HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 25 July 2017.

PRESENT: Councillors E Dryden (Chair), A Hellaoui, J McGee, G Purvis and M Walters

OFFICERS: C Breheny, E Kunonga, T Parkinson and E Scollay

APOLOGIES: Councillor C Hobson and B Hubbard

ALSO IN ATTENDANCE: Councillor J Young
Amanda Hume – Chief Officer South Tees CCG
Kathryn Warnock – South Tees Integration Programme Manager

1 ****DECLARATIONS OF MEMBERS' INTERESTS**

There were no Declarations of Interest made by Members at this point in the meeting.

2 ****MINUTES**

The minutes of the Health Scrutiny Panel meeting held on 28 April 2017 were approved as a correct record subject to the following amendment:-

That the approved scrutiny topic of the health needs of school age children with particular reference to obesity and dental health be amended. The review topic identified for 2017/18 was the health needs of school aged children and any particular focus would be identified following the initial 'Setting the Scene' presentation by Public Health. The Director of Public Health advised that the department was currently in the process of producing the Children and Young People Strategic Needs Assessment and it would be an opportune time for the panel to focus on this topic.

3 **THE DDTHRW SUSTAINABLE TRANSFORMATION PARTNERSHIP**

The Chair introduced those present and explained that there had been considerable confusion nationally in respect of the STPs. It had been difficult to gain an understanding on what STPs were, information provided had been on an ad-hoc basis and only recently had it been advised that Sustainable Transformation Plans had now evolved into Sustainable Transformation Partnerships.

The Chief Officer at South Tees CCG confirmed that a presentation on the STP had been prepared in advance of the meeting to provide some background information for all Members. It was confirmed that the South Tees CCG's attendance at today's meeting was to answer questions on the STP that were of the greatest importance to the panel.

In brief the STP was a group of organisations coming together to plan what health and social care services should look like in the future and how they could be delivered both differently and collectively. Health and Social Care Services in South Tees had been working in partnership for many years through the development of the IMPROVE programme and partnership working was not something new. The handling of the STP process nationally, if anything, had knocked the collaborative work taking place locally off balance through the noise, confusion and mistrust created. Reference was made to the closure of the Carter Bequest Hospital, as a result of this work. The Chief Officer at South Tees CCG advised that funding previously spent on very old community hospitals had been reinvested to support people at home in a completely different

way. It was advised that significant progress had been made in respect of collaborative working, although there remained a lot of work to do. The focus to date had been on the vulnerable and elderly and there was a need to expand the progress, which had been made, on a bigger footprint.

The geography of the STP was determined nationally because of the acute reconfiguration work taking place as part of the Better Health Programme, which was again in existence before the STP. The way in which patient flow for secondary care worked meant that the BHP agenda needed to be managed on a bigger geography. The view of clinicians supported by clinical senators had been that for the delivery of clinically specialised care a relatively small number of professionals needed a critical mass of patients. This view had been further developed over the last few years and in order to ensure a sustainable acute sector reconfiguration was needed. The BHP had further confused matters and the geography of the STP had also been amended since inception, as originally North Durham had been included in the DDTHRW STP. However, patient flows in North Durham were quite different and therefore changes to the footprint had been made. The complexity of patient flow were emphasised and although originally the plans may have represented the best configuration for that geography it would not have worked for staff at a local level. With regard to primary care and how GP community services were delivered / the development of GP community hubs was continuing to take place at a very local level.

The Chair made reference to the headline issues including the potential downgrading of A&E departments locally and the impact the STP would have on JCUH. The Chief Officer at South Tees CCG expressed the view that the headlines tended to focus on buildings but the real issue was around securing sustainable services and improving them. In an effort to keep patients at home for longer with only very short periods of acute care. In response to a query from the Chair it was advised that the STP was not at a stage to quantify the impact on JCUH or commence any formal consultation process. It was a myth that the STP was further ahead than it was. At this stage agreement was around the fact that the delivery of services in the future needed to change and be quite different from how services were delivered at present. Workforce pressures meant there was not projected to be the specialist skill sets required in every hospital and nor was it clinically the best option. In the future A&E may not be referred to as A&E, as hospitals could not sustain 24/7 emergency cover by Consultants to deal with major traumas at every centre. Clinically care could not be delivered safely if the practice continued. However, much of what is currently provided through an A&E department will continue to be provided locally.

The Chair queried whether residents in Middlesbrough would continue to be in a position to access services they could reasonably expect from their local hospital following acute reconfiguration. The Chief Officer at South Tees CCG advised scenarios were currently being modelled with consideration given to the potential impact changes in one area may have on another. At present the STP was not in a position to outline any options but it was accepted there was a need to come up with a better offer. The point was made that from a health perspective residents in another area, Hartlepool for example, should not be in receipt of worse service provision than residents in Middlesbrough. It maybe the case that in the future people have to travel further for treatment but they should not have to travel far. It was advised that JCUH was the most stable part of the system, which was unlikely to change. JCUH was already a major trauma centre with the infrastructure to provide care across the spectrum, from highly specialist urgent care to lower level planned service provision. It was advised that the possibility of more planned, routine care being delivered elsewhere such as at the Friarage or University Hospital North Tees was being explored as part of the STP.

It was not envisaged that there would be a scenario where JCUH would separate out planned and emergency care. However, every winter planned operations were cancelled in order to deliver emergency care and a better balance was needed for all patients. At present various scenarios were being modelled and these were some of the issues the STP was grappling with. The point was made that the whole of health is changing constantly, services previously delivered in clinics were now being delivered elsewhere and service provision was changing across the board.

Reference was made to the potential issues arising as a result of delayed discharge for patients treated outside of Middlesbrough when there were already issues with patients receiving treatment at JCUH. The point was made that this needed to be planned through and careful thought needed to be given to how it would work in practice. It was advised that the majority of problems arose in respect of emergency care. If the vast majority of care was planned it was possible to align Health and Social Care systems to ensure that a patient's discharge was planned at the point of admission. It was emphasised, however, by the Director of Health and Social Care Integration that it remained easier to discharge patients the closer they were to home. Often effective discharge planning relied on the strong working relations between colleagues in Health and Social Care. The further from home an individual received treatment the more challenging the discharge arrangements.

The Council's Chief Executive advised that from his perspective it was frustrating that more information was not known or shared in respect of the future acute reconfiguration proposals. The Local Authority was currently budget planning until 2020 and the Chief Executive was keen to head off any future problems around discharge. The Council's budget planning needed to be undertaken in parallel with the STP and the Council needed to influence what the future acute care model incorporated. Given there would be a heavy reliance on Social Care and Public Health service provision more information was needed in order to design a whole system approach to meeting the flow of demand. The point was made that the STP process was intended to address people's behaviours and change the culture around dependency on health service provision. However, the point was made by the Council that the same level of demand would still be present, different types of people would potentially be causing that demand and it would fall on different services i.e. outcomes would be reliant on Social Care and Public Health. The Chief Officer at the CCG advised that all organisations had to work together to ensure the plan was right. It was again emphasised that the focus on this issue was continually drawn to hospitals and buildings, which was not the primary purpose of the STP. It was about collectively managing the demand in the system. The Chief Executive expressed concern, however, that the larger the footprint the more complex the system would become.

Reference was made to the recent outstanding assessment awarded to the DDTHRW STP by NHS England and NHS Improvement in respect of performance across the DDTHRW footprint. The point was made that as a health community the footprint delivered to a high standard on, for example, A&E services. However, the preventative element and health needs of the population were not considered in the assessment matrix. Had they been included the findings may have indicated that support was needed in terms of investment. The point was made that irrespective of where people would receive care it was emphasised that, in the future, there would be a higher demand on acute residential and nursing care provision. In response to these points the panel queried the plans to address the extra care demand that would be placed on the care home / nursing care providers. The Council's Chief Executive stated that at present these demands were not being modelled and it would be too late once budgets had been approved. The point was made that a joint vision needed to be articulated. However, at present it was very frustrating for partners, as the STP remained NHS led when the issues faced were much broader than health.

A Member of the panel expressed the view that in order to be in a position to articulate a joint vision the Council needed to be a part of that vision. Consideration also needed to be given to how that vision translated into reduced health inequalities in Middlesbrough, what the offer was around the preventative agenda and what real difference any proposed changes would make. Health, Social Care and Public Health would all be involved into translating the vision into better health outcomes for the town. The Chief Officer at the CCG stated that as the accountable officer for the CCG she was operating within the broader agenda but a significant part of her budget was spent on acute care. From a South Tees perspective the CCG was committed to developing a joint vision. In terms of the town as a whole, what was needed was significant investment in health prevention and early intervention, as the acute aspect represented a very small element of the system. The point was made that the system needed to be built from the bottom up. The danger, however, was that the negative perceptions around STP had side swiped the rest of the work taking place locally.

The Chair queried how as a panel we could have some control over the agenda rather than simply being pushed along. Middlesbrough did not want to be left with problems that could have been addressed earlier. The question was put to the Chief Officer at South Tees CCG as to whether she would be happy to spend elements of her budget in another Trust area. It was stated that the budget for which she had responsibility was for the South Tees population. At present the position reflected the fact that people were becoming reliant on emergency service provision owing to the fact that services had not intervened earlier.

Reference was made for the need to continue to reduce the amount of activity taking place in a hospital setting, which could be better provided elsewhere. At present a very medical model of care was in place and yet often a clinical intervention was not what was needed. A more holistic approach in respect of the individual’s needs was required. The Chair queried as to what work was taking place in the South Tees that would be beneficial to this objective. It was advised that integration and action work was taking place. In respect of what were the risks associated with this work it was advised that there was a risk that the STP process could jeopardise the work undertaken to date and propose a completely different model. The Council’s Chief Executive advised that in his capacity as the Chief Executive Lead on the STP Board he had written to the NHS STP Lead in respect of his concerns. The letter had stated that from a local authority perspective there were issues with the way the STP was operating. The Chair expressed the view that it would be beneficial for the Council’s Chief Executive in his capacity as the Chief Executive Lead on the STP Board for South Tees to attend a meeting of the Joint DDTHRW STP Overview and Scrutiny Committee and present on these issues. The Chief Executive confirmed that he was available to attend, although he would not be able to provide the STP Lead’s perspective. The point was made that at present the Council and South Tees CCG were relatively small organisations trying to have an influence but the agenda felt very much dominated by the acute sector. NHS England had recently also outlined ambitions for STPs to evolve into ‘accountable care systems’ (ACS). The DDTHRW STP could therefore potentially be incorporated in a North East and Cumbria ACS. The influence of individual Councils and CCGs would further decrease as the footprint widened.

In response to a query from the Chair the Chief Officer at the South Tees CCG advised that there were no plans, from a commissioning perspective, to commission any additional private sector capacity. The question was posed as to what areas from the Joint STP OSB Board’s perspective should Members be focussed on. The following aspects were highlighted:-

- The Programme Board for the STP needed to be strengthened in terms of Local Authority voice. The Chair of the Adults Safeguarding Board had recently been appointed to the STP Board.
- The home care / nursing care market was vulnerable and the STP was struggling to grasp the significance of the provider market.
- A greater and more complex demand would be placed on the independent care sector and it would take time for the market to develop.
- Quality jobs were needed in the home care and nursing care. However, local authorities across South Tees had very different views on homecare payment rates, with Middlesbrough paying higher rates than others.
- Accountability needed to be further developed and a clear understanding of membership of the STP Board, meeting arrangements and the body it was accountable to was needed. The Chief Executive expressed the view that the STP Board should be accountable to the Health and Well-Being Board.

In terms of resourcing reference was made to the possibility of joint funding and how that could potentially operate at a local level. It was advised that the Better Care Fund had been developed on this premise and had worked relatively well. In terms of the STP the bottom line was the STP was a complex process.

The Chair queried what would happen if people from North Tees come into South Tees for treatment. The Chief Officer at the CCG advised that the modelling activity taking place had highlighted that the current model of service delivery was not the right model. For example approximately 30 per cent of people accessing A&E services were not in need of the service they accessed. Sustained efforts were being made to reduce inappropriate demand but it was acknowledged that as of yet there had been no significant reduction in demand. The view was expressed that this situation could start to change if there was a will to deliver services differently.

Reference was made to the Public Health Grant and the Panel was informed that the Council had confirmation of funding for one more year. However, after that period Public Health would be funded through business rate retention. At present the Council collected less than it was given and Middlesbrough retained approximately 49 per cent of business rates. The proposal was for the Government to provide a safety net payment. However, the payment could be £3m less than what was needed. It was therefore unknown as to the amount of business rates that would be retained by Middlesbrough Council.

The point was made that one of the opportunities presented by the STP was the possibility of adopting a whole system approach and there was nothing preventing Health, Social Care and Public Health deploying those resources in the broadest sense. If the intention was to reduce acute admissions some tough decisions would need to be made and everyone had to work within the resources available.

It was also advised that in some areas, for example, South Tees CCG were spending more money than other CCGs, with similar benchmarked populations, on delivering the same type of services / operations. There was a need to establish the reasons for such differentials and what action could be taken to reduce them. The point was made that the entire predication of the STP was around the transference of funding from the acute sector to the community sector. If service delivery continued in its current form the NHS would continue to fund a revolving door. The Chief Officer at South Tees CCG stated that brave and bold action needed to be taken. It was confirmed that the financial assumptions detailed in the STP were based on the growth and funding anticipated over the STP period. The £281m gap in funding was the shortfall projected

if transformational change was not achieved. The Council's Chief Executive expressed the view that the figure should be set higher, in the region of £300m, as the additional funding needed to be invested in the community sector. Based on financial calculations the larger the footprint the bigger the financial gap would become.

Reference was made to the use of language and it was advised that from the Council's perspective 'Community Services' incorporated Homecare and the Prevention Agenda whereas from the STP's perspective these were not 'Community Services'. It was acknowledged that to date the STP had very much been a health driven initiative, which now needed to be considered from a different perspective.

Clarification was sought around the information contained in the section of the STP entitled 'System management – Financial flows, contracting mechanisms and commissioning.' The documentation stated that the STP was working towards a 'capitation based approach' across the system. The Chair expressed the view that such an approach represented a fundamental change compared with the current payment by results (PBR) tariff system. A budget based on population figures, whereby Middlesbrough received the same amount of funding per head of population such as Richmond for example, was extremely concerning. The STP also made reference to the major upskilling of the preventative agenda, and yet the assessment matrix adopted by NHS England and used in the recent STP assessment made no reference prevention. The comment was made that if a capitation budget approach was adopted all organisations, which made up the STP, would have a shared responsibility to make the biggest difference.

It was stated that at present the biggest demand on acute service provision was from the elderly. The Chief Officer at South Tees CCG stated elderly people should not be waiting around in A&E. Work was currently being undertaken in partnership with South Tees Hospitals NHS Foundation Trust to develop a frailty unit, as it was widely acknowledged that an elderly person's independence deteriorated significantly following a hospital stay, and this also impacted on Social Care provision. The view was expressed that a range of different care options needed to be available.

In terms of the South Tees integration work it was explained that there were a whole range of projects and programmes taking place, which each of the four leads oversaw. The Council and South Tees CCG jointly managed the Better Care Fund (BCF) across South Tees and although the BCF sat with the Council, the CCG had to sign off on any expenditure. A single point of access had been established and a significant amount of work was taking place.

The Chair made reference to the areas of focus on which the panel wished to concentrate and the following were highlighted:-

- The STP from a Local Authority perspective (to be considered by Joint OSC)
- 'Major prevention upscaling' in Middlesbrough
- Addressing issues in the independent nursing care market
- The implications of the BHP / scale of change
- The South Tees Integration Programme
- Understanding a capitation based budget approach

The point was made that the Lead Officers around the table were very clear about the work that needed to be undertaken and the Council and South Tees CCG had developed very good working relationships. It was acknowledged, as with all partnerships, there were times when they did have different and sometimes conflicting imperatives.

AGREED as follows:-

1. That copies of the presentation prepared by South Tees CCG on the STP be distributed electronically to all Members.
2. That the Chief Executive be invited to a meeting of the DDTHRW STP Joint Overview and Scrutiny Committee (OSC) to present on the challenges facing the STP from a Local Authority perspective.
3. That information be provided by Public Health on the prevention strategy for adults and older people 2017-2020.
4. That an invitation be extended to the STP Lead Officer to present on the implications of the BHP, the political impact, the scale of change and Obstetrics, Paediatricians and workforce generally.
5. That an invitation be extended to all South Tees leads to advice on the integration work taking place across South Tees.
6. That the Chief Officer at South Tees CCG be invited to attend a further meeting to discuss the implications of moving towards a capitation budget approach.
7. That a letter be drafted for approval by the Council's Executive on the potentially catastrophic impact of funding Public Health expenditure through business rate retention.