NHS and Local Authority leadership seminar

27 June 2017

INFORMAL notes

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

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

Preventative services.

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

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

Community engagement

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

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

The financial challenges

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

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

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

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

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

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

Q&A Session

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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