HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 13 November 2018.

PRESENT: Councillors E Dryden (Chair), S Biswas, A Hellaoui, C Hobson, J McGee, L McGloin, J A Walker and M Walters

ALSO IN ATTENDANCE: Craig Blair - Director of Strategic Planning and Performance - NHS South Tees Clinical Commissioning Group

OFFICERS: Caroline Breheny - Democratic Services Officer
Edward Kunonga - Joint Director of Public Health and Public Protection
Erik Scollay - Director of Adult Social Care and Health Integration

18/23 **MINUTES - HEALTH SCRUTINY PANEL - 4 SEPTEMBER 2018**

The minutes of the Health Scrutiny Panel meeting held on 4 September 2018 were approved as a correct record.

18/24 **MINUTES - HEALTH SCRUTINY PANEL - 28 SEPTEMBER 2018**

The minutes of the Health Scrutiny Panel meeting held on 28 September 2018 were approved as a correct record.

18/25 **INTRODUCTION TO NEW SCRUTINY TOPIC: VULNERABLE AND FRAGILE HEALTH SERVICES**

The Director of Strategic Planning and Performance at STCCG was in attendance to provide an overview of the health service commissioned provider contracts due for renewal in 2018/19 to 2020/21.

Prior to discussing the contract renewal arrangements the Chair requested that a brief update be provided to the panel in respect of STCCG's financial position. The Director advised in 2018/19 the organisation was required to save £20m and to provide some context to that level of saving it was advised that STCCG's annual budget was in excess of £460m.It was explained that traditionally CCG's would make efficiency savings through demand management, whereby patients who genuinely needed access to services were given access and individuals whose needs could possibly be better met through other means were directed to access other support. For example, if there was no clinical benefit in an individual having an outpatient appointment or clinical procedure undertaken then the CCG would encourage suitable alternatives that might better meet the patient's needs, whilst also reducing the CCG's spend. However, there were also opportunities when contracts came to an end to review whether or not there were better and more cost effective ways of delivering those services.

The CCG Director explained that one of the questions he had been asked in advance of attending the meeting was if he was able to provide an overview of the contracts that the CCG held that were coming to an end. The panel was advised that the majority of contacts were in place for between 1 and 3 years, the CCG's contract register was published on the CCG's website. There were hundreds of contracts and it would not have been practical to take the panel through all of those contracts. However, the information was publically available for Members to access. When contracts came to an end there was an opportunity to have a conversation about whether a different set of services could be put in place. Tools such as the JSNA, feedback from patients, service providers and groups such as Overview and Scrutiny were taken into consideration when reviewing service provision.

Reference was made to the recently signed aligned incentive contract between STCCG and South Tees Hospitals NHS Foundation Trust and the Chair emphasised that the panel was focused on the services that fell outside of that block contract. The CCG's Director acknowledged that JCUH was the biggest provider but there were a range of other providers

from which services were commissioned including both the independent sector and the VCS. It was acknowledged that when contracts were due to expire the CCG would review the service and although there may have been occasions in the past where those reviews may not have not been as open and transparent as everyone would have wanted the CCG would never willingly go out and make changes to service provision without undertaking a formal engagement process.

In terms of fragile and vulnerable services the CCG Director expressed the view the use of this terminology meant different things in different forums. Across the North East at the moment rheumatology and breast services were perceived as being fragile services. These services were fragile, not because commissioners did not want to commission them, but because providers did not necessarily have the trained staff available to provide these from all of the locations from which they were currently delivered.

The Director of Social Care Integration expressed the view that there were a couple of different ways of thinking about fragility. If you were in a position of financial deficit then that brought a certain degree of jeopardy about all services that you could deliver across the board. There was also difficult dilemmas around where there were services that you knew you statutorily had to provide and others where you might be providing more than absolutely required to in law. As a local authority the Council was not immune from those difficult dilemma's either.

The Chair posed the question as to what those difficult dilemmas for STCCG were and where would the organisation need to trim back on service provision to what was statutorily required. The Director expressed the view that it was not all 'black and white' and instead the CCG were looking at areas where there was a potential that the CCG was duplicating provision through a range of different contracting arrangements. It was explained, for example, that the CCG had a block contract in place with TEWV, the mental health service provider. However, the CCG also funded individual packages of care that were in place through Continuing Health Care (CHC) where the CCG worked with local authority colleagues around understanding an individual's needs and then funded the care to meet those needs. There were times when the package of care put in place duplicated a service that the CCG commissioned through its block contract arrangements.

In terms of contracting it was explained that the CCG predominately used the single contract framework, which was an NHS standard contract used nationally. If key performance standards were not being met through a contract there were mechanisms in place to introduce break clauses. The CCG could issue 6 / 12 month notice periods, whereby if a provider was unable to recover their performance the contract would be revoked. Reference was made to the recent significant safety concerns around the out of hours' service, where the CQC had flagged concerns, and it was explained that the CCG had worked with the provider ELM Alliance to improve the provision. In doing so the CCG had issued a contract notice and had the provider been unable to improve the offer to patients the contract would have been withdrawn. The CQC had since revisited the out of hours' service and significant improvements had been made.

A member of the panel expressed the view that the panel's overriding concern was in respect of the 'bottom line'. It was evident that £20m worth of funding would be taken out of our local health and social care system by March / April 2019 and the question for the panel was how would achieving those target savings impact on the individuals Middlesbrough Councillors represented. Was the approach being taken one whereby the CCG cut a fraction from a whole range of different services or would large savings be made in certain areas, where perhaps a service would be lost to save in the region of £5m rather than shave off smaller amounts across a number of areas? Would more savings need to come in place from 1 April 2019 and if so had those plans been made, given that the CCG was already 7 months into 2018/19?

The CCG's Director advised that the CCG had been required to produce a financial recovery plan on how it would balance the books and it had been agreed with NHS England that STCCG would close the year with a deficit. The CCG would still spend more than its allocated fair share funding but would gain access to a national pot of funding - the Commissioning Sustainability Fund, which would assist the CCG in getting through the financial year. If the

CCG was successful in not overspending by more than £5m NHS England would provide the CCG with additional resources to cover the shortfall.

In terms of the savings made to date £8m the bulk of those savings had so far been achieved through the signing of the aligned incentive contract, of which the annual value was £228m. The remainder would be achieved from a number of different areas including prescribing waste. The panel was informed that STCCG spent more on prescribing in 2017/18 than any other CCG in the North East of England. STCCG therefore needed to look at whether these prescribing levels were appropriate and if patients were being prescribed drugs whether they were making use of them. The CCG's expectation was that £4m could be saved from the prescribing budget in 2017/18, although it was hoped that up to £6m could be achieved.

The panel was informed that the remaining savings need to come from a range of different areas. For example, STCCG invested more in primary care than any other CCG in the North East, which included the recently established out of our hour's hubs. Continuing Health Care (CHC) spend had also continued to increase and growth in CHC costs was outstripping savings achieved in other areas.

In response to a query it was explained that there were different elements to CHC but fundamentally it was about the total cost of health and social care services that supported an individual. It was acknowledged that although there were disagreements at times between the CCG and the local authority in respect of CHC, a legal framework in terms of eligibility had to be worked through. The Chair queried the figure that the CCG anticipated saving from their CHC budget in 2018/19. It was advised that the CCG was intending to achieve savings of around (£4m).

A member of the panel queried whether a counterargument had been put to NHS England STCCG in terms of its funding allocation. The Director of the CCG advised that the CCG had explained to NHS England that it had not been possible it to provide all of the services it was legally required to provide within the resources the CCG had been allocated. There had been an acceptance from NHS England that STCCG's expenditure in response to identified needs was in effect £4m less than its fair share allocation. The remaining savings balance of £4m would therefore be drawn from NHS England's Commissioning Sustainability Funding.

The Chair queried the areas of disagreement between health and social care services. The Director of Adult Social Care and Health Integration made reference to section 256 arrangements, which were agreements whereby the CCG had a contract with the Local Authority for it to commission services on its behalf. Various arrangements were in place and the initial action taken by the CCG in respect of reviewing those arrangements had been less considered than it may have been. However, the narrative had really changed in the last few months and health and social care had been working much more closely together. The real concern remained as to whether STCCG would make sufficient progress to access the Commissioning Sustainability Funding. It was emphasised that health and social care need to work collectively to pull in this £3.7m of funding. In terms of progress towards the target the Director at the CCG advised that from the information he had received the CCG was on track to make the necessary savings.

In response to a query regarding the possibility of funding duplication for mental health services it was advised that STCCG had made a commitment to extend IAPT services, and although the CCG was not investing in many areas it was investing in mental health and supporting more people to deliver access such as IAPT. The point was made that the uptake for IAPT service had never been what it needed to be and as many people as possible who were suffering with anxiety / depression needed to access the system in order to help reduce over prescribing.

The Director of Public Health also made the point that although investment in prevention did lead to better outcomes the current risk was that more preventative services had 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 were accessing A&E services as a result of those issues, was under threat due to cuts in Public Health Funding.

AGREED that an invitation be extended to the local medical committee and local pharmaceutical community, to attend a future meeting of the panel to discuss the issue of overprescribing.

18/26 **INTEGRATION OF HEALTH AND SOCIAL CARE SERVICES**

The Director of Adult Social Care and Health Integration was in attendance to provide an update to the panel in respect of the progress made to date and challenges still to overcome in respect of health and social care integration locally. The panel heard that there were varying degrees of sophistication in respect of different approaches adopted nationally to health and social care integration. Locally, the Tees Community Equipment Service (TCES), was a very effective example of joint working arrangements between health and social care. However, in other parts of the North East for example in Durham, which was further ahead in terms of the strategic integration of health and social care services a joint strategic commissioning plan had been produced. The joint plan had been developed by health commissioners, local authority commissioners (including from both adult and children's social care) and local public health officials.

During discussion the following points were raised:-

• Small local authorities punching above their weight had always been a challenge.
• As an individual local authority did the Council have the capacity to meet the increasing demands on its budgets?
• Would the integration of health and social care services lead to better outcomes?
• New individuals were involved in the South Tees HWBB and it was clear that there were numerous views about what an integrated service meant.
• Health and social care professionals were bedevilled by common language that meant different things.
• In October 2018 the HWBB Executive had been tasked with revisiting the original visioning event and bringing together key stakeholders for a conversation about health and social care integration in South Tees.

The panel queried whether there was professional resistance to health and social care integration locally. The Director of Adult Social Care and Health Integration advised that from his perspective there was no professional resistance. However, it was acknowledged that at present perhaps partners on the HWBB held different views on their vision of health and social care integration. There was also a question as to whether or not there was a political will to integrate services locally.

The Director of Adult Social Care and Health Integrated advised that at a recent HWBB meeting where partners were talking about the scale of ambition in terms of integration, the Council's Chief Executive had asked the question as to whether it would be more beneficial to operate a joint adult social care department across South Tees. The Chief Executive had acknowledged that there should be no red lines around integration, subject to political agreement.

In light of the professional suggestion from the Council's Chief Executive with regard to the possibility of establishing a joint adult social care department across South Tees the Chair asked the panel as to whether politically there was a need to ascertain the views of the Mayor and Leader of Redcar & Cleveland Borough Council on such a proposal. Members expressed the view that such considerations could not rest solely on the desk of the Director of Social Care and Health Integration or the Joint Director of Public Health. The panel was in agreement that the views of the joint HWBB Chairs be sought and fed back to the panel.

In terms of integration in the other parts of the country the Director of Health and Social Care Integration advised that he had undertaken a visit to North East Lincolnshire, which had developed a place based plan for health and social care services. However, it was explained that although North East Lincolnshire did what they set out to do in their plan really well they were unable to deliver anything additional and therefore caution needed 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 had cross cutting benefits in other areas. Equally there were actions that could be taken in the Growth and Place directorate that could positively impact on health and social care services. There was also a risk that through closer integration with another organisation you could lose a degree of integration already established within your own organisation.

The Joint Director of Public Health and Public Protection made the point that there was also a real need to consider the importance of broader health and well-being integration. For example, if you progressed down the route of closely integrating health and social care services exclusively then you risked missing opportunities to involve some of the other key stakeholders involved in the wider determinants of community health and well-being. Services could become geographically integrated but not locally integrated. In addition there were different population groups that required different forms of service integration. For example, those individuals with multiple and complex needs including substance misuse and homelessness placed very different demands on an integrated health and social care system to a frail and elderly individual.

In reflecting on the establishment of the joint Public Health Service the Joint Director of Public Health expressed the view that prior to any consideration regarding the establishment of a joint adult social care service across South Tees a very clear business case would need to be put forward.

In terms of structural integration with health the Director of Adult Social Care and Health Integration advised that another of his concerns was that NHS England was a very hierarchical organisation and CCG's were directly responsible to NHS England. In contrast Local Authorities had much more autonomy. The Director of Public Health also reminded the panel that although health was being talked about in this context as a single body, there was a real need for increased inter health integration to take place prior to further integration of health and social care. The challenges patients faced in transition between primary and secondary care and even within secondary care were testament to this requirement. If, for example a patient required specialist services in Newcastle or Leeds there were a number of different tiers in terms of the commissioning arrangements in place. Specialised commissioners were responsible for commissioning those services outside the remit of local CCG's and there was a need for more integrated health commissioning.

The Director of Adult Social and Health Integration advised that the difficult dilemma from his perspective was 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 was a difficult tightrope to walk. There was also the question as to where we were regionally on the journey to developing an integrated care system? Would, for example, more decisions be made on a regional basis? How would the newly appointed Chief Clinical Officer and Chief Operating Officers of the 5 CCG model be held politically accountable? What new governance structures were in place and were those structures robust? The Chair expressed the view that as a health scrutiny panel it was a challenge in terms of where to focus our attention. The point was also made that there were risks involved in closer integration and health scrutiny was particularly challenging at the moment given that Members were scrutinising a moving feast.

The Director of Public Health advised the Committee that to date what we had witnessed in terms of proposed changes to acute service provision was that in areas that were likely to experience the biggest changes residents were the most vocal. The NHS inevitably undertook increased engagement in those areas and so in the previous round of proposals where the possibility of Darlington losing their local district hospital had been mooted a lot of NHS activity had been undertaken because the politicians had been very vocal about it. The Director of Public Health expressed the view that the danger for Middlesbrough was that we would be told we were safe, you have JCUH, nothing would change and then services were gradually changed without our input. The panel was advised that the panel still needed to ensure the NHS remained accountable even if JCUH as a site was protected because the Council needed to understand the impact of specialist services being delivered from JCUH hospital, as

well as the impact on our residents of needing to travel out of Middlesbrough to access other services.

The Director of Adult Social Care and Health Integration advised that the interesting dilemma for him was that although JCUH would not be going anywhere and there would always be plenty of activity at the site. It would 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.

AGREED that the Chair of Health Scrutiny Panel and Chair of Adult Social Care and Services Scrutiny Panel jointly write to the Mayor and Leader of Redcar & Cleveland Borough Council, in their capacity as joint Chairs of the HWBB, regarding the future delivery model of social care provision across South Tees.

18/27 **PUBLIC HEALTH OVERVIEW AND UPDATE**

The Director of Health advised that beyond next year there was still no clarity around how Public Health would be funded. A few options had been debated and these were as follows:-

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

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

Option 3:- The third option was to redistribute the Public Health grant using a new formula rather than allocate based on historic allocations. If that formula was introduced Middlesbrough would lose in excess of £1m. The formula was based on premature deaths. However, the use of that indicator did 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.

A report published nationally had highlighted that in the most affluent local authorities residents enjoyed 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 were already in receipt of palliative care. There had been no clarity over which of the options would be favoured, however, this was causing significant concerns for local authorities across the region. If option 3 were to be introduced 11 out of the 12 local authorities in the North East would be negatively affected. Durham anticipated that they would lose in the region of £20m and Redcar and Cleveland would lose in the region of £3.3m. Pressure on reactive services would only increase.

AGREED that panel Members wrote to their MP's in respect of this issue and that the Health Scrutiny Panel made its own representation to the Department of Health to request that the proposed funding formula accurately reflected the needs of Middlesbrough residents.

18/28 **OSB UPDATE**

The Chair provided a verbal update in respect of the matters considered by the Overview and Scrutiny Board on 2 and 29 October 2018.