GATESHEAD METROPOLITAN BOROUGH COUNCIL

NORTHUMBERLAND TYNE & WEAR & NORTH DURHAM STP HEALTH SCRUTINY COMMITTEE MEETING

Monday, 19 March 2018

PRESENT: Councillor L Caffrey (Gateshead Council) (Chair)

Councillor(s): Watson and Armstrong (Northumberland CC), Charlton and Maughan (Gateshead Council), Clark (substitute – North Tyneside Council), Chequer (Sunderland CC), Flynn, Hetherington and Huntley (South Tyneside Council), Taylor, Mendelson and Schofield (Newcastle CC) and Robinson, Temple and Davinson(Durham CC)

IN ATTENDANCE: Councillor(s): M Hall (Gateshead Council) (observer)

17 APPOINTMENT OF CHAIR

The Joint Committee had previously appointed Councillor Mary Foy (Gateshead Council) as Chair of the Joint Committee. However, due to unforeseen circumstances Councillor Foy advised she was no longer able to continue in that position.

In view of the aforementioned the Joint Committee:-

RESOLVED – That Councillor Lynne Caffrey (Gateshead Council) be appointed as Chair of the Joint Committee.

18 APOLOGIES

Councillor (s) Simpson (Northumberland and Dodd (substitute - Northumberland) Bell, Grayson and Hall (North Tyneside Council)

19 DECLARATIONS OF INTEREST

Councillor Taylor (Newcastle CC) declared an interest as a member of Newcastle Hospitals NHS FT.

Councillor Chequer (Sunderland CC) declared an interest as an employee of NTW NHS FT and Gateshead Health NHS FT.

20 MINUTES

The minutes of the last meeting held on 15 January 2018 were approved as a correct record.

Matters Arising

Prevention Workstream

The Chair advised that there had been a launch event in Gateshead relating to the all-party parliamentary report on Creative Health which highlights the use of arts in improving health and wellbeing. The Chair of the Group had attended the launch and Dr Pilkington had provided a presentation on the role of arts in promoting health and wellbeing.

The Chair advised that there was a summary version of the report and a full version which contains a number of case studies which might prove useful for colleagues. A link to the report would be circulated to the Joint Committee following the meeting.

Community Asset Based Approach Event – Durham

Councillor Schofield advised that she had attended the above event which had been held in Durham. Dr Pilkington had also provided a presentation for this event and one of the key issues which had come out was about how it was important to get the voluntary sector much more involved.

Joint STP OSC Work Programme

Councillor Mendelson noted that it was proposed that the Joint Committee received a progress update on the development of integrated care systems at its June meeting and asked that as part of this update the links to Health and Wellbeing Boards are explained.

It was agreed that Workstream leads be asked to address this issue as part of the proposed update.

The Chair also noted that an NHS consultation had been launched recently in relation to contracting arrangements and she queried whether this would have an impact on the development of integrated care systems.

The Joint Committee was advised that greater clarity was being sought from NHS England on this issue.

The Chair noted that as the Joint Committee would be receiving an update on integrated care systems at its June meeting it would be helpful to have clarification on this matter for that meeting.

21 UPDATE ON URGENT AND EMERGENCY CARE WORKSTREAM

Gary Collier outlined the structure of the Urgent and Emergency Care Network. Gary advised that the Board has complete oversight of the work undertaken and links with all A& E Delivery Boards to make sure that the strategic direction of the Board can be delivered.

Gary also highlighted the role of the Clinical Reference Group which was made up of multiple clinicians who provide advice to make sure that the work carried out is focusing on the right pathways.

The Network also incorporates two other regional groups, the delivery team and operational groups which focus on identifying challenges which will be progressed via task and finish groups such as the ambulance turn around group which is currently looking at trying to improve arrivals and discharges.

A three - year strategy had been signed off at the beginning of 2017 which had subsequently focused on the vanguard programme. However, a longer-term programme was now needed focusing on a range of areas.

Gary highlighted a range of outcomes achieved as a result of the strategy so far. These included the development of the flight deck which provides an understanding of activity in A & E and ambulance service pressures; the development of mental health training; behavioural analysis as to why patients move around the system the way that they do as part of the Great North Care Record System; the development of the NHS Health Child App which sets out the types of care children might need and provides information on where services are located and which recently won an award; the development of an emergency care programme which looks at patient flows and training for care home staff on when patients need to move into hospital settings.

Gary stated that one of the key advantages of this Network is that it has an understanding of what is happening in primary care and the demands on the system. This has meant that in Newcastle and South Tees they have been able to implement a cardiology and transport service where there is a dedicated transport service.

Gary also highlighted the work to develop a Directory of Services and stated that as part of this work they were looking to see how they could get more voluntary services included in the Directory.

The Joint Committee was also provided with a high-level overview of the income and cashable and non- cashable savings achieved by the Network so far. It was noted that not all of the work of the Network was quantifiable, for example, work around clinical assessment services, which created benefits in ensuring that patients were in the right place.

Gary stated that it was considered that the Network had made some really good progress so far and he introduced Bas Sen, Chair of the Clinical Reference Group, who would highlight some of the performance metrics.

Bas stated that he would provide the Joint Committee with information on the work of the Network and how it dovetails with the STP and would also provide an update on performance in relation to this winter.

Bas stated that the Urgent and Emergency Care Network was unique in that it spans the whole region whereas others don’t. In terms of performance this year Bas noted

that the Joint Committee would be familiar with the A & E standards and that patients should be seen and treated within four hours of arrival. Bas noted that these standards had not taken into account the increasing volume of attendances year on year. Bas stated that never-the-less Cumbria and the North East was leading the country in terms of performance. Bas referred the Joint Committee to slides setting out attendances and admissions which highlighted that these had flattened and decreased which might raise the question as to why performance had not improved. Bas stated that the key reason for this was that emergency admissions had gone up by 25 %. Bas indicated that reducing emergency admissions was the key to improved performance.

Bas noted that the Joint Committee would also be familiar with delayed transfers of care which refers to patients who remain in hospital for a variety of reasons although they are medically fit to be discharged. Bas indicated that this winter delayed discharges as a result of issues relating to home care were more of a problem than last year.

Bas also highlighted performance in relation to ambulance handovers and noted that there were a number of delays and work had been ongoing to address these.

Bas also highlighted the NHS 111 system which he considered was a huge success as the number of calls had increased year on year and had gone up by 23 %. However, Bas noted that an issue with the system was that as call handlers were not medically trained they are guided by a medically driven protocol which errs on the side of caution and so they send more people to hospital and send more ambulances.

As a result, a second step had been added in to the 111 system, which is clinician involvement and this created a shift in performance of approximately 80% which has since continued.

Bas stated that in terms of how the work of the Network dovetails with the STP it is acknowledged that going into the future a radical change in the health system is necessary which may involve many steps.

Bas noted that the Joint Committee might be familiar with the system in the US and United Health and Kaiser Perminente and the way that organisations such as this look at value added steps. This involves analysing patient centred work flows and looking at value added steps and non-value added and taking out the non-value added steps eg the amount of time a patient spends in a waiting room. Bas stated that the aim of the STP was to take out the non-value added. The Network has also carried out this type of work in relation to heart attacks, paediatrics and major trauma. Bas advised that he was involved in developing the major trauma system in this region and the work undertaken had led to a decrease in mortality of between 30% to 50% since 2012. This had been achieved by taking patients to a designated centre so that whilst an accident might occur in Durham the patient would be taken to Newcastle or South Tees where the two hospitals in question were manned 24/7 by highly skilled staff and with high levels of technical equipment in areas such as radiology facilitating the scanning of patients in 3 minutes thereby cutting down on diagnostics in major trauma. Bas stated that this means that patients can be in

theatre within 30 minutes which was impossible under the old system. Bas stated that he felt that this approach was the way forward.

The Chair thanked Bas for the information provided and noted that some of the Committee could remember when Kaiser Perminente was considering coming to the UK.

The Chair asked if Ian could also highlight the triage work that the Queen Elizabeth Hospital had been taking forward in relation to emergency care.

Ian advised that he is one of the Co - Chairs of the Urgent and Emergency Care Network and the Halo system which the Chair was referring to had been adopted by most hospitals now. It involved a Hospital Ambulance Liaison Officer who was a member of NEAS becoming part of the team. It had been trialled in hospitals suffering the most challenges and it had subsequently become a vital part of the system and had made a definite difference. Ian advised that the Queen Elizabeth Hospital had been lucky in that this approach had been introduced at the time the hospital had opened its emergency care centre. The work on HALO had emerged as a result of the work of the Urgent and Emergency Care Network.

It was however noted that Newcastle did not have the HALO system and its handover times were the best in the region.

The Chair noted that they had received information that admissions had increased and she queried why this was the case.

Bas explained that this is because the system is not integrated so when a call is made to NHS 111 and a patient advises they have chest pains, even if they are young and have been relatively fit and well up to that point, they had to be taken to the emergency department in a hospital via an ambulance. Bas stated that there is a need for a virtual ward which could give care to a patient at home. However, for such a model to be in place there would need to be an integrated service where the first point of contact could be someone's carer who could then have access to a district nurse/OT/social worker / GP or other relevant specialist where needed. Bas stated that if such a system was to be in operation then he believed that this would mean that 50% of patients could stay at home and would not need to be admitted to hospital.

The Chair also noted that information had been provided on the NHS 111 pilot of making referrals direct to local pharmacies and she queried whether this was likely to be rolled out across the region.

Andre advised that he would provide the Joint Committee with information on this project later on in the meeting.

Councillor Robinson noted that the £682,000 funding for winter pressures worked out at 40 pence per head of population and he queried how the NHS had worked out that the population in that area was only worth a spend of 40 pence. Councillor Robinson also advised that he had a stroke approximately six weeks ago and if he had to go to James Cook Hospital rather than the local hospital, where he received

excellent care from the staff, he would likely not have survived.

Bas advised that he was not saying that all stroke cases should go to major centres, only complex highly specialised cases need to go to major trauma centres. Bas stated that most hospitals can deal with acute strokes and the work they are doing is not about taking good care away.

Bas advised that the £682,000 was the amount of funding allocated to the Urgent and Emergency Care Network for collective schemes. Alongside this there was also significant funding allocated to NHS providers in the region amounting to millions of pounds.

The Chair asked if the £682,000 funding allocation to the Network had been ringfenced.

Bas explained that the funding had been allocated to the Network and the Network had collectively prioritised what the funding should allocated for and it had been used in a number of ways eg to have NEAS staff in A & E Departments, provide additional IT and storage equipment for paramedics etc.

The Chair asked whether the monies allocated to providers had been allocated on a needs basis and whether this had been ringfenced.

Bas stated that the process for allocating the monies effectively meant that the monies were ring fenced. NHS England had advised that if providers could not provide adequate explanations as to how the monies were to be spent then these monies would be clawed back.

Councillor Schofield noted that many members on the Joint Committee were aware of the health care system adopted in the US and were concerned about going down that path. Councillor Schofield stated that there were millions of people in the US who were disenfranchised from the health care system because they could not afford to be part of it. Councillor Schofield stated that any valued added system developed in the patch must ensure that people are not disenfranchised.

Bas stated that there was no intention of blindly adopting the US system.

Councillor Schofield stated that it was pleasing to hear that the work of the Network would dovetail with the STP and she queried how this would work, would it have to be specifically incorporated or was it something that was built in to the STP.

Bas explained that the Network has some independence as they scrutinise clinical models and the Network would not endorse a model which was not appropriate.

Councillor Schofield queried what would happen if there were ever problems with the NHS 111 system given the high level of calls.

Gary advised that no provider operates in isolation so if there was a significant incident which affected the North East and NHS 111 provision the work would be shared with another NHS 111 provider.

It was queried how the work being progressed would affect payments to different parts of the system. Gary noted that work was often tariff driven which did not always facilitate transformation by the Network. However, work was starting to take place to look more broadly at how they could ensure that finite monies could be shared in different ways amongst providers. Providers are engaged in this work and the NHS is trialling new payment systems in vanguard areas. However, this type of work could not be implemented overnight.

Ian explained that active conversations were taking place with local commissioners who were looking to develop a local payment mechanism.

Ian stated that United Health and Kaiser Perminente had been set up for a very different type of healthcare system and this was why the approach here was different and was being focused on developing an integrated care system. Bas stated that the secret to an integrated care system was that it was not just about services but about integrated finances also.

Councillor Charlton noted that the number of abandoned calls to the NHS 111 system appeared to have increased hugely and she queried the reasons for this.

Gary explained that this was as a result of a significant increase in call volumes which could not have been predicted and which the staffing model had not been geared up for in terms of activity. As a result, changes had been made to the staffing model and performance is back on track.

Councillor Charlton queried whether the increased number of abandoned calls had led to additional admissions. Gary stated that he would argue not as the calls to NHS 111 tend to relate to lower risk health issues unlike 999 which deal with more serious health matters. Gary advised that there was some ongoing analysis taking place to see if there was a link to A & E attendances but at this current point in time it was not believed to have had an impact.

Bas indicated that he was not certain that this was the case as he was concerned that people did not always know which number to call in all circumstances. Bas considered that sometimes people were confused as to which number to call. Bas considered that there was a natural tendency in some people not to call 999 and he considered that if calls were not effectively filtered then this might increase admissions.

Councillor Watson noted that handover delays could definitely fall under the category of non – value added. Councillor Watson also noted that this could apply to circumstances which he was aware of when family members had to wait for seven hours to be admitted to a hospital bed only to be seen and then told to go home and circumstances where people wait for six hours to receive medication from the pharmacy. Councillor Watson queried whether these were common occurances which could be sorted.

Bas indicated that this was a really important point and work was taking place to try and resolve these types of issues but it was important to remember that the Network

only started three years ago.

The Chair indicated that it would be helpful for the Joint Committee to have a further update on the progress being made by the Network at a future meeting.

22 PHARMACY AND STP

Stephen Blackman, Chief Officer, North of Tyne LPC, advised the Joint Committee that he was here to highlight the role of Pharmacy which he considered was not addressed within the STP currently.

Stephen stated that Pharmacy can support both urgent care and primary care and the key message was that Pharmacy wanted to transform and be part of the integration of services at both a national and regional level.

Stephen noted that 88% of the population is within a twenty minute walk of a local pharmacy and that there are 390 pharmacies in our area which deliver important services such as Stop Smoking. Stephen stated that the area has a long history of pharmacies delivering a range of services and in some areas pharmacies help with hospital discharges.

Stephen noted that the NHS 111 Community Referral Scheme was a great success.

Stephen stated that currently there is not a national contract for pharmacy but this is the direction that pharmacy wants to move towards.

In terms of the direction of pharmacy, as set out in the Five Year Forward View, there were three areas of focus; supporting long term conditions; acting as the first port of call for health advice and treatment and acting as a health and wellbeing hub.

Stephen stated that they had looked at the STP priorities and how it is aligned to the vision of the Forward View and it matches. They had also looked in detail at the services already being delivered and where Pharmacy can evolve and extend.

Stephen stated that currently they have a patchwork of services across the region and nationally and they would like to look strategically at a framework of services. Stephen stated that he considered that there was great potential for Pharmacy to be integrated.

In the area of long term care there are great opportunities as there is much more that can be done to support patients to manage their medicines and conditions eg asthma care. The Community Pharmacy Referral Scheme is already providing some support in this area.

In terms of transfers of care, pharmacy is also providing some help so that discharges can take place more quickly. Stephen stated that moving forwards there were opportunities to build on the foundations of the work already taking place and relieve pressure on other areas and be more integrated with primary and urgent care.

Andre Yeung, Chair of Northumberland Tyne and Wear LPN outlined further details regarding the Community Pharmacy Referral scheme and its achievements to date and opportunities for working better together.

Andre stated that he works closely with colleagues in the Durham, Darlington and Tees Valley area so that there is coverage across the whole region.

Andre explained that in August 2014 Durham University had carried out some research which suggested that community pharmacy bucked the inverse care law and deprived communities were best served by the services it provided.

At that time, less than 1% of referrals from NHS 111 were going to community pharmacy and it was considered that there was scope for integration between the two. As a result, a proposal was developed for the Community Pharmacy Referral Scheme which is regional and covers all ten CCGs across the North East and a population of 2.8 million with 618 pharmacies in that area. In order to tie in to urgent and emergency care systems the algorithms to NHS 111 were changed and it was identified that there were a potential 35,000 patients who could be referred to community pharmacy. The aim is to help increase resilience in urgent care by helping patients to self - care and by helping to deliver care closer to home. The project went live on 4 December 2017 and has been up and running for three months now. During this period Pharmacy had been seeing high levels of patients with 62.5% attending consultations with pharmacists and 30% receiving telephone consultations and 100% of patients are being supported with self -care. In terms of advice provided to patients 60% had been happy with the advice provided and this had included the sale of over the counter medicines in some circumstances. Some cases are escalated to NHS 111 for other support or to GPs. There has been 85% patient satisfaction with the service overall. The service is providing real benefits as most of the patients supported would have gone to out of hours services of their GP if they had not been able to access this support.

Andre advised that the project was committed to run until September this year when there was to be a full evalutation of the project.

Andre echoed Stephen's view that there were also other ways that Pharmacy could support the work being carried out in the STP around prevention which would save time in general practice for example in dealing with blood pressure.

Councillor Mendelson queried the position around funding and whether there might also be capacity issues if Pharmacy was to take on other areas of work.

Andre noted that time is precious for Pharmacy as with many other providers and if Pharmacy is taking significant numbers of patients out of the system and supporting them then they would require funding for this. Andre stated that the Local Pharmacy Network made a business case for this project to national colleagues and secured funding and it was hoped that if the project proves successful that this will then be rolled out to other areas.

Stephen noted that Community Pharmacy has had its budgets cut. Most regions have had 20% to 30% reductions in community pharmacy funding which has led to

some redundancies although not to closures. Funding is difficult but there is capacity amongst Pharmacy teams as there was a shift in the service model and this would make Pharmacy more sustainable.

Councillor Taylor queried whether all pharmacies were willing and able to take on additional work and whether there was anything else which could be done to support pharmacies take on the types of work outlined.

Stephen stated that what was needed was to make the services outlined part of Pharmacy's every day work when the new contract was put in place. Under the current framework pharmacies receive more money by dispensing more medicines. Stephen stated that they are suggesting that if there was a regional framework which included a number of services as part of pharmacy's daily business this would ensure that Pharmacy was involved in the integration agenda.

Stephen stated that Pharmacists are keen to become independent prescribers but can't issue medications and so they would like services to become a larger part of what Pharmacy does.

Stephen stated that Community Pharmacy is not the same as general practice. Much of the service provision is opportunistic as it relies on people coming through the door. This means that when they are designing services there is a need to understand what is to be achieved to ensure the right structures are in place and patients are targeted appropriately eg blood pressure.

Councillor Charlton noted that some of the facilities at Pharmacies did not provide much privacy for consultations and queried whether this was likely to prove off putting for patients.

Stephen acknowledged that there is some variability in facilities although some now have three consulting rooms and a second Pharmacist. Stephen considered that facilities would develop.

The Chair asked Mark whether he had any comments on the issues highlighted in relation to future contracts and commissioning arrangements.

Mark stated that the points in the presentation had been well made and the pilots referenced and Andre's role as part of NHS England were pivotal in taking matters forward via various processes. One of the starting points for this work was through the Urgent and Emergency Care Network where they are working to bring Pharmacy in.

Caroline stated that, within the Urgent and Emergency Care Network, Pharmacy is a cornerstone in the Behaviour and Child Illness App which identifies local pharmacies as a route for support services. Caroline acknowledged that there was a need to raise public awareness further that Pharmacy is the place to go in a range of circumstances.

Councillor Robinson highlighted the position of rural communities and noted that the Durham dales had lost a number of rural pharmacies due to the GP contract.

The Chair considered that it was surprising that Pharmacy was not yet integrated into the STP. The Chair hoped that consideration was being given as to how to change that position with a view to further progress being provided to the Joint Committee going forwards.

23 INTERIM UPDATE - WORKFORCE WORKSTREAM

Ian Renwick advised that he was Co-Chair of the Workforce Workstream, alongside Amanda Hulme.

Ian advised that he would be attending the Joint Committee meeting in June to provide a full update in relation to the workstream. However, at this stage Ian was able to advise that the workstream was one of three key planks in the STP. This is due to recognition that there are a number of challenges in areas such as recruitment where there are difficulties in relation to recruitment and retention of GP's and in areas of hospital based care.

Ian stated that these challenges are borne out by recent statistics which highlighted that nationally and locally this is the first year where many more nurses have left the NHS than joined. Within the NHS there are also issues in relation to the employment of locums and agency staff. There are also huge pressures on adult social care as a result of a number of years of austerity which means that for ADASS workforce is also a key area of focus and where the challenges are similar. As a result, ADASS are developing a three year workforce strategy. The aim is to dovetail both areas of work.

Ian advised that together the NHS and ADASS are actively engaging their key workforces.

Ian advised that the Social Partnership Forum brings together NHS employers and Unions and is the route for employers to share information. Going forwards the Forum will be a mechanism for consultation on key service pathways. Ian advised that at the last meeting of the Social Partnership, representatives from local authorities also attended.

A workforce summit was also held on 24 February and the key issues challenges and opportunities highlighted were as follows:-

- Innovation and quality improvement are subordinate to daily fire fighting and crisis management
- Demand, specialisation, reducing numbers of trainees, staff retirement and the intensity of modern working practice
- A reliance on expensive locum and agency staff is making the existing configuration of services unsustainable
- The workforce is fragmented in silos and divided by organisational and professional boundaries
- Social care shares similar challenges and is under significant pressure due to Local Authority budget cuts
- There is huge untapped potential in the community and voluntary sectors – but this too requires investment and development

Group discussions were held in the context of a Cumbria / North East approach and work was carried out to identify potential quick wins. For example it was noted that a lot of back office functions are similar across sectors. Work also focused on potential new ways of working with the NHS and local government. Consideration is also being given to the greater portability of skills and how these might influence integration. In terms of recruitment and retention work is also focusing on sustainable ways of working. An example of this can be seen in the work relating to trainee GPs. Northumbria Healthcare has led on a project called Find Your Place which was a collaborative marketing campaign aimed at newly qualified doctors coming out of medical school with a view to attracting them to positions in the North East. All Trusts in the North East came together as part of a partnership Health Education North East and contributed 10k each to showcase the strengths of the North East and that it meets 15 out of the 17 GMO survey. The campaign has led to a 9% increase in trainees coming to the North East and will lead to fewer locums needing to be used. The return on investment for the campaign is estimated at three quarters of a million pounds and the campaign is being refreshed for 2018-19 with the commitment of all trusts.

Councillor Taylor queried whether there was any information on the impact of Brexit on the numbers of EU nationals who have left the NHS since the referendum or reductions in applications for posts in the NHS.

Ian advised that he did not have that information today but would look to bring some information on this to the next meeting.

Councillor Taylor noted that training for staff was crucial and needed to be appropriately funded going forwards. Ian agreed and also noted that they would be looking to assess the impact of the withdrawal of bursaries for nurses.

Councillor Schofield stated that she was unclear as to what was meant by the phrase the “whole workforce” and asked that a definition be provided. Councillor Schofield also considered that there should be opportunities for shared training across the health and social care workforce which would be a real culture shift. Ian agreed and stated that this should also include Continual Professional Development (CPD). Ian agreed to provide a clearer definition in relation to the workforce at the next meeting.

Ian advised that they would soon be appointing a Strategic Lead for Workforce. Ian considered that there was likely to be even more momentum in relation to the Workstream following this appointment.

Councillor Mendelson noted that the Joint Committee was keen to see that the Trade Unions are being engage and involved in the Workforce Workstream and queried whether this was happening.

Ian confirmed that engagement with the trade unions was taking place via the Social Partnership Forum and that trade union representatives had attended the Workforce Summit in February.

24 JOINT STP OSC WORK PROGRAMME

The Joint Committee considered and agreed its provisional work programme as follows:-

Meeting Date	Issue
25 June 2018	• Workforce Workstream – Progress Update • Integrated Care System
Additional Meeting (date tbc)	• Empowering Communities

The Joint Committee agreed that in relation to the Workforce Workstream update in June, trade union representatives should again be invited to the meeting considering this issue.

The Joint Committee also agreed that Professor Pollack should be invited to address councillors on the Joint Committee regarding her perspective on Accountable Care Organisations at a separate session, following on from a Joint Committee meeting. It was considered that this would facilitate a fuller discussion of the issues given the time constraints at meetings of the Joint Committee.

The Joint Committee also agreed to hold an additional meeting (date to be confirmed) to consider an update on how it is planned to engage with and involve communities in the whole Integrated Care System process.

The Chair also advised that, given the full agenda at today's meeting, councillors and external parties attending the meeting could email any outstanding written questions and a response would be provided in due course.

25 DATE AND TIME OF NEXT MEETING

AGREED That the next meeting of the Joint Committee be held on 25 June 2018 at 2pm at Gateshead Civic Centre.

Chair……..