse** with only some effect on ability to function

Beneficiaries have moved from showing **definite indicators** of deliberate self-harm or risk of suicide to **minor concerns** about self-harm and suicide risk

Beneficiaries behaviour has moved from **risk to property and/or risk to physical safety** of others to **minor anti-social behaviour**

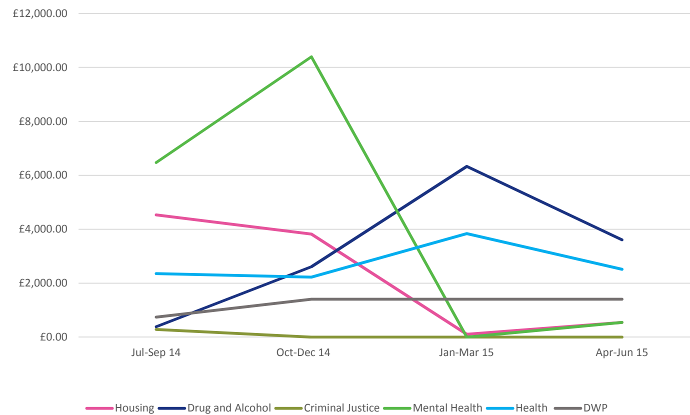
COSTS TO THE SYSTEM

- Estimated average cost of **£45,000 per person** annually
- This equates to an approximately **£133 million** per year to Newcastle and Gateshead



INDIVIDUAL COST ESTIMATE EXAMPLE

From July 2014 – June 2015 it is estimated that Grace has cost approximately **£55,500**.



EXAMPLES OF SYSTEM CHANGE ACTIVITY

- Workforce development for GP receptionists
- Extending the principles of Fulfilling Lives programme into new care models:
  - navigation in Northumbria Probation CRC
  - proposed System Brokers / Peer Mentors in CCG and NTW Urgent Care Hub
- Psychologically Informed Environments

RECOMMENDATIONS

Gateshead Health and Wellbeing Board:

1. Continue to work within the Fulfilling Lives Partnership - to improve outcomes for people with multiple and complex needs who face ingrained inequality

2. Consider the potential for using the Navigator Model for working with vulnerable clients in other settings

3. Support Fulfilling Lives' efforts to demonstrate the costs of the client group and identify opportunities for budget savings

4. Consider opportunities for joining up future commissioning decisions for this client group, across Newcastle/Gateshead and across all statutory bodies.

This page is intentionally left blank

Our Today, Our Tomorrow

Gateshead Strategy for Older People 2014 - 2017

"I enjoyed growing up in Gateshead, I hope to enjoy growing older here too."

Contents

Page

Foreword 3

Executive summary 4

Background 4

Strategic aims and themes 4

National drivers 4

Local drivers 5

Partners involved in Gateshead Older People's Partnership 5

How the strategy has been developed 5

Themes and key outcomes 2014 - 2017 6

Delivering the Strategy 7

Foreword

Older people are an important and growing section of the population due to the fact that people are now living longer. At a national and local level the proportion of older people in the population will continue to rise, meaning it is likely that more people will need to access health and social care services.

This brings challenges for services, to ensure that they can continue to meet the needs of older people, particularly at a time of reduced funding. However, it also gives an impetus to services, organisations, and to older people themselves, to change the way we work together by developing skills and making best use of the knowledge and experience of older people to the benefit of themselves and others.

Gateshead Council has a long history of partnership working around older people's needs and aspirations, through the Gateshead Older People's Partnership and various other partnership arrangements. The Gateshead Older People's Partnership is made up of a range of key statutory and voluntary organisations. The Partnership has recently conducted a review of its membership, terms of reference and organisation, and a number of new partners and members are now involved. This is crucial to the delivery of the strategy.

The Partnership has developed this strategy and is keen to take forward work on developing and implementing actions to improve the quality of life and health and well-being of older people in Gateshead.

Gateshead Council is pleased to endorse this strategy, and to play a key role, with other partners, in delivering it.

Councillor M. McNestry - Cabinet Member for Adult Social Care
Councillor C. Donovan - Cabinet Member for Health and Wellbeing

Executive Summary

Gateshead Older People's Strategy 2014 – 2017 sets out a framework for partners to work together to improve the quality of life and health and wellbeing of older people in Gateshead.

The strategy is structured around four key themes, under which a number of key outcomes for the next three years have been identified.

The strategy has been developed by Gateshead Older People's Partnership, and the Partnership will be responsible for taking forward and implementing it. The Partnership will produce an annual report on progress to share with older people and other stakeholders.

Background

Gateshead Older People's Strategy 2014 - 2017, is Gateshead's third strategy for older people. It has been written by Gateshead Older People's Partnership, a multi-agency partnership, made up of statutory and voluntary agencies that develop, commission or provide services for older people, or which seek to give a voice to older people. It is a refresh and update of the Older People's Strategy 2011 – 2014.

Strategic aims and themes

The overall aim of the strategy is to improve the quality of life and health and wellbeing of older people in Gateshead.

We want to achieve this for all older people in Gateshead, regardless of where they live, their culture, religion, beliefs, gender, gender identity or sexual orientation, or whether or not they have a disability. We will do this by working in partnership with local agencies, local communities and local people.

The strategy seeks to meet the needs of a diverse range of older people, including more vulnerable older people who may receive care services, older people with dementia and other mental health problems, and tomorrow's older people, who are now in their 50s.

The Older People's Strategy is structured around four key themes:

- Making a positive contribution
- Being informed
- Living well
- Keeping healthy and active.

National drivers

There have been a number of significant changes at a national level in the last three years which have, and will continue to, impact on older people. In particular;

- The creation of Clinical Commissioning Groups, which puts GP's and clinicians at the front line of commissioning for health services with the aim of serving patients and the population more effectively.

- The creation of Health and Wellbeing Boards and the transfer of the Public Health function to local authorities.

- The introduction of the Better Care Fund, which will be used to drive better integration between health and social care, with the ethos of – the **Right Care**, in the **Right Place** at the **Right Time.**

- Most recently the Care Act received Royal Assent in May 2014 and will come into effect from 2015. As well as consolidating the law relating to adult social care and support, the Act also introduces a number new duties and responsibilities for local authorities, and new financial arrangements.

Local drivers

Gateshead Older People's Strategy contributes towards Vision 2030, Gateshead's Sustainable Community Strategy, and its vision for Gateshead:

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

Partners involved in Gateshead Older People's Partnership

The key partners involved in Gateshead Older People's Partnership currently are:

- Age UK Gateshead
- Gateshead Older People's Assembly
- Sight Service
- Equal Arts
- Stroke Association
- Gateshead Council
- Gateshead Clinical Commissioning Group
- Gateshead Health Foundation Trust
- South Tyneside Foundation Trust
- The Gateshead Housing Company

How the strategy was developed

The strategy is a refresh of the Gateshead Older People's Strategy 2011 – 2014. The four key themes emerged during the development of that strategy, from what older people told us was important to them, and from considering national and local policy and strategies and the evidence base. The Gateshead Older People's Partnership reviewed these themes as part of the development of the refreshed strategy and agreed that they still provide a useful structure to our work.

The strategy builds on the progress we have made in the last three years on the priorities and actions identified in the last strategy. A separate end of strategy report is available which details those achievements.

Under each theme in the strategy we identify the key outcomes that the Older People's Partnership will be concentrating on over the next three years, to improve the quality of life and health and wellbeing of older people for 'today and tomorrow'.

In developing this refreshed strategy we have considered what changes there have been in the last three years, nationally and locally, feedback from older people, and what work is being taken forward through other strategies and partnerships that impact on older people, so that we compliment, not duplicate, their work.

The key outcomes in this strategy cover the areas where the Older People's Partnership will be concentrating our effort, where we think we can bring added value by working together.

We will also ensure that the work going on across other partnerships and organisations is taking into account the needs and concerns of older people.

Themes and key outcomes 2014 - 2017

Under the four key themes we have identified a number of key outcomes for the coming three year period. This will give a structure to how we will develop and monitor our work to deliver the strategy.

Making a positive contribution

Older people building on and using their experience, skills and knowledge.

Key outcomes

- Assist older people to develop their skills and knowledge.
- Encourage older people's involvement in volunteering.
- Support older people to have their say and contribute to service development.

Being informed

Easy access to good quality information and advice about services and opportunities to enable independence, choice and control.

Key outcomes

- Support older people to access the information and advice they need.
- Encourage the availability and use of advice and advocacy services for older people when required.
- Help older people to maximise their income, and reduce fuel poverty.

Living well

A focus on housing, community, and access to safe and good quality health and social care services.

Key outcomes

- Support more opportunities and initiatives to tackle social isolation among older people.
- Strengthen ways to enable older people to remain in their homes and communities for as long as they want to.
- Promote older people friendly communities and initiatives.
- Contribute to vulnerable older people being able to achieve the best possible quality of life.

Keeping healthy and active

Prevention, wellness, and opportunities to access local leisure and lifestyle services

Key outcomes

- Promote key prevention areas to improve older people's health as well as supporting older people to access services and support available to them.
- Improve older people's access to lifestyle and leisure services.

Delivering the strategy

The Older People's Partnership is responsible for monitoring the strategy and ensuring that it is implemented.

Building on the themes and key outcomes we have identified in the strategy we will develop a detailed Improvement and Development Action Plan, and will involve older people in this process. The action plan will identify the specific issues and actions that we will take forward over the coming three years, who will be responsible for them, and the outcomes we expect.

We will monitor the action plan through the regular meetings of the Older People's Partnership. This will allow us to respond quickly to any future changes and new priorities.

The Older Peoples Mental Health Strategy Group will develop and monitor a separate Improvement and Development Action Plan focusing on older people's mental health. This group will give regular updates to the Older People's Partnership.

The Older People's Partnership will produce an annual report of our progress to share with older people and other stakeholders.

The Older People's Partnership is made up of the following key partners:

- Age UK Gateshead
- Equal Arts
- Gateshead Clinical Commissioning Group
- Gateshead Council
- Gateshead Health Foundation Trust
- Gateshead Older People's Assembly
- Sight Service
- South Tyneside Foundation Trust
- Stroke Association
- The Gateshead Housing Company

Produced by Gateshead Council on behalf of the Older People's Partnership @ July 2014

Gateshead Older People's Partnership-Gateshead Council Strategy for older people 2015-2017

Aim and Rationale- To improve the quality of life and health and wellbeing of older people in Gateshead. There is an increasingly ageing population in Gateshead which brings with it challenges and opportunities. To enable older people to live independent, active, healthy lives and that their knowledge, skills and experience contributes to a diverse and vibrant Gateshead.

THEMES	WHAT THIS IS ABOUT	KEY PRIORITIES
Making a Positive Contribution	Older People building on and using their experience, skills and knowledge	1. Assist older people to develop their skills and knowledge 2. Encourage Older People's involvement in volunteering 3. Support Older People to have their say and contribute to service development
Being Informed	Easy access to good quality information & advice about services and opportunities to enable independence, choice and control.	1. Support Older People to access the information and advice they need. 2. Encourage the availability and use of advice and advocacy services for older people when required 3. Help older people to maximise their income and reduce fuel poverty
Living Well	Focus on housing, community and access to safe and good quality health and social care services	1. Supporting more opportunities and initiatives to tackle social isolation for older people 2. Strengthen ways to enable people to remain in their homes and communities for as long as they want to 3. Promote older people friendly communities and initiatives 4. Contribute to vulnerable older people being enabled to achieve the best possible quality of life.
Keeping Healthy and Active	Prevention, wellness and opportunities to access leisure and lifestyle services	1. Promote key prevention areas and improve older people's health as well as supporting older people to access services and support available to them. 2. Improve older people's access to lifestyle and leisure services.

Theme 1 Making a Positive Contribution:

1.0 Assist older people to develop their skills and knowledge

Actions	Lead	Partner	Time	Outcome	Evidence	Rag
• Offer and promote opportunities to learn how to use new technology	**Craig Bankhead**	GOPA Equal Arts Gateshead Council GVOC Gateshead Carers	2015-17	Equal Arts 10 groups by 2017	10 groups in place	
• Encourage older people to develop skills & knowledge to run own groups				Promote Volunteering Opportunities to Older People Across Gateshead – Gateshead OPA to employ a Volunteer Coordinator who will work with Kate Marshall (GMBC) and Sandra Brack (GVOC) to link opportunities OP	Increase in the number of volunteers (as measured by GMBC, GOPA and GVOC	
• Offer opportunities to develop skills and Knowledge around caring.				GOPA to work with Kelechi Dibie (Training Officer at Gateshead Carers) to develop a training package for older people across the borough	24 older people trained/supported with information and knowledge re caring/carers	
• Promote all opportunities for older people to develop skills and knowledge				GOPA to promote (via monthly newsletter and social media) a round-up of training opportunities, including U3A, TGHC, Learning Skills and other training providers.	GOPA's monthly newsletter containing training opportunities.	
1.1Making a Positive: Encourage older people's involvement in volunteering						
• Promote Volunteering-how to find out about it and get involved.	**Craig Bankhead**	GOPA GVOC GMBC	2015-17	Sandra Brack from GVOC and Kate Marshall to liaise with GOPA Volunteering Officer to make them aware of opportunities and GOPA VO to promote at events and through newsletter	Attendance at events, copies of newsletter, information from volunteers	
• Explore getting people to volunteer at retirement				GOPA (CB), GVOC (SB) and GMBC (KM) to organise and annual conference/event for people about to retire, inviting guest speakers and voluntary sector organisations	Annual Event	
1.2 Making a Positive: Support Older people to have their say and contribute to Service development						
• Review how people can have their say about ASC and health services	**Craig Bankhead**	GOPA,GMBC CCG,GVOC (Our Gateshead)	2015-17	Promote CCG Local Engagement Boards, PUCPI meetings and GOPA Monthly Assemblies to members of GOPA via monthly newsletter	Copies of newsletters	

Theme 2 . Being Informed

2.0 Support Older People to access the information and advice they need

Actions	Lead	Partner	Time	Outcome	Evidence	Rag
• Develop and promote OurGatedhead Website as a key information and signposting source for older people	**L.K-Shervington**		2015-17	1.Review/Develop session at Partnership 2.Partners populate their own pages and update. 3.Promote through partner networks, contact lists and databases.		
• Make best use of other communication channels to better inform people				4.Map opportunities, e.g., Care call annual visits, future use		
• Identify how we can communicate better with older people				5.Identify gaps and how these can be met e.g. Sight Service and GCA.		
2.1 Being Informed: Encourage Availability and use of advocacy services for older people when required.						
• Review Advocacy Provision which supports people to express their views	**L.K-Shervington**	ASC Commissioning	2015-17			
2.2 Being Informed: Help Older People to maximise their income and reduce fuel poverty						
• Highlight advice, guidance ,information n and advice –money matters	**L. K-Shervington**	Financial Inclusion Partnership/AGEUK/ CAB	2015-17			
• Develop Self-help approaches -money matters				1. Map out existing approaches identify gaps and fill these gaps.		

Theme 3. Living Well;

3.0 Support More opportunities and initiatives to tackle social isolation among older people

Actions	Lead	Partner	Time	Outcome	Evidence	Rag
• Identify existing initiatives addressing social isolation among older people	**D McKenna**		2015-17	1.Promoting and expand existing initiatives and plan to fill gaps		
• Develop volunteering opportunities to address the social isolation needs				2.Identify new funding sources and bids as required 3.Pool Partnership resources , identify socially isolated people at risk 4.Equal Arts to develop creative friends opportunities		
3.1 Living Well; Strengthen ways to enable people to remain in their homes and communities for as long as they want to						
• Increase the quality and choice of housing to better meet the needs and aspirations of older people	**D McKenna**	ASC Housing Services Commissioning team / Care Call/ Health and ASC	2015-17			
• Review the policy on adapting housing.						
• Review Extra Care Housing						
• Make use of technology where it can help with social care and health needs						
• Deliver Better Care initiatives to join up and improves health and social care services and support peoples independence.						
3.2 Living Well; Promote older People friendly communities						
• Develop Older peoples Champions and networks across Gateshead	**D McKenna**		2015-17			
3.3 Contribute to vulnerable older people being able to achieve the best possible quality of life.						
• Ensure that service users are involved throughout the safeguarding process and focus on achieving satisfactory outcomes.	**D McKenna**		2015-17			

Theme 4. Keeping Healthy and active:

4.0 Promote key prevention areas to improve older people's health to access services and support available to them .

Actions	Lead	Partner	Time	Outcome	Evidence	Rag
• Encourage Older people to access all appropriate health screening programmes	**Cath Scott / Douglas Hunter.**	Public Health/Judith's section/other	2015-17	1.Deliver Cancer screening awareness workshops in community setting 2.Specific group awareness raising i.e. carers uptake poorer in this group		
• Encourage older people to lead healthier and active lifestyles				3. Support be clear on cancer campaign to access older peoples groups.		
• Raise awareness around eye health						
4.1 Improve people's access to lifestyle and leisure services.						
• Link in with the new wellness service to maximise the impact on older people	**Cath Scott / Douglas Hunter.**	Public Health/Judith's section/other	2015-17	1.Develop referral pathways for older people 2.Develop social prescribing projects aimed at older people based around 5 ways to wellness 3.Promote Live Well Gateshead with other people and partners.		
• Improve older people's access to cultural and creative activities.		Equal Arts Libraries/other				

This page is intentionally left blank

Gateshead Council

HEALTH AND WELLBEING BOARD
26th February 2016

TITLE OF REPORT: VANGUARD CARE HOME PROGRAMME

Purpose of the Report

1 The purpose of this report is to provide a further update to the Gateshead Health and Wellbeing Board about the Vanguard Care Home Programme.

Background

2 Members received an update in September 2015 regarding the development and implementation of the National Vanguard Programme and specifically the Gateshead Care Home Vanguard Porgramme. Just to remind members, in January 2015, the NHS invited individual organisations and partnerships to apply to become 'vanguard' sites for the new care models programme, one of the first steps towards delivering the NHS Five Year Forward View and supporting improvement and integration of services.

3 There are now 50 vanguards throughout England and each one was selected following a rigorous process, involving workshops and the engagement of key partners and patient representative groups. Each vanguard site will take a lead on the development of new care models which will act as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system.

Gateshead Care Vanguard

4 This Gateshead Vanguard is a pioneering approach to try and improve the health and wellbeing of older people in Gateshead and aims to provide better and more joined up support for older people by embedding health and rehabilitation services within a residential environment.

The Gateshead programme will also be considering adopting a new outcome based contracting and payment system that supports the development of a Provider Alliance Network (PAN) delivery vehicle.

5 The programme is being co-designed and implemented through various work streams including:

- Care pathways; a team of practitioners has been formed to examine the key elements of the pathway of care; including enhanced primary care, responsive care, dementia care, palliative care and end of life, medicines management, nutrition and hydration care and Telehealth. The focus of their work will be around designing / developing, implementing and evaluating a new model of care for older people. Work is also being undertaken to establish a workforce strategy for the new care model.
- Commissioning, contract, payment. Through this area of work a new contracting, payments and commissioning will be explored along with the development of a Provider Alliance Network (PAN) - which may result in alliance contracting being developed in the future.
- An outcomes framework is also being developed that will support the implementation of a new care pathway and lead to an outcomes based

commissioning model through the PAN. This area of work is supported by a range of initiatives focusing on involvement, engagement and communications,
- Work is also underway to evaluate and monitor the programme, although the majority of this work will be undertaken at a national level to allow for a more strategic overview of the impact of the different programme.

Governance of the Programme

6 A multi-agency Steering Group has been established to ensure that the:
- Care Home Vanguard Programme works to improve the care for older people (over 65's) in Gateshead; and to
- Ensure that improvements are replicable and scalable in line with national requirements.

7 Representation on the Steering Group is wide and diverse and apart from the CCG and local authority representatives, members of the group also include patient / public representatives; Voluntary Sector Organisations; Newcastle University and Northumbria University; and key health providers including; Foundation Trusts; Independent Sector Care Home Representative and Gateshead Community Based Care Limited. The group report into the Integrated Health Programme Board, which has a route to the Health and Wellbeing Board and Gateshead Council members of the steering group take responsibility to report through their existing governance structure.

Future Delivery of the Programme

8 All Vanguard Programmes have now had to produce a range of documents which will allow NHS England to monitor the impact of the new models of care and identify areas of replicability. However the recently published NHS England Planning Guidance (which includes the requirement to produce two separate but connected plans – a Five Year Sustainability Plan and an annual Operational Plan) stipulates that the sustainability and delivery of the Vanguard Programmes must now be included within these plans to allow the impact of transformation to be identified and mainstreamed into current NHS activity.

9 The development of the programme locally and nationally is well underway. Within Gateshead a local Vanguard Team has been established (with support from 2 members of staff within the council), five other areas who are also working on similar Vanguard Programmes are now providing peer support.

A regional Vanguard Network has been established to facilitate the sharing of best practice and finally within NHS England a National Vanguard Team has been created who provide all local teams with a package of support.

Recommendations

10 The Health and Wellbeing Board is asked to consider the contents of this report and agree to receive further reports in the future regarding the progress of this Programme.

Contact: Caroline Kavanagh – caroline.kavanagh3@nhs.net

Health and Wellbeing Board

26 February 2016

TITLE OF REPORT: Emerging Themes: Development of OSC Work Programmes 2016-17

---

1. **Purpose of the Report**
   This report seeks views on the emerging themes for the Council's main Overview and Scrutiny Committee (OSC) work programmes for 2016-17.

2. **Background**
   Each year the Council consults its partners on the emerging priority issues for all of its Overview and Scrutiny Work Programmes, to assist the Council in identifying the right priority areas to take forward and help shape the focus of specific areas of work. The Board has previously indicated that it may wish to ask Overview and Scrutiny to examine specific issues on its behalf in future work programmes.

   Views are being sought from Gateshead Strategic Partnership and other Partnership Boards and feedback to date will be shared at the meeting.

   Overview and Scrutiny Committees are due to agree their work programmes for 2016-17 at meetings scheduled at the end of March/ April 2015.

3. **Proposals**
   The emerging themes for all OSCs are set out in Appendix 1. These themes are being put forward following consideration of a range of factors including:-
   - Vision 2030
   - The Council Plan 2015-20
   - The Health and Well-Being Strategy for Gateshead
   - Relevant Legislation
   - Performance Information
   - Issues of concern to local people
   - Issues highlighted by councillors on Overview and Scrutiny Committees
   - Public Health Commissioning Priorities
   - Clinical Commissioning Group Priorities
   - Safer Gateshead Partnership Priorities

- Children Gateshead (the plan for children, young people and families)

4. Recommendation

The views of the Board are sought on:

- the emerging themes for OSCs for 2016-17
- whether the Board considers there are any additional priority issues it would wish to ask Overview and Scrutiny to include in its work programmes for 2016/17 or future work programmes.

Contact: Angela Frisby angelafrisby@gateshead.gov.uk

Emerging Issues for OSCs – 2016-17 **APPENDIX 1**

Care, Health and Wellbeing OSC

Review Topic-

Review of Impact of Housing Conditions on Promoting Health and Wellbeing (to focus on housing conditions – impact of changes in the housing market, shift to private sector provision and vulnerability of specific tenants; low income families, people with complex issues and learning disabilities, isolated older people).
Links to
Vision 2030
Council Plan 2015-20

Case Study
Delayed Transfers of Care and Hospital Discharges (to focus on the joint work being progressed by the Council and Health Partners to avoid delayed discharges, specific challenges and examples of good practice / to be linked to evaluation of new model for Adult Social Care).

Links to
Vision 2030
Council Plan 2015-20
Performance Issue – (below 2015-16 target of 88.7% and decline in performance compared to the same period last year).

Corporate Resources OSC

It is proposed that this OSC focus on

Two Case Studies within its 2016-17 work programme

Case Study 1 – Implementation/Roll Out of Universal Credit (examine impact on residents in light of ongoing implementation / roll out and mitigating actions being put in place)
Links to:-
Vision 2030
Council Plan 2015-20

Case Study 2 – Workforce Strategy (examine progress being made in preparing the workforce to meet the changing role of the Council and adapt working practices / meet the demands of the business / next steps)
Links to:-
Council Plan 2015-20

Families OSC

Review Topic

Review of Children's Oral Health in Gateshead (potential areas of focus – inequalities in access / ward variations, prevalence of dental decay in five year olds, levels of hospital admissions, commissioning and planning arrangements)
Links to:-
Vision 2030
Council Plan 2015-20
Director of Public Health Report – focus on health inequalities and wider determinants of health, health in childhood and particularly the role of health services in child health improvement.

Case Studies

Case Study 1 – Consequences of Alcohol Consumption in Pregnancy (potential focus on current position/ impacts across the system and longer term / progress in tackling the issue)
Links to:-
Vision 2030
Council Plan 2015-20
Director of Public Health Report – focus on significance of achieving best start in life to reduce health inequalities in subsequent years

Case Study 2 – Support for Care Leavers who are NEET (specific focus on how the Council is fulfilling its corporate parenting responsibilities in this area)
Links to:-
Vision 2030
Council Plan 2015-20
Area of Improvement highlighted by Ofsted

Communities and Place OSC

Review Topic

Review of Impact of Gambling on the Borough (to focus on the financial /health and wellbeing impacts on Gateshead residents /consider how these issues are currently being addressed / potential areas for improvement)
Links to
Vision 2030
Council Plan 2015 - 20
Area of concern identified by Cabinet members.

Case Study

Street Cleanliness – Enforcement, Education and Community Involvement (to focus on how Council and communities can work together to tackle issues such as dog fouling and litter / highlight best practice schemes being developed in communities)
Links to
Vision 2030
Council Plan 2015-20
Residents Survey 2012 – street cleanliness issue for improvement.

This page is intentionally left blank

HEALTH AND WELLBEING BOARD
26 February 2016

TITLE OF REPORT: Better Care Fund: 3rd Quarterly Return (2015/16) to the Department of Health

---

Purpose of the Report

1. To seek the endorsement of the Health & Wellbeing Board to the Better Care Fund return to the Department of Health for the 3rd Quarter of 2015/16.

Background

2. The HWB approved the Gateshead Better Care Fund (BCF) submission for Gateshead at its meeting on 19 September 2014, which in turn was approved by NHS England in December 2014.

3. NHS England introduced quarterly monitoring arrangements for the BCF which requires a template return to be submitted in respect of our BCF Plan.

4. The Board has previously endorsed the Quarter 4 return for 2014/2015 and Quarters 1 and 2 returns for 2015/16.

5. The Board's Forward Plan for 2015/16 includes a Performance Management section of the agenda which is being used to update the Board on progress in relation to the BCF and other key indicators linked to our health and wellbeing agenda. It has previously been agreed that this, in turn, will be used to inform future returns to NHS England/ Department of Health.

Quarter 3 Template Return for 2015/16

6. The Board considered a Performance Review Update report at its last meeting on 15th January, which included the BCF. It was noted that this would be used for inform the Quarter 3 return - due for submission on 26th February.

7. A return has been prepared for submission to the Department of Health which reflects the data trends reported to the Board at its January meeting. The return provides a progress update and sets out the current position in relation to funding arrangements, national BCF conditions, metrics, potential support from NHS England etc.

Future BCF Quarterly Returns for 2015/16

8. The deadline for the completion of the final quarterly return for 2015/16 is the 27th May 2016.

9. As per the Forward Plan, the Board will consider a performance update (including the BCF) at its meeting on 22nd April which will inform the Q4 quarter return to the Department of Health. As part of this, any issues likely to impact upon the return will be brought to the attention of the Board for consideration. Similar arrangements will apply for subsequent returns as required.

Proposal

10. It is proposed that the Board endorse the 3rd Quarter BCF return for 2015/16.

Recommendations

11. The Health and Wellbeing Board is asked to endorse the Better Care Fund 3rd Quarter return for 2015/16 (attached as an excel document) to the Department of Health in line with the arrangements previously agreed for the submission of returns.

Contact: John Costello (4332065)

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 26th February 2016.

The BCF Q3 Data Collection

This Excel data collection template for Q3 2015-16 focuses on budget arrangements, the national conditions, payment for performance, income and expenditure to and from the fund, and performance on BCF metrics.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an overview of progress with your BCF plan, the wider integration of health and social care services, and a consideration of any variances against planned performance trajectories or milestones.

Cell Colour Key

Data needs inputting in the cell
Pre-populated cells
Question not relevant to you

Throughout this template cells requiring a numerical input are restricted to values between 0 and 100,000,000.

Content

The data collection template consists of 9 sheets:

Checklist - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements - this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Non-Elective and Payment for Performance - this tracks performance against NEL ambitions and associated P4P payments.
5) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
6) Metrics - this tracks performance against the two national metrics, locally set metric and locally defined patient experience metric in BCF plans.
7) Understanding support needs - this asks what the key barrier to integration is locally and what support might be required.

8) New Integration metrics - additional questions on new metrics that are being developed to measure progress in developing integrated, cooridnated, and person centred care
9) Narrative - this allows space for the description of overall progress on BCF plan delivery and performance against key indicators.

Checklist

This sheet contains all the validations for each question in the relevant sections.
All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 9 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This plays back to you your response to the question regarding Section 75 agreements from the Q1 and Q2 2015-16 submissions and requires 2 questions to be answered. Please answer as at the time of completion. If you answered 'Yes' previously the 2 further questions are not applicable and are not required to be answered.

If your previous submission stated that the funds had not been pooled via a Section 75 agreement, can you now confirm that they have?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the six national conditions detailed in the Better Care Fund Planning Guidance are still on track to be met through the delivery of your plan (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/). Please answer as at the time of completion.

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' and 'No - In Progress' that these are on track. If 'No' or 'No - In Progress' is selected please provide a target date when you expect the condition to be met. Please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31st March 2016.
Full details of the conditions are detailed at the bottom of the page.

4) Non-Elective and Payment for Performance

This section tracks performance against NEL ambitions and associated P4P payments. The latest figures for planned activity and costs are provided along with a calculation of the payment for performance payment that should have been made for Q4 - Q2. Two figures are required and one question needs to be answered:

Input actual Q3 2015-16 Non-Elective Admissions performance (i.e. number of NEAs for that period) - Cell O8
Input actual value of P4P payment agreed locally - Cell F19
If the actual payment locally agreed is different from the quarterly payment suggested by the automatic calculation in cell AR8 (which is based on your input to cell O8 as above) please explain in the comments box
Please confirm what any unreleased funds were used for in Q3 (if any) - Cell F34

5) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the following information:

Forecasted income into the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual income into the pooled fund in Q1 to Q3
Forecasted expenditure from the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual expenditure from the pooled fund in Q1 to Q3

Figures should reflect the position by the end of each quarter. It is expected that planned income and planned expenditure figures for Q4 2015-16 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan or amendments to forecasts made since the previous quarter.

6) Metrics

This tab tracks performance against the two national supporting metrics, the locally set metric, and the locally defined patient experience metric submitted in approved BCF plans. In all cases the metrics are set out as defined in the approved plan for the HWB and the following information is required for each metric:
An update on indicative progress against the four metrics for Q3 2015-16
Commentary on progress against the metric

If the information is not available to provide an indication of performance on a measure at this point in time then there is a drop-down option to indicate this. Should a patient experience metric not have been provided in the original BCF plan or previous data returns there is an opportunity to state the metric that you are now using.

7) Understanding support needs

This tab re-asks the questions on support needs that were first set out in the BCF Readiness Survey in March 2015. These questions were then asked again during the Q1 2015-16 data collection in August. We are keen to collect this data every six months to chart changes in support needs. This is why the questions are included again in this Q3 2015-16 collection. The information collected will be used to inform plans for ongoign national and regional support in 2016-17.

The tab asks what the key barrier to integration is locally and what support might be required in putting in meeting the six key areas of integration set out previously. . HWBs are asked to:

Confirm which aspect of integration they consider the biggest barrier or challenge to delivering their BCF plan
Confirm against each of the six themes whether they would welcome any support and if so what form they would prefer support to take

There is also an opportunity to provide comments and detail any other support needs you may have which the Better Care Support Team may be able to help with.

8) New Integration Metrics

This tab includes a handful of new metrics designed with the intention of gathering some detailed intelligence on local progress against some key elements of person-centred, co-ordinated care. Following feedback from colleagues across the system these questions have been modified from those that appeared in the last BCF Quarterly Data Collection Template (Q2 2015-16). Nonetheless, they are still in draft form, and the Department of Health are keen to receive feedback on how they could be improved / any complications caused by the way that they have been posed.

For the question on progress towards instillation of Open APIs, if an Open API is installed and live in a given setting, please state 'Live' in the 'Projected 'go-live' date field.
For the question on use and prevalence of Multi-Disciplinary/Integrated Care Teams please choose your answers based on the proportion of your localities within which Multi-Disciplinary/Integrated Care Teams are in use.

9) Narrative

In this tab HWBs are asked to provide a brief narrative on overall progress in delivering their Better Care Fund plans at the current point in time with reference to the information provided within this return.

Better Care Fund Template Q3 2015/16

Data collection Question Completion Checklist

1. Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

2. Budget Arrangements

S.75 pooled budget in the Q4 data collection? and all dates needed
Yes

3. National Conditions

	1) Are the plans still jointly agreed?	2) Are Social Care Services (not spending) being protected?	3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	i) Is the NHS Number being used as the primary identifier for health and care services?	ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	6) Is an agreement on the consequential impact of changes in the acute sector in place?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" estimated date if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Comment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

4. Non-Elective and P4P

Actual Q3 15/16	Actual payment locally agreed	Cumulative quarterly Actual Payments >= Cumulative suggested quarterly payments	If the actual payment locally agreed is <> suggested quarterly payment	Any unreleased funds were used for: Q3 15/16
Yes	Yes	Yes	Yes	Yes

5. I&E (2 parts)

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Please comment if there is a difference between the annual totals and the pooled fund
Income to	Forecast	Yes	Yes	Yes	Yes	Yes
	Actual	Yes	Yes	Yes		
Expenditure From	Forecast	Yes	Yes	Yes	Yes	Yes
	Actual	Yes	Yes	Yes		
	Commentary	Yes				

6. Metrics

	Please provide an update on indicative progress against the metric?	Commentary on progress
Admissions to residential Care	Yes	Yes

	Please provide an update on indicative progress against the metric?	Commentary on progress
Reablement	Yes	Yes

	Please provide an update on indicative progress against the metric?	Commentary on progress
Local performance metric	Yes	Yes

	If no metric, please specify	Please provide an update on indicative progress against the metric?	Commentary on progress
Patient experience metric	Yes	Yes	Yes

7. Understanding support needs

Which area of integration do you see as the greatest challenge or barrier to the successful implementation of your Better Care plan	Yes

	Interested in support?	Preferred support medium
1. Leading and Managing successful better care implementation	Yes	Yes
2. Delivering excellent on the ground care centred around the individual	Yes	Yes
3. Developing underpinning integrated datasets and information systems	Yes	Yes
4. Aligning systems and sharing benefits and risks	Yes	Yes
5. Measuring success	Yes	Yes
6. Developing organisations to enable effective collaborative health and social care working relationships	Yes	Yes

8. New Integration Metrics

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Yes	Yes	Yes	Yes	Yes	Yes
From Hospital	Yes	Yes	Yes	Yes	Yes	Yes
From Social Care	Yes	Yes	Yes	Yes	Yes	Yes
From Community	Yes	Yes	Yes	Yes	Yes	Yes
From Mental Health	Yes	Yes	Yes	Yes	Yes	Yes
From Specialised Palliative	Yes	Yes	Yes	Yes	Yes	Yes

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Yes	Yes	Yes	Yes	Yes	Yes
Projected 'go-live' date (mm/yy)	Yes	Yes	Yes	Yes	Yes	Yes

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Yes

Total number of PHBs in place at the beginning of the quarter	Yes
Number of new PHBs put in place during the quarter	Yes
Number of existing PHBs stopped during the quarter	Yes
Of all residents using PHBs at the end of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	Yes

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes

9. Narrative

Brief Narrative	Yes

Cover

Q3 2015/16	
Health and Well Being Board	**Gateshead**
completed by:	Hilary Bellwood / John Costello
E-Mail:	hilarybellwood@nhs.net/johncostello@gateshead.gov.uk
Contact Number:	0191 217 2960 0191 4332065
Who has signed off the report on behalf of the Health and Well Being Board:	Councillor Lynne Caffrey, Chair Gateshead Health and Wellbeing

Question Completion - when all questions have been answered and the validation

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	24
4. Non-Elective and P4P	5
5. I&E	17
6. Metrics	9
7. Understanding support needs	13
8. New Integration Metrics	67
9. Narrative	1

Budget Arrangements

Selected Health and Well Being Board: Gateshead

Question	Answer
Have the funds been pooled via a s.75 pooled budget?	Yes
If it has not been previously stated that the funds had been pooled can you now confirm that they have?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question which is pre-populated, the data is from the Q1/Q2 data collection previously filled in by the HWB.

National Conditions

Selected Health and Well Being Board: Gateshead

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a date **and** a comment in the box to the right

Condition	Q4 Submission Response	Q1 Submission Response	Q2 Submission Response	Please Select (Yes, No or No - In Progress)	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Commentary on progress
1) Are the plans still jointly agreed?	Yes	Yes	Yes	Yes		
2) Are Social Care Services (not spending) being protected?	Yes	Yes	Yes	Yes		
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	No - In Progress	Yes	Yes	Yes		
4) In respect of data sharing - confirm that:						
i) Is the NHS Number being used as the primary identifier for health and care services?	Yes	Yes	Yes	Yes		
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	Yes	Yes	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes	Yes	Yes	Yes		
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	No - In Progress	Yes	Yes	Yes		
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes	Yes	Yes	Yes		

National Conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Footnotes:
Source: For each of the condition questions which are pre-populated, the data is from the quarterly data collections previously filled in by the HWB.

Better Care Fund Revised Non-Elective and Payment for Performance Calculations

Selected Health and Well Being Board: Gateshead

	Baseline				Plan					Actual			
	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
D. REVALIDATED: HWB version of plans to be used for future monitoring	6,584	6,396	6,571	6,935	6,387	6,204	6,374	6,727	6,716	6,924	6,773	6,211	6,495

	% change [negative values indicate the plan is larger than the baseline]	Absolute reduction in non elective performance	Total Performance Fund Available	Planned Absolute Reduction (cumulative) [negative values indicate the plan is larger than the baseline]			
				Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
D. REVALIDATED: HWB version of plans to be used for future monitoring	3.0%	795	£1,183,979	198	389	587	795

	Maximum Quarterly Payment				Performance against baseline			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
D. REVALIDATED: HWB version of plans to be used for future monitoring	£294,325	£285,917	£293,734	£310,003	-340	-377	360	440

	Suggested Quarterly Payment				Total Performance fund	Total Performance and ringfenced funds	Q4 Payment locally agreed	Q1 Payment locally agreed	Q2 Payment locally agreed
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16					
D. REVALIDATED: HWB version of plans to be used for future monitoring	£0	£0	£0	£125,497	£1,183,979	£4,531,000	£0	£0	£0

Which data source are you using in section D? (MAR, SUS, Other)	MAR	If other please specify	
Cost per non-elective activity	£1,490		

	Total Payment Made			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Suggested quarterly payment (taken from above)*	£0	£0	£0	£125,497
Actual payment locally agreed	£0	£0	£0	£0

If the actual payment locally agreed is different from the suggested quarterly payment (taken from above) please explain in the comments box (max 750 characters)	Improvement in Non Elective performance due to changes to Ambulatory Care activity reporting in line with agreed pathways. Reduced funding through Non Elective admissions is matched by increased funding to Ambulatory Care attendances, and therefore the performance fund released in Q3 is used to offset this cost growth elsewhere in the system.

	Total Unreleased Funds			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Suggested amount of unreleased funds**	£294,325	£285,917	£293,734	£184,506
Actual amount of locally agreed unreleased funds	£294,325	£285,917	£293,734	£310,003

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Confirmation of what if any unreleased funds were used for (please use drop down to select):	acute care	acute care	acute care	acute care

Footnotes:

Source: For the Baselines, Plans, data sources, locally agreed payment and cost per non-elective activity which are pre-populated, the data is from the Better Care Fund Revised Non-Elective Targets - Q4 Playback and Final Re-Validation of Baseline and Plans Collection previously filled in by the HWB. This includes all data received from HWBs as of 11th December 2015.
*Suggested quarterly payment (taken from above) has been calculated using the technical guidance provided here http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/. The key steps to calculating the quarterly payment are:
a. take the cumulative activity reduction against the baseline at quarter end and divide it by the cumulative Q3 2015/16 target reduction;
b. multiply that by the size of the performance pot available; and
c. subtract any performance payments made for the year to date.
The minimum payment in a quarter is £0 (there will not be a negative payment or 'claw back' mechanism) and the maximum paid out by the end of each quarter cannot exceed the planned cumulative performance pot available for release each quarter.

**Unreleased funds refers to funds that are withheld by the CCG and not released into the pooled budget, due to not achieving a reduction in non-elective admissions as set out in your BCF plan. As payments are based on a cumulative quarter end value a negative (-) quarter actual value indicates the use of surplus funds from previous quarters.
HWBs should consider whether there is a need to make adjustments to Q3 payments where over or under payments may have occurred in Q4 2014/15, Q1 2015/16 or Q2 2015/16 due to changes made to NEA baselines and targets.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Gateshead

Income

Previously returned data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£4,303,500	£4,303,500	£4,303,500	£4,303,500	£17,214,000	£17,214,000
	Forecast	£4,303,500	£4,303,500	£4,303,500	£4,303,500	£17,214,000	
	Actual*	£4,017,583	£4,009,766				

Q3 2015/16 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£4,303,500	£4,303,500	£4,303,500	£4,303,500	£17,214,000	£17,214,000
	Forecast	£4,303,500	£4,303,500	£4,303,500	£4,303,500	£17,214,000	
	Actual*	£4,017,583	£4,009,766	£3,993,497			

Please comment if there is a difference between either annual total and the pooled fund	N/A

Expenditure

Previously returned data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£4,303,500	£4,303,500	£4,303,500	£4,303,500	£17,214,000	£17,214,000
	Forecast	£4,303,500	£4,303,500	£4,303,500	£4,303,500	£17,214,000	
	Actual*	£4,017,583	£4,009,766				

Q3 2015/16 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£4,303,500	£4,303,500	£4,303,500	£4,303,500	£17,214,000	£17,214,000
	Forecast	£4,303,500	£4,303,500	£4,303,500	£4,303,500	£17,214,000	
	Actual*	£4,017,583	£4,009,766	£3,993,497			

Please comment if there is a difference between either annual total and the pooled fund	N/A

Commentary on progress against financial plan:	Actual expenditure figures show full expenditure against schemes less the value of the Performance fund for Q3, which was not released to the BCF pool due to the levels of Non Elective overperformance experienced year to date.

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB.

National and locally defined metrics

Selected Health and Well Being Board:	Gateshead

Admissions to residential Care	% Change in rate of permanent admissions to residential care per 100,000
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	For April to December 2015, there were 252 permanent admissions as reported under the BCF definition. This represents 666.05 admissions per 100,000. At the same point last year there were 247 admissions which equates to 652.83 per 100,000. This target is challenging as there is an ageing population that faces high levels of health inequality. Of the 252 admissions, 52% were aged 85 years or more. Almost 43% have dementia.

Reablement	Change in annual percentage of people still at home after 91 days following discharge, baseline to 2015/16
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	The indicator value stands at 85.3% (584 out of 685) for all of those that were discharged from hospital into reablement and still at home 91 days later. The value for the period is higher than the same period last year, which was 84.3% but below the challenging target of 88.7%. Performance remains above the England average for 2014/15 (82.1%).

Local performance metric as described in your approved BCF plan / Q1 / Q2 return	Estimated diagnosis rate for people with dementia
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Improvement in Q3 to 69.8 in excess of the end of year trajectory

Local defined patient experience metric as described in your approved BCF plan / Q1 /Q2 return	Patient/Service User Experience metric Improve the percentage of patients who responded " Yes Definitely" to the following question from the GP patient survey: "For respondents with a long-standing health condition: In the last 6 months, have you had enough support from
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	Data for Q1 2015/16 (43%) shows an improvement of the 2014/15 level where performance had decreased to (40%). Target is 46%, next survey results due in December. LTCs and Mental health programme boards have a number of work streams that are tackling the care for people with LTCs with both physical and mental health components: in particular work around LTC prevalence across General Practice, Disease specific programmes of

Footnotes:

Source: For the local performance metric which is pre-populated, the data is from a local performance metric collection previously filled in by the HWB.
For the local defined patient experience metric which is pre-populated, the data is from a local patient experience previously filled in by the HWB.

Support requests

Selected Health and Well Being Board:	Gateshead

Which area of integration do you see as the greatest challenge or barrier to the successful implementation of your Better Care plan (please select from dropdown)?	4.Aligning systems and sharing benefits and risks

Please use the below form to indicate whether you would welcome support with any particular area of integration, and what format that support might take.

Theme	Interested in support?	Preferred support medium	Comments - Please detail any other support needs you feel you have that you feel the Better Care Support Team may be able to help with.
1. Leading and Managing successful better care implementation	Yes	Central guidance or tools	A more streamlined approach towards the support offers around new models of care and the BCF.
2. Delivering excellent on the ground care centred around the individual	Yes	Case studies or examples of good practice	Further work /alignment with National Voices and PPI groups
3. Developing underpinning integrated datasets and information systems	Yes	Hands on technical or delivery support	National recomendations and support with technical guidance to suuport local system - advice from NIB
4. Aligning systems and sharing benefits and risks	Yes	Central guidance or tools	Exploring new payment models and 'draft contracts' outlined in the Vanguard National Suport Offer to facilitate integration
5. Measuring success	Yes	Access to technical expertise to troubleshoot issues	An application has been submitted to the Better Care Support Programme for support around analytical and modelling capacity to enable us to identify local outcome measures and associated metrics that are applicable to the full system.
6. Developing organisations to enable effective collaborative health and social care working relationships	Yes	Peers to peer learning / challenge opportunities	Collabortaive redeisgn across systems (beyond organisations)

New Integration Metrics

Selected Health and Well Being Board: Gateshead

1. Proposed Metric: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Metric: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Shared via interim solution
From Hospital	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Shared via interim solution
From Social Care	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Shared via interim solution	Not currently shared digitally
From Community	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Shared via interim solution
From Mental Health	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Shared via interim solution	Not currently shared digitally
From Specialised Palliative	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Shared via interim solution

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	In development	In development	Unavailable	In development	In development	In development
Projected 'go-live' date (dd/mm/yy)	N/A	N/A	N/A	N/A	N/A	N/A

3. Proposed Metric: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot being scoped

4. Proposed Metric: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the beginning of the quarter	2
Rate per 100,000 population	1

Number of new PHBs put in place during the quarter	0
Number of existing PHBs stopped during the quarter	0
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	100%

Population (Mid 2015)	201,572

5. Proposed Metric: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	Yes - in some parts of Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	Yes - throughout the Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2012-based (published May 2014).
http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/2012-based-projections/stb-2012-based-snpp.html

Narrative

Selected Health and Well Being Board: Gateshead

Remaining Characters	31,388

Please provide a brief narrative on overall progress in delivering your Better Care Fund plan at the current point in time, please also make reference to performance on any metrics not directly reported on within this template (i.e. DTOCs).
While developing the BCF plan for 2016/17 we are taking the opportunity to review the curent schemes and aligning them with emerging new models of care eg Care Homes Vanguard, Urgent Emergency Care Vanguard and Other Emerging Models of Care such as redesign of community health services, primary care, out-of-hospital care, prevention, assertive early intervention & enablement services etc We are also assessing the effectieness of the schemes overall achievements, what has worked well, challenges, what has not worked so well and what are the key next steps to progress and re-focus work, mindful of how this will support reductions in unplanned admissions and hospital delayed transfers of care In terms of overall performance cumulative Non elective admissions are still above plan year to date, however an improved position for Q2 and Q3 of 2015/16 has brought the level of overperformance against plan down significantly, which paired with accurate recording of Ambulatory Care activity is expected to bring activity in line with plan by the end of the year.