MIDDLESBROUGH COUNCIL

DRAFT FINAL REPORT OF THE HEALTH SCRUTINY PANEL

- VULNERABLE AND FRAGILE HEALTH SERVICES: FUTURE SYSTEM INTEGRATION

CONTENTS

AIM OF THE INVESTIGATION – PROGRESS MOVES AT THE PACE OF TRUST

1. The aim of the investigation is to ensure the lines of communication in respect of vulnerable health services locally remain open.

2. In 2018 the Care Quality Commission's (CQC) annual assessment on the state of health and social care services in England stated that, the urgent challenge for Parliament, commissioners and providers is to change the way services are funded, the way they work together, and how and where people are cared for. The alternative is a future in which care injustice will increase and some people will be failed by the services that are meant to support them, with their health and quality of life suffering as a result.[1]

3. The Health Scrutiny Panel is keen to ensure that irrespective of the challenges facing the health and social care sector Middlesbrough residents are supported by a health and social care system that works collaboratively, effectively and efficiently.

MAYOR'S VISION

4. The scrutiny of this topic fits within the following priority of the Mayor's Vision 2025[2]:

    - Fairer – Fairness and reduced inequalities in income and health – we will work with local communities and partners to better integrate local health and social care services to help local people live longer and healthier lives and reduce inequalities in health outcomes.

COUNCIL'S CORE OBJECTIVES

5. The scrutiny of this topic also aligns with the following core objective as detailed in the Strategic Plan 2017-2021[3]:

    - Social Regeneration – we will work to improve local health and well-being and reduce health inequalities within the town, focusing particularly on self-care, community led prevention and early intervention.
    - - we will join up health and social care, working with partners (including education providers) to keep children and adults healthy, avoid admissions to hospital and improve care once people are discharged from hospital.

TERMS OF REFERENCE

6. The terms of reference for the scrutiny panel's investigation were as follows:

    a) To gain an overview of health services commissioned provider contracts due for renewal in 2018/19 and 2019/20.
    b) To examine progress made to date and challenges still to overcome in respect of health and social care integration.
    c) To consider the potential impacts of reductions in Public Health funding on local service

[1] The state of health care and adult social care in England 2017/18, Care Quality Commission, October 2018

[2] Middlesbrough 2025 – The Mayor's Vision

[3] Middlesbrough Council's Strategic Plan 2017-2021

provision by 2021.

d) To examine the approach taken by other local health and social care systems recognised for having developed a strong collaborative approach.

BACKGROUND INFORMATION AND RESEARCH

7. For nearly a decade, the NHS has experienced a significant slowdown in funding growth, while demand for services – and the cost of delivering those services – has grown rapidly. Cuts to public health and social care funding have added further pressure. As a result, NHS performance has declined. Key waiting time targets are being consistently missed and the finances of NHS providers have deteriorated rapidly; in 2017/18, the year-end aggregate provider overspend was £960 million. Workforce shortages are widespread, with more than 100,000 whole-time equivalent staff vacancies in hospitals, including more than 40,000 nurse vacancies. Last year's winter crisis – the effects of which were still being felt well into the summer – underlined the fragile state of the service.[4] The Kings Fund has stated workforce shortage are currently the biggest challenge facing the health service.

8. The funding challenges detailed above are well known and in June 2018 the government announced an extra £20.5 billion funding for the NHS by 2023/24. The NHS Long Term Plan was launched in January 2019 and set out the priorities for how this money will be spent over the next 10 years. However, no similar long-term funding solution for adult social care has yet been announced.

9. In 2016/17 the CQC stated that a number of services had in effect reached 'a tipping point', whereby options to consolidate provision and decommission services would have to be taken.[5] For the panel this led to the question as to which of our local health services are deemed the most vulnerable and what are the difficult decisions that will need to be taken locally about consolidating and decommissioning 'vulnerable and fragile' health services over the next few years.

10. In the CQC's 2017/18 annual assessment of health and social care in England[6] it was stated that good, sustainable care is no longer just about whether individuals can deliver good care, but whether they can successfully collaborate with other services as part of an effective local system. Middlesbrough Council, STH NHS FT, STCCG, TEWV, NEAS and the VCS all have key roles to play in this process. In reaching its conclusions the CQC considered five factors that affect the sustainability of good care for people. These factors are as follows:-

    1. **Access to care and support**
    2. **Quality of care for people**
    3. **Workforce to deliver care**
    4. **Capacity to meet demand**
    5. **Funding and commissioning**

11. These factors have been considered as key reference points throughout the review.

[4] The NHS long-term plan explained – The Kings Fund, 23 January 2019

[5] The state of health care and adult social care in England 2016/17, Care Quality Commission, October 2017

[6] The state of health care and adult social care in England 2017/18, Care Quality Commission, October 2018

TERMS OF REFERENCE A) TO GAIN AN OVERVIEW OF HEALTH SERVICES COMMISSIONED PROVIDER CONTRACTS DUE FOR RENEWAL IN 2018/19 AND 2019/20

Funding and Commissioning

12. In 2018/19 STCCG was required to produce a financial recovery plan and generate savings of in the region of £20m. STCCG agreed with NHS England that it would close the year with a deficit but will gain access to a national pot of funding (Commissioning Sustainability Funding) if not overspent by more than £5m by 31 March 2019. If this is achieved NHS England will provide STCCG with the additional resources to cover the shortfall.

13. The questions for scrutiny have been how will achieving these target savings impact on Middlesbrough residents? Will the approach taken be one whereby STCCG will cut a fraction from a whole range of different services or will large savings be made in certain areas, where perhaps a service will be lost to save in the region of £5m rather than shave off smaller amounts across a number of areas? Do more savings need to be found from 1 April 2019 and if so have any proposed budget savings been drafted?

14. Traditionally CCG's generate efficiency savings through demand management. Where there is no clinical benefit in an individual having an outpatient appointment or clinical procedure undertaken a suitable alternative will be encouraged. Opportunities to reduce expenditure are also explored when contracts come to an end. The majority of contacts held by STCCG are in place for between 1 and 3 years and a copy of STCCG's contract register is published on their website.

15. ST NHS FT is STCCG's largest provider and there are a range of other providers from which services are commissioned, including both the independent sector and VCS. In terms of 'fragile and vulnerable services' there are a number of different definitions. Currently across the North East rheumatology and breast services are, for example, perceived as fragile services. These services are fragile not because commissioners do not want to commission them, but because providers do not necessarily have the trained staff available to provide services from all the locations from which they are currently delivered.

16. A number of the other key services include:-

    - **Urgent and Emergency Care**
    - **Paediatric, Maternity (Gynaecology modelling interdependencies)**
    - **Elective care: Spinal; Breast; Urology**
    - **Frailty services**
    - **Stroke services**

17. There are also difficult dilemmas around the provision of discretionary services, whereby more support is provided to an individual than absolutely required in law. The local authority is not immune from these difficult dilemma's either.

18. In respect of solving the difficult dilemma's and considering areas of service provision that may need to be reduced the solution is not 'black and white'. STCCG is looking at areas

where there is a potential that STCCG is duplicating provision through a range of different contracting arrangements. For example, STCCG has a block contract in place with TEWV, the mental health service provider. However, STCCG also funds individual packages of care that are in place through Continuing Health Care (CHC) where the CCG works with its local authority colleagues around understanding an individual's needs and then funds the care to meet those needs. There are times when the package of care put in place duplicate a service that STCCG commissions via its block contract arrangements.

19. In terms of contracting STCCG predominately uses the single contract framework, which is an NHS standard contract used nationally. If key performance standards are not met there are mechanisms in place to introduce break clauses. STCCG can issue 6 / 12 month notice periods, whereby if a provider is unable to recover their performance sufficiently the contract can be revoked. Reference was made to the significant safety concerns raised by the CQC around the out of hours' service. STCCG worked with the provider, ELM Alliance, to improve the provision. In doing so STCCG issued a contract notice and had the provider been unable to improve the offer to patients the contract would have been withdrawn. The CQC has since revisited the out of hours' service and significant improvements have been made.

20. In terms of the savings made to date of approximately £8m, the bulk of those savings have been achieved through the signing of the aligned incentive contract (AIC) between STCCG and STH NHS FT of which the annual value is £228m. The remainder will be achieved from a number of different sources including:-

    - £4m - £6m waste prescribing
    - £4m Continuing Health Care
    - £3.7m NHS England Commissioning Sustainability Funding

21. The most significant change in respect of the aligned incentive contract relates to how as an organisation STH NHS FT interacts financially with STCCG; the performance and quality measures remain the same. The basic premise of the aligned incentive contract is for STH NHS FT to evaluate with STCCG the total sum of money available, to consider collectively the pressures in the system and establish the best way of allocating the South Tees pound.

22. Financial savings have been made at STH NHS FT through the introduction of the AIC, given there is no longer a need for STCCG and the FT to challenge one another in respect of costs. Previously, the internal market created uncertainty in the system, which impacted on the Trust's financial assumptions and could delay payments to suppliers. The aligned incentive contract affords a degree of certainty in respect of cash flow for the Trust in 2018/19.

23. In recent years ST NHS FT has been unsuccessful in achieving its financial control target. However, in 2018/19 productivity and efficiency savings of £35.6m have been identified and in total £33.9m of savings have been delivered. These savings include a number of one-off savings linked to PFI funding and ST NHS FT plan to deliver a further £1.7m worth of savings for 2018/19. In terms of the national picture 163 out of 230 providers are reporting a deficit. This equates to 92 per cent of the acute sector.

24. It is evident that the establishment of the aligned incentive contract locally has served only

to incentivise STH NHS FT, STCCG and GP's to work more collaboratively. In the past one of the issues with the internal market has been that on occasion the financial incentive for STH NHS FT to generate income inhibited the development of the most appropriate clinical pathway. For example, local GP's previously put forward a suggestion that seeking advice from Paediatricians via telephone would be clinically beneficial for their patients. However, the financial impact for ST NHS FT was estimated to equate to approximately £1m per annum and therefore the proposal was not pursued.

25. Equally, there has been a perception amongst CCG's nationally that often acute Trusts would 'up code' activity and apply the highest tariff. Increasingly CCG's had been challenging the treatment costs, as submitted, in response to their own budget reductions. The real issue across the Tees Valley, as in other parts of the UK, is that there is simply not enough money in the health system. There are also difficulties in terms of what services are provided across different hospital sites.

Waste Prescribing

26. In 2017/18 STCCG spent more on prescribing than any other CCG in the North East of England. Consideration therefore needs to be given as to whether current prescribing levels are appropriate, whether patients being prescribed with drugs are making use of them and if alternative options could be considered. STCCG's expectation is that £4m can be saved from the prescribing budget in 2018/19, although it is hoped that up to £6m can be achieved.

27. The remaining savings will be drawn from a range of different areas. For example, STCCG invests more in primary care than any other CCG in the North East, which includes funding for the recently established out of our hour's hubs. Continuing Health Care (CHC) spend has also continued to increase and growth in CHC costs is outstripping the savings achieved in other areas. CHC is fundamentally about the total cost of health and social care services which support an individual. It was acknowledged that although there are disagreements at times between STCCG and Middlesbrough Council in respect of CHC, a legal framework in terms of eligibility has to be worked through. STCCG anticipates savings of £4m from its CHC budget in 2018/19.

NHS England - Commissioning Sustainability Funding

28. In terms of STCCG's overall funding allocation it was queried whether a counterargument has been put to NHS England in respect of the level of funding awarded. STCCG advised NHS England that it was not possible to provide all of the services it is legally required to provide within the resources allocated. There has since been an acceptance from NHS England that STCCG's expenditure in response to identified needs in 2018/19 is in effect close to £4m less than its fair share allocation.

29. In relation to areas of disagreement between health and social care services reference was made to section 256 arrangements. These are agreements whereby the CCG has a contract with the Local Authority for it to commission services on the CCG's behalf. Various arrangements are in place and the initial action taken by STCCG in respect of reviewing those arrangements had been less considered than it may have been. However, the narrative has changed in recent months and health and social care are now working much more collaboratively in respect of the 256 arrangements.

30. The concern remains, however, as to whether STCCG will make sufficient progress to access NHS England's Commissioning Sustainability Funding of £3.7m. It was emphasised that health and social care need to work collectively to pull in this funding for the local area. In terms of progress towards the target STCCG advised that it is on target to make the necessary savings.

TERMS OF REFERENCE B) – TO EXAMINE PROGRESS MADE TO DATE AND CHALLENGES STILL TO OVERCOME IN RESPECT OF HEALTH AND SOCIAL CARE INTEGRATION

31. In 2017 a National Audit Office (NAO) report concluded that nearly 20 years of initiatives to join up health and social care by successive governments has not led to system-wide integrated services[7]. In July 2018 a further NAO report entitled '*The health and social care interface*' stated that more joined-up health and social care offers the prospect of saving money across the whole system, in the longer term. However, while there is a lot of good work being done nationally and locally to overcome the barriers to joint working, this is often not happening at the scale and pace needed. The report highlights 16 financial, cultural, structural and strategic issues that hinder progress.[8]

32. These are detailed as follows:-

Financial challenges

- Both the NHS and local government are under financial pressure, which can make closer working between them difficult. This could deter organisations in partnership from seeking system-wide benefits that may be detrimental to them as individual organisations.
- Short-term funding arrangements and uncertainty about future funding make it more difficult for health and social care organisations to plan effectively together.
- Additional funding for health and social care has at times been used to address the immediate need to reduce service and financial pressures in the acute sector.
- Current accountability arrangements, set by legislation, emphasis the need for individual organisations to balance their books.
- Different eligibility requirements for health and social care make it difficult to plan services around the needs of the individual.

Cultural and Structural

- Traditional boundaries between the NHS and local government, and between individual organisations within these sectors, lead to services being managed and regulated at an organisational level.
- The NHS and local government operate in very different ways, and can have a poor understanding of how the other side's decisions are made.
- Complex governance arrangements are hindering decision-making within local health and social care systems.
- Problems with local leadership can destabilise or hold back efforts to improve

[7] Health and social care integration, National Audit Office, February 2017

[8] Health and social care interface, National Audit Office, July 2018

working across health and local government.

- The geographical areas over which health and local government services are planned and delivered often do not align, which can make it difficult for the relevant organisations and their staff to come together to support person-centred care.
- Problems with sharing data across health and social care can prevent an individual's care from being coordinated smoothly.
- New job roles and new ways of working could help to support person-centred care, but it is difficult to develop these because of the divide between the health and social care workforces.

Strategic Issues

- Differences in national influence and status, as well as public misunderstanding of how social care is provided and funded, have contributed to social care not being as well represented as the NHS.
- Organisations across a local system may have misaligned strategies, which can inhibit joint local planning.
- Central government in the past had unrealistic expectations of the pace at which the required change in working practices can progress.
- Progress to date has demonstrated that joining up health and social care can support a greater focus on preventative services and the wider determinants of health.

33. There are varying degrees of sophistication in respect of the different approaches adopted nationally to health and social care integration. In other parts of the region, for example in Durham, which is further ahead in terms of system integration an integrated commissioning plan is in place. The plan has been developed by health commissioners, local authority commissioners (including representatives from both adult and children's social care) and local public health officials.

34. In terms of integration in other parts of the UK reference was made to North East Lincolnshire, where a place based plan for health and social care services has been developed. The point was made, however, that although North East Lincolnshire deliver the elements contained in their joint commissioning plan very effectively they are unable to deliver any additional services and therefore caution needs to be exercised. The view was also expressed that the boundaries of Council's directorates should not be too rigid, as work undertaken in adult social care has cross cutting benefits in other areas. Equally there are actions that can be taken in the Growth and Place directorate that can positively impact on health and social care services. There is also a risk that through closer integration with external organisations you can lose a degree of integration already established within your own organisation.

35. The importance of broader health and well-being integration was also emphasised. The point was made that by closely integrating health and social care services exclusively there is a risk that opportunities available to involve other key stakeholders involved in the wider determinants of community health and well-being can be missed. Services can become geographically integrated but not locally integrated. In addition there are different population groups that require different forms of service integration. For example, those individuals with multiple and complex needs including substance misuse and

homelessness place very different demands on an integrated health and social care system than a frail and elderly individual.

36. The difficult dilemma from a local authority perspective is trying to find opportunities around integration while managing the risk associated with the challenges facing the health service both financially and in terms of restructuring. Finding opportunities for closer integration whilst simultaneously balancing risk is a difficult tightrope to walk. There is also the question as to where we are regionally on the journey to developing an integrated care system? Will, for example, more decisions be made on a regional basis? How will the newly appointed Chief Clinical Officer and Chief Operating Officers of the 5 CCG model be held politically accountable? What new governance structures will be in place and are those structures robust? Health scrutiny is itself a real challenge at present in terms of where attention needs to be focussed; Members are scrutinising a moving feast.

37. In terms of system integration another concern is that NHS England is a very hierarchical organisation to which CCG's are directly responsible. In contrast Local Authorities have a much greater degree of autonomy. Despite health being talked about in this context as a single body, there is also a real need for increased inter health integration to take place prior to further integration of health and social care. The challenges patients face in transition between primary and secondary care and even within secondary care are testament to this requirement. If, for example a patient requires specialist services in Newcastle or Leeds there are a number of different tiers, in terms of the commissioning arrangements, in place. Specialised commissioners are responsible for commissioning those services outside the remit of local CCG's and there is a need for more integrated health commissioning.

38. In terms of proposed changes to acute service provision where there have been proposals to make significant changes residents are the most vocal. The NHS inevitably undertakes increased engagement in the area affected. In the previous round of proposals, for example, where the possibility of Darlington losing their local district hospital was mooted significant NHS activity was undertaken and the politicians were extremely vocal.

39. The risk locally is that although JCUH will certainly remain as an acute hospital site individuals services may gradually be moved to other hospitals without consultation. Health scrutiny needs to ensure the NHS remains accountable even if JCUH as a site is protected. The Council needs to understand the impact of any additional specialist services being delivered at JCUH hospital, as well as the impact on our residents of having to travel out of Middlesbrough to access services previously delivered at JCUH. There will always be plenty of activity at JCUH, however, it will only take relatively small changes in the structure at JCUH to have a disproportionately large impact on the provision of adult social care services in Middlesbrough.

South Tees Integration and the Better Care Fund (BCF)

40. The vision for South Tees Integration involves South Tees working together to promote health and wellbeing, reducing dependency and minimising the need for ongoing care. Ensuring our citizens are well informed and can access the right services at the right time, in the right place. This vision will be achieved through maximising integration opportunities,

great partnership working and a real focus on prevention and sustainable outcomes.[9]

41. The aim by 2020 is to create a health and social care support system where:

- Services and pathways are designed around people's needs;
- Traditional barriers between primary, acute, community and social care are broken down and better coordinated care is provided;
- Barriers around accountability, information, incentives and time are removed;
- Care is brought closed to home;
- Traditional Information technology is best used to its best effect to integrate systems, records and information;
- Capacity is increased by extending access, eliminating waste by reducing hand offs, duplication and making the best use of all health and social care resources i.e. the best use of the South Tees Pound (£);
- There is a cohesive, whole system planning and commissioning through aligned teams and pooled budgets arrangements.
- There is a more holistic, lifelong and seamless people centric approach to health and well-being, rather than illness.

42. South Tees integration is not about cost shunting or removing individual responsibilities but ensuring the best use of the South Tees pound. In terms of integration 4 projects were identified, which have been worked on to help alleviate the financial and demand pressures and help organisations move closer together. The 4 projects are as follows:-

- Keeping People Healthy
- Admission Avoidance
- Discharge Home
- Out of Hospital Care

43. Each project has a senior lead officer assigned and these include the Council's Director of Adult Social Care and Health Integration, the South Tees Director of Public Health, the Director of Policy and Operations at South Tees CCG and the Director of Adult Care and Health at Redcar and Cleveland Borough Council.

Keeping People Healthy - Reduction in people developing long term conditions

44. STH NHS FT employs 9000 staff and a quarter of Middlesbrough's population visits JCUH each year. It is about capturing that audience and engaging them in choosing to live a healthy lifestyle. Work is also being undertaken with the college and university to develop an ExtraLife package for staff, students and residents, which is again focussed on health promotion and positive wellbeing.

45. The question now is how Public Health can work with other local agencies to promote that same message, especially with services / organisations that people have a relationship with and have the ability to influence them to make positive changes and healthy lifestyle choices. Public Health campaigns operate from the Live Well Centre with the aim of maximising awareness raising for residents. It is intended that the Live Well Centre

[9] Better Care Fund (BCF) Plan 2017/18 -2018/2019

becomes a single, trusted source of information and that information provided by the Centre is standardised and recognisable.

46. Another area of focus relates to the ability for services to take preventative measures where there is evidence of risk. For example, the wave 3 national diabetes programme is now in operation and allows for people to have earlier tests, which means they can be provided with information as to whether they are at risk of diabetes earlier. A new programme was also launched in 2018 in respect of prehabilitation work, in partnership with Primary Care colleagues to ensure people are well supported. It maybe that in advance of their operation they have a social need, which needs to be met, for example they maybe socially isolated or affected by fuel poverty. Instead of a medical prescription they may need a social prescription. Safe and well visits have taken place in 10,000 homes across Teesside.

Admission Avoidance - Reduction in non-elective admissions

47. Admission avoidance focuses on preventing people from stepping up to access acute health care, as well as supporting them when stepping down. There are also financial benefits to be gained in preventing people from needing higher level care.

48. In terms of step up care it is often the case that an individual may need some form of reablement but not necessarily intermediate care and consideration therefore needs to be given, as to whether it is possible to provide that targeted reablement in a different way. There are 22 intermediate care beds in Middlesbrough and many individuals require reablement support. The purpose of expanding this type of provision is to help people with their physical recovery, with the aim of achieving the maximum benefits from collective resources. Led by Occupational Therapists targeted reablement in the home environment means immediate care can be used as both a step up and step down approach.

49. Reference was made to the high reliance on Care Homes which is an issue Adult Social Care is working to reduce. This is an area where a substantial level of focus has been invested and a pilot was established to highlight some assistance people could receive at home to improve their quality of life. Nurses have undertaken additional visits around care planning and their involvement has resulted in a reduction in Care Home admissions. The majority of this work was funded from pooled budgets and the projects need to be evaluated to assess which have had the biggest impact. This work has been undertaken collectively and will form part of the evaluation to assess if financial benefits can be achieved where reinvestment should take place.

50. Other work in respect of this project focus' on improved nutrition, falls prevention, additional staff training, the patient passport folder and additional work on infection control. 24/7 access to Consultants in A&E is also having a significant impact, as confident / assured decisions are being taken about whether a patient needs to be admitted. The single point of access has been rolled out and health and social care staff are co-located as one team. Work continues to better promote integrated working, which is very much a work in progress.

51. GP feedback and incentives make up the final component of the project and consist of a payment scheme to support GP's. The aim of the scheme is for GP's to offer services above their core service provision, which will assist in reducing hospital admissions.

Discharge Home - Reduction in delayed transfers of care

52. Some of the interventions involved focuses on moving people through the hospital and looking at how services can work together, as part of a Multi-Disciplinary Team (MDT) to ensure the right packages of care are in place at the point of discharge. Discharge to assess and the provision of seven day services are also included as part of the project.

Out of Hospital Care – Reduced dependency on hospital services

53. One of the core priorities for the BCF programme is to target key NHS out of hospital services. There has been additional investment in services which are expected to lead to reductions in acute activity and unplanned admissions. Better Care Fund support has been provided to enable the progression of a number of GP based schemes targeted at supporting primary care to reduce the need and dependency on emergency admissions and attendances. Schemes include GP Urgent Care Scheme, additional rehabilitation beds in community based setting along with Intermediate Care facilities, enhanced (integrated) falls service and enhanced (integrated) rapid response service.

TERMS OF REFERENCE C) – TO CONSIDER THE POTENTIAL IMPACTS OF REDUCTIONS IN PUBLIC HEALTH FUNDING ON LOCAL SERVICE PROVISION BY 2021

54. Nationally there are very high levels of uncertainty on future funding arrangements and funding levels for public health from 2020/2021 onwards. The Government is currently consulting on proposals for business rate retention to commence in 2020/2021 and for that arrangement to include the public health grant. It is not yet clear how the public health element of the proposed arrangement will work, how the resources will be allocated and whether the ring fencing that currently exists for the public health grant will remain. The early proposals for the funding formula, if implemented, would result in approximately a £1m further reduction in the public health allocation for Middlesbrough Council.

55. Beyond next year there is still no clarity around how Public Health will be funded. A few options have been debated and these are as follows:-

Option 1:- One option is to carry on with the current arrangements i.e. the money is ring fenced and awarded to local authorities.

Option 2:- The second option is for Public Health to be funded out of business rate retentions i.e. local areas will retain their business rates and use that to fund Public Health arrangements.

Option 3:- The third option is to redistribute the Public Health grant using a new formula rather than allocate based on historic allocations. If that formula is introduced Middlesbrough will lose in excess of £1m. The formula is based on premature deaths. However, the use of that indicator does not take into account healthy life expectancy for people in Middlesbrough was much lower than in other parts of the UK. Our residents spend a lot of time living with ill health.

56. In 2018 a report by the Kings Fund highlighted that in the most affluent local authorities' residents enjoy a good disability free life up to their early 70s. In contrast in some of the most deprived local authorities people in their late 60s are already in receipt of palliative

care.[10] There is no clarity over which of the 3 options will be favoured, however, this is causing significant concerns for local authorities across the region. If option 3 is introduced 11 out of the 12 local authorities in the North East will be negatively affected. Durham anticipates that it will lose in the region of £20m and Redcar and Cleveland will lose in the region of £3.3m. Pressure on reactive services will only increase.

57. Despite evidence that investment in prevention does lead to better outcomes the current risk is that more preventative services have to be cut in an effort to balance the books in the short term. It was advised, for example, that a service operated by Change, Grow, Live at JCUH to provide additional support to those experiencing substance misuse issues, who are accessing A&E services as a result of those issues, is under threat due to cuts in Public Health Funding.

58. On 12 March 2019 the Executive Member for Adult Social Care and Public Health and the Director of Public Health and Public Protection submitted a report to the Executive entitled 'Public health grant update and proposals for addressing future funding reductions and uncertainty.' The report set out the approach that the Council is taking to respond to reductions in grant funding that will continue to 2020/21.

59. The report highlights that Public health transferred from the NHS to local government in April 2013 and as part of that transfer the Council continued to receive a ring fenced public health grant to deliver statutory public health duties. The 2019/20 public health grant for Middlesbrough was confirmed in December 2018 as £16,344m, a reduction of £443,000 from the 2018/19 allocation.

60. The Council's approach to address the proposed reductions in the public health grant based on the information currently available from the Department of Health and Public Health England is outlined as follows:-

    i. A proposal to bring forward savings from 2020/21 to 2019/20, for transforming drugs and alcohol services and the healthy child programme.
    ii. That the proposed approach to identify and develop four programmes, which planned to develop alternative models of delivery and identify savings from Council services funded from the public health grant, be approved. That further reports, with detailed proposals and recommendations for 2020/21, be received.
    iii. That a letter be sent, by the Chair of the Health and Wellbeing Board (signed by the partnership), to the Secretary of State highlighting the impact of reductions in the public health grant on public health outcomes for the local population

61. The report also details the key milestones for progressing the review of Council services funded from the Public Health grant.

TERMS OF REFERENCE D) – TO EXAMINE THE APPROACH TAKEN BY OTHER LOCAL HEALTH AND SOCIAL CARE SYSTEMS RECOGNISED FOR HAVING DEVELOPED A STRONG COLLABORATIVE APPROACH.

62. In September 2018 the Local Government Association published a series of case studies

[10] What is happening to life expectancy in the UK? The Kings Fund, August 2018

on the integration of health and social care, as part of an evidence review commissioned from the Institute of Public Care. North East Lincolnshire was included as one of the case studies[11] and a copy of the case study can be accessed via the following link https://www.local.gov.uk/integrating-health-and-social-care-north-east-lincolnshire-case-study

63. The NHS and local government in North East Lincolnshire have been working together for more than ten years with a common aim to improve health and care outcomes for their population.

64. North East Lincolnshire is a geographically remote area that has historically been characterised by economic decline and significant health inequalities associated with poverty and poor living standards, leading to a dependency on services. Early commitment to addressing these challenges has centred on a vision to integrate around the whole person, from cradle to grave, to promote healthy living, self-care and prevention. As well as adult health and social care, the integration agenda includes the 0-19 age group, and the broader determinants of health and wellbeing such as public health, housing, education and skills.

65. A shared vision for their 'place', owned across political parties, and led by the 'Union' of the Council and CCG has driven a joint approach to commissioning, service delivery and financing to the point that integrated working is seen as business as usual.

66. The case study offers an example of an advanced whole system approach which has weathered the many changes in the NHS and local government, remaining committed to their core principle that integration is the best vehicle for advancing health and wellbeing.

CUMBRIA AND NORTH EAST (CNE) INTEGRATED CARE SYSTEM (ICS)

67. The NHS Long Term plan states that by April 2021 Integrated Care Systems will cover the whole country. Integrated Care Systems (ICSs) are not statutory bodies or organisations, they have evolved from the 44 Sustainable Transformation Partnerships (STPs).

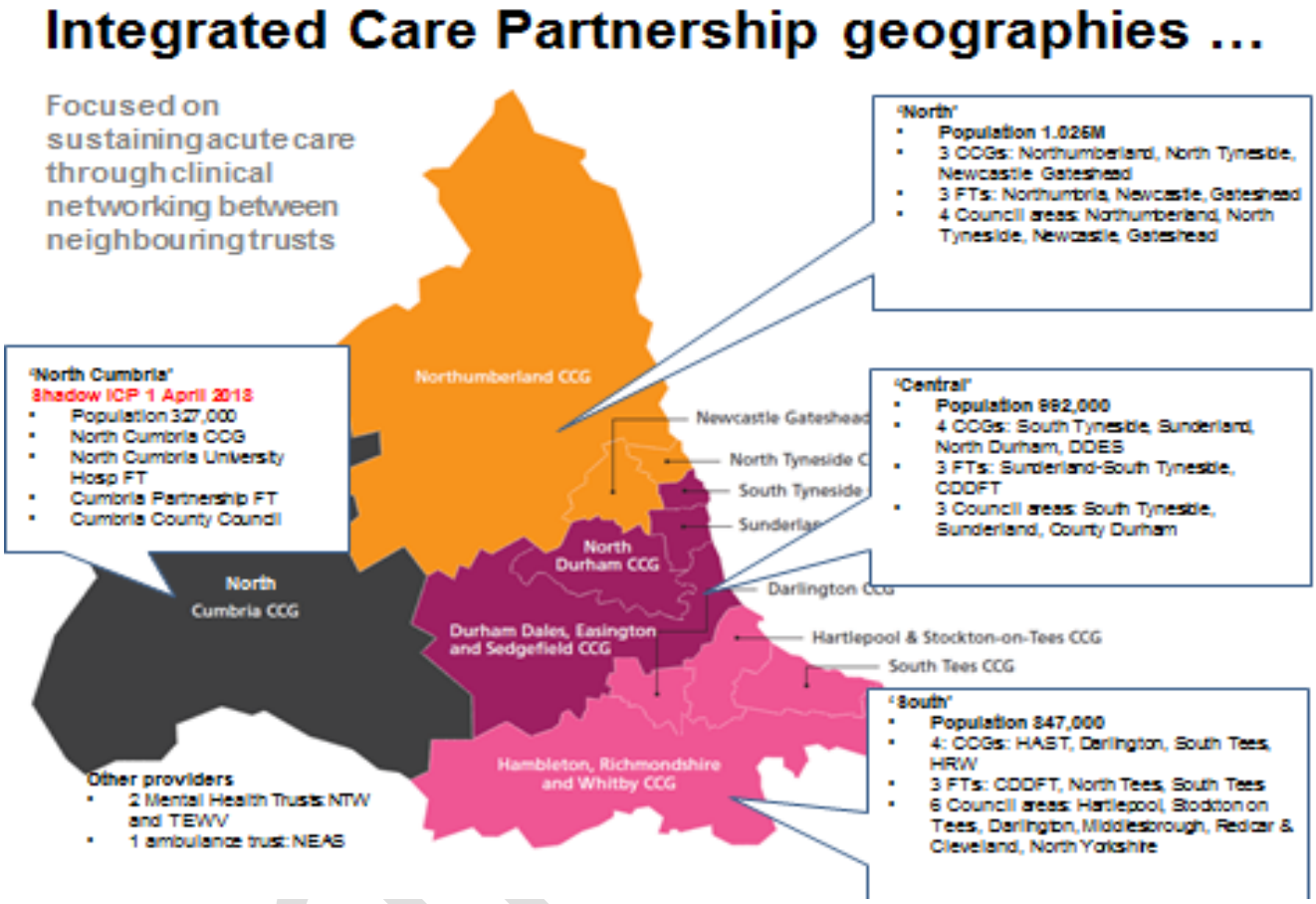
68. The proposals :-
    - The intention is to form a North East and North Cumbria ICS
    - Covering 3.3 million people
    - The region is currently in the 'aspirant' ICS Programme
    - There is the potential for the CNE ICS to formally come into being in April 2019
    - The CNE ICS will be comprised of 4 Integrated Care Partnerships, similar model to Lancashire and South Cumbria

69. The key challenges in CNE:-
    - The key challenges in CNE include the fact that despite having very high performing health services there remain massive inequalities in terms of health outcomes.
    - The gap in life expectancy between the most affluent and most deprived areas had

[11] https://www.local.gov.uk/integrating-health-and-social-care-north-east-lincolnshire-case-study

increased from a 12 year gap to a 14 year gap and overall life expectancy rates are also decreasing.

- There is a real need to increase the disease free length of life for people in our region.



70. Members of the panel attended an event entitled 'Join our Journey; Shaping Health and Social Care', hosted by Professor Chris Gray, Medical Director NHS England (Cumbria and the North East; CNE) at the Riverside Stadium on 30 January 2019. The event was organised by the Academic Health Science Network North East and North Cumbria on behalf of NHS England. The purpose of the event was to enable a wide range of participants from the NHS, Local Authorities and the Voluntary Sector working at grass roots level to review the high level Health & Care Strategy for the Cumbria and North East Integrated Care System.

71. A number of presentations were given at the event including 'Delivering the changes we need' by Professor Stephen Singleton (Cumbria Learning and Improvement Collaborative) and CNE Solutions for Radiology by Drs Elizabeth Loney and Anne Anstee.

72. Feedback from the event has since been reviewed, validated, prioritised by NHS England and will be fed into existing clinical/non-clinical strategies, where appropriate. It is also being used to create a set of recommendations that will help shape healthcare delivery across north Cumbria and the North East over the next four to five years.

73. NHS England has summarised some of the key themes/suggested areas of focus from the

event as follows:-

- Workforce, new roles, working differently and more flexibly and enabling factors like staff passports to facilitate working across different organisations.
- A way of listening to the patients and public more effectively. For example tapping into or aligning with local authority approaches to effectively engage citizens.
- Capitalising on the richness of public health data and intelligence to shape decision making that makes a real impact on public health.
- Allied health professionals, optometrists and pharmacists play a critical role in delivering healthcare differently. How do we bring their voices to the table in a more effective way?
- Effective mechanisms for the sharing/diffusion of innovation and improving practice across the system, including levers to enable the rapid adoption of good practice from area to area. For example, co-ordinating and connecting agencies working together in related fields to learn from each other.
- Clarity on where decision making sits most appropriately (place, integrated care partnership (ICP) or integrated care system (ICS) level) and the relevant support.
- Making decisions for the system and not for the individual organisation whilst mitigating risk – where decisions are made for the benefit of the system but may impact on individual organisations.
- Further discussion on the role of the NHS influencing the wider determinants of health/public health; not only as the biggest single employer promoting health and wellbeing in staff, but also by creating a collective voice to supporting individual local authorities.
- Potential role of Primary Care Networks within the ICS as the fundamental building blocks of the system.
- Information technology seen as key to accelerating improvement across many of the recommendations.

INTEGRATED CARE PARTNERSHIPS IN CUMBRIA NORTH EAST (CNE)

74. Integrated care partnerships (ICPs) are alliances of providers and commissioners who are collaborating to deliver care. In North Cumbria and the North East, the proposal is for ICPs to be in place, to run alongside a Cumbria and North East ICS, which will take responsibility for overall coordination of the whole geographical area, by April 2019. Health providers include hospitals, community services, mental health services, GPs, and independent and third sector providers.

75. The ICPs will focus initially on bringing together enough critical mass to sustain vulnerable acute services within their geography, and the commissioning of non-specialist acute care. CCG's within these ICP geographies will continue to develop place-based arrangements for the planning and provision of primary and community care and health and social care integration, aligned to the overall ICS strategy.[12]

76. Four Integrated Care Partnerships, will be formed as follows:-

[12] Narrative and communications pack for NHS organisations in North Cumbria and the North East, as developed by the communications and engagement workstream for the CNE ICS.

North Cumbria; population 327,000, ICP lead Stephen Eames
North; population 1,026m, ICP lead Jim Mackey
Central; population 847,000,ICP lead Ken Bremner
South; population 992,000, ICP lead Siobhan McCardle (Chief Executive, South Tees Hospitals NHS Foundation Trust).

The South Integrated Care Partnership includes 4 CCG areas, 3 NHS Foundation Trusts and 6 Local Authorities:-

- NHS South Tees CCG
- NHS Hartlepool and Stockton-on-Tees CCG
- NHS Darlington CCG
- NHS Hambleton, Richmondshire and Whitby CCG

- South Tees Hospitals NHS Foundation Trust (acute)
- North Tees and Hartlepool NHS Foundation Trust (acute)
- County Durham and Darlington NHS Foundation Trust (acute)

- Middlesbrough Local Authority
- Redcar & Cleveland Local Authority
- Stockton-on-Tees Local Authority
- Hartlepool Local Authority
- Darlington Local Authority
- North Yorkshire Local Authority

77. Whilst North Durham CCG and NHS Durham, Dales, Easington and Sedgefield CCG are not included in the scope of the South ICP (due to the population mainly accessing services from the University Hospital of North Durham or hospital services based in Sunderland, Gateshead and Newcastle more often than in Teesside), the South ICP will consider the potential impact of patient flow and service provision on these hospitals within these CCG areas as a result of any new service models.

78. The ICP's operating principles are detailed as follows:-

- The needs of people will have priority over organisational interests
- Staff will work in clinical networks across hospital sites - sharing scarce resources to maintain local services
- Staff will work collaboratively, urgently and with pace on system reform and transformation
- Costs can only be reduced by improving co-ordinated care
- Waste will be reduced, duplication avoided and activities stopped which had limited value or where benefits to our population was disproportionate to cost

79. In terms of the work currently being undertaken in respect of the ICP it was advised that:-

- Clinicians have been developing the Clinical Strategy
- Each of our hospitals will be preserved for the future by using them differently and in a more joined up way to benefit all patients

- Some changes and improvements may be necessary to services currently provided from different hospital sites
- New ways of working will need to be introduced so that clinicians can work easily across multiple organisations and clinical sites
- There will be an expansion in the use of new roles and care models that will help to manage demand and drive an improvement in outcomes.

80. The Clinical Strategy will focus on how a number of key services will be delivered in the future including:

- **Urgent & Emergency Care**
- **Paediatric, Maternity (Gynaecology modelling interdependencies)**
- **Elective care: Spinal; Breast; Urology**
- **Frailty services**
- **Stroke services**

81. The Clinical Strategy had been due to be finalised and agreed in January/February 2019. However, at the time of publication in April 2019, further details in respect of the Clinical Strategy are yet to be presented.

CONCLUSIONS

The scrutiny panel reached the following conclusions in respect of its investigation:

82. **TERM OF REFERENCE A – To gain an overview of health services commissioned provider contracts due for renewal in 2018/19 and 2019/20**

83. **TERM OF REFERENCE B – To examine progress made to date and challenges still to overcome in respect of local service integration**

84. **TERM OF REFERENCE C – To consider the potential impacts of reductions in Public Health funding on local service provision by 2021**

85. **TERM OF REFERENCE D – To examine the approach taken by other local health and social care systems recognised for having developed a strong collaborative approach**

RECOMMENDATIONS

86. Following the submitted evidence, and based on the conclusions above, the Health Scrutiny Panel's recommendations for consideration by the Executive are as follows:

ACKNOWLEDGEMENTS

87. The Health Scrutiny Panel would like to thank the following for their assistance with its work:

Craig Blair, Director of Strategic Planning and Performance, South Tees CCG
Edward Kunonga, Joint Director of Public Health, Middlesbrough Council and Redcar & Cleveland Council

Steven Mason, South Tees Hospitals NHS Foundation Trust
Erik Scollay, Director of Adult Social Care and Health Integration, Middlesbrough Council
Kathryn Warnock, South Tees Integration Programme Manager

BACKGROUND PAPERS

88. The following sources were consulted or referred to in preparing this report:

- Minutes of meetings of Health Scrutiny Panel held on 3 October, 7 November 2018, 19 December 2018 and 8 January 2019
- Middlesbrough 2025 – The Mayor's Vision – Middlesbrough Council
- Strategic Plan 2017-2021 – Middlesbrough Council
- Better Care Fund Plan (BCF) 2017/18 – 2018/19
- Health and social care integration, National Audit Office, February 2017
- The state of health care and adult social care in England 2016/17, Care Quality Commission, October 2017
- Health and social care interface, National Audit Office, July 2018
- What is happening to life expectancy in the UK? The Kings Fund, August 2018
- Narrative and communications pack for NHS organisations in North Cumbria and the North East, as developed by the communications and engagement workstream for the CNE ICS, August 2018
- The state of health care and adult social care in England 2017/18, Care Quality Commission, October 2018
- The NHS long-term plan explained – The Kings Fund, 23 January 2019

ACRONYMS

CHC – Continuing Health Care
CNE – Cumbria and the North East
CQC – Care Quality Commission
ICP – Integrated Care Partnership
ICS – Integrated Care System
HWBB – Health and Well Being Board
JCUH – James Cook University Hospital
STCCG – South Tees Clinical Commissioning Group
STH NHS FT – South Tees Hospitals NHS Foundation Trust
TEWV NHS FT – Tees, Esk and Wear Valley NHS Foundation Trust

COUNCILLOR E DRYDEN
- CHAIR OF HEALTH SCRUTINY PANEL

The membership of the scrutiny panel is as follows:

Health Scrutiny Panel 2018-2019
Councillors E Dryden, (Chair), S Biswas, (Vice-Chair), A Hellaoui, C Hobson, J McGee, L McGloin, M Walters and J Walker.

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