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

Monday, 15 January 2018

PRESENT: Councillor Caffrey (appointed Chair for the meeting) (Gateshead Council)

Councillor(s): Charlton (substitute – Gateshead Council) Armstrong (Northumberland CC) and Dodd(substitute - Northumberland CC) Chequer (Sunderland CC), Clark (substitute - North Tyneside Council), Davinson and Temple (Durham CC),Hetherington and Huntley (South Tyneside Council),Mendelson, Schofield (Newcastle CC) and Huddart (substitute – Newcastle CC)

10 APOLOGIES

Councillor (s); Foy and Maughan (Gateshead Council) Taylor (Newcastle CC) Bell, Grayson and Hall (North Tyneside Council), Simpson and Watson (Northumberland CC) Flynn (South Tyneside Council) Robinson (Durham CC) Heron and Leadbitter (Sunderland CC)

11 DECLARATIONS OF INTEREST

Councillor Mendelson (Newcastle CC) declared an interest as a member of NTW NHS FT Council of Governors.

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

12 MINUTES

The minutes of the last meeting held on 13 November 2017 were approved as a correct record subject to it being noted that, at item 3 Declarations of Interest, Councillor Chequer (Sunderland CC) had declared an interest as an employee of NTW NHS FT and Gateshead Health NHS FT.

13 STP PREVENTION WORKSTREAM - PROGRESS UPDATE

Dr Guy Pilkington, Chair of the regional STP Prevention Board, explained that a Board had been established to progress this area of work to demonstrate a system wide commitment to prevention work in the north east.

Dr Pilkington advised that his role was that of SRO and he was supported by

Directors of Public Health from across the patch and Terry Collins, Chief Executive Durham County Council who was acting as sponsor for the work and Alan Foster STP Lead so that assurance can be provided to the STP Board in relation to this area. Prevention is viewed as central to the success of the STP process.

Dr Pilkington noted that Prevention work was critical. Although there are financial constraints in the north east there are still good services being delivered. However, in spite of these factors there are still very poor health outcomes in the north east and there is a significant health and wellbeing gap that needs to be closed.

Dr Pilkington stated that the North East Combined Authority and local NHS organisations had established a Commission for Health and Social Integration in 2016 as part of a devolution bid and this had reported its findings in " Health and Wealth: Closing the Gap in the North East" which had provided a good steer. This work had complemented the NHS Five Year Forward View which set out the need for the NHS to support a step change increase in prevention. The Marmot Report in 2010 also supported the need for building on existing prevention activity.

As NHS budgets are fully stretched it is important to shift the focus towards prevention otherwise services will always struggle to meet demand. There has also been an increasing recognition that to progress prevention work there cannot be a reliance on local authorities alone. It is also important to shift activity and investment to support the prevention agenda in order to close the health and wellbeing gap.

As part of upscaling prevention work there is a regional ambition to address the harm caused by tobacco and the target is to reduce smoking to 5% by 2025.

Dr Pilkington advised that there is a need for system leadership to drive forward the prevention agenda and this would be the role of the Board. Dr Pilkington set out the proposed work programme for the Board.

Work focuses on action to embed prevention at all levels and in particular for the STP primary and secondary prevention.

In relation to primary prevention, this would deal with what is being done to improve the health of the population before they become ill and focus on tackling key areas such as smoking, alcohol, providing children with the best start in life and preventing / reducing obesity. Dr Pilkington stressed the importance of people being active to keep well and the fact that there is significant evidence to support intervention in this area.

In relation to secondary prevention, this would look at reducing premature mortality in areas such as Cardio Vascular Disease (CVD) Cancer, Chronic Obstructive Pulmonary Disease (COPD) and Diabetes.

The Joint Committee was advised that this winter there had been a number of pressures on the system and outbreaks of norovirus had exacerbated those pressures. In addition, a flu epidemic had affected the primary care workforce highlighting a need for extra take up of the flu immunisation amongst that workforce. An important focus for the Board's work will therefore be getting better rates of

workforce and population immunisation. Workplace health is an important area of focus within the prevention agenda. However, shifting spend to prevention is still a challenge when particular crises take up the available budgets. The Board will therefore be looking at how partners can make the shift and think differently and imaginatively about potential options.

Dr Pilkington advised that going forwards a community asset based approach would be key as part of social prescribing. Public Health England would be leading a conference on this area in the next couple of months. The methodology behind this is to make every health contact count. This means that the workforce would act as health champions and consideration will need to be given to how they are skilled and trained to provide brief advice. The aim will be to have the most skilled regional workforce who can deliver health messages at every opportunity.

The Joint Committee was advised that the Prevention Board would also be working closely with the mental health workstream in relation to people at risk and suicide prevention. The ambition is to have zero suicides. It is also planned to work with local maternity services to progress work to become smoke free.

Alice Wiseman, Director of Public Health for Gateshead, advised the Joint Committee that the initial focus for the region has been on preventing tobacco harm through implementation of a smoke free NHS. This area was addressed as a priority as it is one of those areas which will make the greatest difference to health and wellbeing of our populations. This Prevention Board has prioritised and endorsed this work to support a regional vision of having only 5% smoking prevalence by 2025 which is an ambitious target. The aim is to ensure that tobacco dependency is treated the same as other dependencies.

A dedicated Task Force has been established, chaired by Dr Eugene Milne and Tony Branson, which has representation from both NHS and local authorities with a view to ensuring that all Trusts fully implement NICE guidance PH48.

Amongst other things, this will mean that every person the Trusts come into contact with will be asked their smoking status and a conversation will be had on their admission to hospital and nicotine replacement therapy will be provided whilst an individual is in hospital. Subsequently work will continue with individuals in the community and support offered.

This approach has been endorsed at the STP oversight group and consideration is now being given to proposals for implementation.

Dr Pilkington stated that resources will be allocated to support acute trusts to become smoke free. In relation to secondary prevention work this will mean that opportunities will be provided to consider individuals' tobacco use prior to any planned procedures.

Dr Pilkington stated that one of the most significant challenges was around the amount of work involved in a single element in a process. Dr Pilkington stated that there is a need to examine whether it is feasible to shortcut some of the processes and have a governance arrangement which will drive forward a combined agenda.

Dr Pilkington highlighted an example of shared commitment where there was a need to expand the broad agenda. Peter Kelly will therefore be convening a meeting in the next couple of months. There will be a need to confirm the focus for funding and assure the system as a whole that appropriate outcomes will be delivered.

Dr Pilkington stated that the Prevention Board will continue to review its membership and its terms of reference to ensure that these are appropriate. Alice noted that as the Board was an important vehicle for delivering and implementing the recommendations of the Health and Social Care Commission, which also link to economic development, it was important to make sure that the Board was linking into the right forums to deliver on that agenda. A report had been taken to the North East Combined Authority (NECA) Overview and Scrutiny Committee where it had been agreed that there was a need to focus on those priorities.

Councillor Mendelson noted that there are an increasing number of workplaces, where employees may be on temporary contracts and there is no union involvement, where it may be difficult to drive forward the health prevention agenda. There are also a number of individuals who are on the edge of workplaces and Councillor Mendelson was concerned at how these individuals can be supported. Councillor Mendelson noted that the Joint Committee had received information about the prevention strategy and the mechanism for taking this forward but queried what the Joint Committee could expect to see in terms of a delivery plan as there appeared to be lots of disparate initiatives.

Dr Pilkington advised that given the geography of the STP a lot of activity would take place in local areas. In terms of local authority footprints there was no ambition to shoehorn localities together to form one area. The aim is to look at how individual local delivery plans can be made more effective. However, finances will need to be dealt with at a regional level.

One area of activity would focus on flu immunisation and the aim that every organisation with a cohort of the population should be in the top quartile of flu immunisation rates nationally. In addition, the aim was to have all children in primary education in the north east in the top quartile for immunisation. Having agreed this ambition processes will then need to be put in place to ensure that each local area is able to report back on its success in achieving this ambition and that there is peer to peer challenge if areas fall behind.

Dr Pilkington acknowledged that workplace terms and conditions have an impact on physical and mental health and indicated that the Prevention Board would be happy to engage with others to think about how such issues might be addressed.

Alice advised that health and workforce were key considerations for Councils and a number of recommendations had been developed and this included access to psychological therapies. The Better Health at Work Award has also been developed as a region and continues to be supported although it is recognised that one of the challenges relates to progressing the agenda with smaller employers. Alice stated that this needs to link into the Strategic Economic Plan as there is a real economic argument for employers to engage.

The Chair of NewcastleGateshead Healthwatch highlighted the importance of developing community asset based approaches and stated that if such approaches are to be developed then it is important to start conversations with communities early. The Chair of NewcastleGateshead Healthwatch also noted that due to budget issues there are now fewer staff to initiate such conversations and queried how it was planned to develop such work in light of such challenges.

Dr Pilkington stated that it was planned that work would focus on social prescribing and supporting practitioners to take a broader view of individuals' ability to stay healthy and think holistically about individuals and the fact that homes and relationships play a key part. Dr Pilkington stated that it would be important to develop a regional language around this work and collectively bid for NHS funding to put in place a more co-ordinated and easier to understand system. In times of reduced funding community assets are important and need to be supported. There is a really vibrant voluntary and community sector in the region and it will be important to tap into this. It was noted that Public Health England would be holding a conference on Community Asset Based approaches in March.

The Joint Committee noted that the Empowering Communities Model cuts across the work of all the STP workstreams and was a potential area for further consideration.

The Chair of the Joint Committee supported Dr Pilkington's view that a regional language needed to be developed.

Councillor Hetherington noted that South Tyneside OSC had carried out a Commission on Smoking last year and one of the key findings was that there are a number of reasons why people start smoking and there is not one solution. Therefore any health contacts with individuals will need to explore those reasons as, until those reasons are identified it will not matter what health benefits are articulated around not smoking and individuals will continue to smoke. It is essential that the root causes of smoking are identified and tackled and that it is recognised that smoking is an addiction and needs to be treated the same as other addictions. Councillor Hetherington noted that there are still some acute trusts which make smoking acceptable by providing places in hospital for individuals to smoke. There is a need to change attitudes.

Dr Pilkington agreed with Councillor Hetherington and stated that there is evidence which suggests that if 40% of smokers were offered brief advice and supported to stop smoking every year then it will be possible for the region to achieve the 5% target.

Dr Pilkington stated that it is not the case that the population lacks awareness that smoking is bad for individuals' health. It is important that when contacts are made with those who smoke they understand that there is no blame attached and they do not feel that they are being punished for smoking. Dr Pilkington stated that e-cigarettes are an enabler for individuals who have tried a number of other avenues.

Dr Pilkington noted that Balance had held a conference about why young people

start to drink alcohol and what the industry do to encourage people to drink alcohol. Dr Pilkington considered that this approach was needed in relation to smoking.

Councillor Huntley stated that the closing the gap ambition was fantastic but queried how robust the Board was to enable it to drive forward this ambition and how it would empower its workforce. Councillor Huntley stated that OSCs in Sunderland and South Tyneside had often received information that workforce were not involved until the later stages.

Dr Pilkington stated that the workforce will be receiving significant engagement from the Prevention Board. The Board would be rolling out training to enable the workforce to support individuals to stop smoking and look at how they can think differently about alcohol as well as being open to individuals in distress so that they can work towards a target of no suicides. Dr Pilkington stated that whilst the Prevention Board has senior management representation it does not have all the levers it needs and this is why it is taking matters to its most senior leadership.

Councillor Schofield thanked Dr Pilkington for the presentation and outlining the ambitions of the Prevention Board. However, Councillor Schofield noted that Newcastle's Overview and Scrutiny Committee had received a presentation on CAMHS and how the model would help to reduce demand on specialist services and it had been hard to see how this could be achieved with the resources available. Councillor Schofield considered that this was the case with many DOH initiatives and this inhibited the rate of change. Councillor Schofield queried where Public Health sat in all of this and whether collaboration would take place through existing mechanisms or new structures and what the legal liabilities would be and whether they would be shared if they were progressed via Partnerships.

Dr Pilkington advised that some of the points raised would be addressed in the update on Accountable Care Organisations. Dr Pilkington stated that it would be important to look at what Partnerships can achieve together that organisations can't currently do alone and how this is managed. Dr Pilkington stated that voluntary and community assets will also need to be used to the full.

The Joint Committee was informed that Public Health are involved in leading on this work jointly with the NHS around population health. The role will focus more on providing advice to the system as there is a recognition that there is only so much that can be done in terms of service delivery.

It was noted that 60% of NHS budgets have been focused on the acute sector and there is a need to shift some of that resource into secondary and tertiary prevention.

Councillor Davinson highlighted that work had been taking place in Durham to reduce smoking rates and whilst these had reduced there were still 38% of people in his area who still smoked so there was still a lot of work to be done. Councillor Davinson also highlighted the importance of exercise as a key element of prevention work as it supported both physical and mental health and if individuals joined clubs then it could also support social inclusion. However, Councillor Davinson considered that prevention initiatives would not have any impact unless they addressed the root causes of why people smoke etc and individuals had a positive view of their lives

and what they might achieve.

Dr Pilkington stated that he supported Councillor Davinson's view and considered that exercise is key to helping prevent diabetes and the mental health component of exercise was very important. Dr Pilkington highlighted that councillors can be considered to be community assets as they can be key to bringing people in communities together and creating connections between them and relevant organisations.

14 ROLE OF ACCOUNTABLE CARE ORGANISATIONS

The Joint Committee received a video presentation outlining the role of Accountable Care Organisations.

Mark Adams advised the Joint Committee that the focus in NE and Cumbria STP areas was on developing Accountable Care Systems and looking at how organisations could work together more.

The approach involved the NHS working under set budgets to improve health and working together with other services such as Social Care and Public Health to achieve this. Some of this work was taking place within the Vanguard pilots which were trialling new models of delivering community based services.

Mark highlighted that this approach would mean that whilst patients would still see their GP and access hospital care they may receive more support and treatment at home. It might also mean that individuals might have to travel further to access hospital care.

Mark stated that the Joint Committee would be able to see from the video presentation that as far as STPs are concerned there has been a lot of discussion around how individual organisations come together and work in different ways. Mark highlighted that one of the key areas in our STP is the emphasis on Prevention which as the video highlighted has not always been seen in other areas. Mark stated that within this STP the key focus will be on looking at what other areas can do and working with other organisations, not just local authorities to see how the best use of resources can be achieved. Mark advised that it will be really important to make sure that the organisations that come together are rooted in local work.

Mark stated that the discussion around Prevention highlight the general understanding of what we want to do collectively and what works well and less well and how it is planned to make changes.

Alan advised that the aim was to have systems working together rather than implementing organisational change. Alan stated that where it makes sense to work at scale there are a lot of things that can be done to try and provide an equitable approach. However, Alan advised that what can be achieved locally is also important. Alan stated that an accountable care systems approach means working together in the North East to agree how we deliver care and how we want to collaborate more with partners such as local authorities and the voluntary sector to

create local systems which will meet needs and improve services for local people. Alan stated that he believed there were real opportunities in progressing such an approach and in ensuring a real interface for patients at a local level.

Alan highlighted that some hospital services in the patch were vulnerable due to staff shortages in areas such as radiology and other areas are also under pressure so this may mean that patients have to travel further.

The Chair stated that on the issue of further privatisation of the NHS this was not in the interests of most people and the recent collapse of Carillion and the need for government to bail out contracts highlighted this. The Chair stated that Gateshead and Newcastle were quite far down the line in discussions on health and social care integration. However, it would be important for public accountability that whatever systems etc are set up that they are accountable to Health and Wellbeing Boards.

The Chair also noted that it will be important to look at how we commission using the Social Value Act. The Chair advised that Gateshead is now looking to ask those who contract with the Council to sign up to a Corporate Responsibility Pledge around wages/ workforce and health and wellbeing.

The Chair considered that integration would help to better deliver services and avoid duplication of effort and she considered that this approach was similar to the approach being outlined by Mark and Alan. The Chair also highlighted that it would be important for the North East to continue to attract resources from central government.

Councillor Hetherington supported the comments Alan and Mark had made about greater joint work across systems as a way forward. Councillor Hetherington considered that all local authorities support this ambition. However, Councillor Hetherington noted that STPs had come in on the back of a great deal of suspicion about the motivation for implementing them and without a great deal of input from the public and local authorities. In addition, Councillor Hetherington noted that Accountable Care Organisations were unfortunately linked to the US healthcare system which is linked to private medical care.

Councillor Hetherington also noted that this approach appeared to be in direct conflict with the Health and Social Care Act which supports competition. Councillor Hetherington queried whether there was any danger of fragmenting services if they were put out to smaller organisations.

Mark stated that Councillor Hetherington was right to say that the structure of the NHS was based on competition. However, Mark stated that as a result of the direction of travel under austerity, STPs were focusing on improving health and the quality of services and as a result of this had learnt that working collaboratively together achieves more and helps to keep funding here.

Councillor Hetherington supported the approach being adopted by Mark and Alan but expressed concern that government may try to override this approach. Dr Pilkington acknowledged that there was a risk but there would be the potential for everyone to challenge such a stance. Dr Pilkington stated that the inequalities

agenda had not been tackled successfully using the NHS focus on competition.

Councillor Clark stated that it was good to hear that a more collaborative approach was planned but expressed concern that this might not be supported nationally.

Mark stated that the Joint Committee's comments were really helpful. Whilst the methodology of Accountable Care Organisations was based on the US model the focus in this STP was on an accountable care systems approach and on how organisations work together. Mark stated that he considered that there was scope to influence government in relation to local approaches to STP delivery.

Councillor Clarke queried whether there was a clear vision as to what accountable care systems look like in the North East.

Mark advised that there is not a clear vision at the minute. It would be necessary to work together to create such a vision and understand what works best at a local level. Mark stated that there is the potential to consider other models and see what this might mean for this STP area.

Councillor Clarke considered that it would be good to have more information on this issue at a future meeting of this Joint Committee.

Councillor Temple noted that there were a lot of tensions in the system, in relation to private and public health, the spread of models and integration work and he queried how much of a challenge this represented in terms of the STP's capacity to achieve its goals.

Councillor Temple also noted that he could not see any evidence of voluntary sector representation or social care providers on the Prevention Board and he queried what was planned in relation to this.

Alan stated that there is a need to get the governance right and get the right people involved with the right approach and this is still work in progress.

Dr Pilkington advised that there were challenges within the system. Within commissioning there is currently a lot of focus on split funding and health responsibilities. However, Dr Pilkington considered that there were still potentially better ways to deliver services through efficiencies and by taking collective responsibility. Dr Pilkington advised that he would be speaking to the ADASS Board about appropriate representation for the Prevention Board. Dr Pilkington stated that by working towards an Accountable Care System the aim was to take a whole population approach and encourage commissioners and providers to be part of a collective solution.

Councillor Schofield expressed concern that a top down approach was being progressed and she was keen to understand how the voice of the community was going to be taken into account. Councillor Schofield also considered that it would be helpful to have a clear definition of an Accountable Care System to avoid confusion and misunderstandings. Councillor Schofield also noted that the issue of transport did not appear to have been covered in any of the discussion and she felt that was

an important area to take into account.

Councillor Mendelson considered that it is beneficial for everyone to work together and there is also a need to campaign for better funding. Councillor Mendelson queried how scrutiny would be built in to the development of the proposed Accountable Care System. Councillor Mendelson considered that this Joint Committee should scrutinise what was happening at various stages of development of the proposed system prior to decisions being made.

Mark acknowledged that at present there is not a collective vision/model as this is still in development. However, Mark assured the Joint Committee that whatever proposals are developed these would not cut across statutory duties to involve and consult the Joint Committee and patients. Mark considered that the views of the Joint Committee would be particularly helpful in providing a strategic steer.

Caroline confirmed that any significant service changes would be brought to the Joint Committee.

Councillor Mendelson stressed that it was important that matters were brought to the Joint Committee before decisions were made.

The Chair invited questions from members of the public.

Carole Reed from Keep Our NHS Public (Durham) highlighted that the talk about ACOs appeared to be very vague and it was unclear as to what was being proposed and who would be accountable. Carole also queried when the final version of the STP would be shared.

Alan stated that finalised STP would be shared once it was fully developed.

Carole also considered that if any reconfiguration proposals arising from the STP had taken place before the winter crisis the system would not have had the capacity to deal with this. Carole also considered that the main focus of the STP was saving money and that ACOs were the same.

The Chair noted that these points had been raised and considered at the last meeting. Carole stated that this was being raised again as there were concerns that ACOs would not be subject to public scrutiny.

Mark assured the Joint Committee that when a vision had been developed for the Accountable Care System both the Joint Committee and the public would be consulted.

A member of the public, who is a carer in Gateshead, expressed concern that when the issue of workforce was raised there appeared to be no mention of the " invisible" workforce which was carers and their contribution to the prevention agenda. The member of the public highlighted the potential negative impact on carers' mental health as a result of their caring role and highlighted the need for carers to be supported to deal with the pressures placed on them.

Alan acknowledged that there would need to be a to link with carers / explore support for carers going forwards and how this fits with working families as more services became more community focused.

The member of the public noted that it had been mentioned that the aim was to keep services as local as possible. However, the member of the public considered that there had been a 50% increase in out of borough services for mental health which had a big impact on his family. The member of the public expressed disappointment that CCGs whose funding had been increased to deliver mental health services had reduced the percentage of funding allocated to those services.

Alan advised the Joint Committee that investment in Northumberland Tyne and Wear NHS FT had reduced a little but mental health spend had grown overall.

15 JOINT STP OSC WORK PROGRAMME

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

Meeting Date	Issue
19 March 2018	• Urgent Care Workstream – Progress Update • Workforce Workstream – Interim Position
June 2018 (date tbc)	• Workforce Workstream – Progress Update • Accountable Care System – Progress Update

It was agreed that progress updates on the development of the Accountable Care System be provided to the Joint Committee on a regular basis and that information on how it is proposed to engage and involve communities in the whole STP/ACS process be brought to the Joint Committee at a future meeting.

The Joint Committee also indicated that it would be helpful to be provided with information on how the unions are being involved in the Workforce Workstream and have information as to how work in relation to the social care workforce was linking with the STP workforce workstream at a future meeting.

16 DATE AND TIME OF NEXT MEETING

AGREED That the next meeting of the Joint Committee be held on 19 March 2018 at 1.30pm at Gateshead Civic Centre.

Chair……..

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