Middlesbrough
moving forward

Legal and Governance

HEALTH SCRUTINY PANEL

Date: **Tuesday 13th July, 2021**
Time: **4.00 pm**
Venue: **Council Chamber**

AGENDA

1. Apologies for Absence

2. Declarations of Interest

3. Minutes- Health Scrutiny Panel - 22 June 2021 — 3 - 8

4. South Tees Hospitals - Quality Accounts 2020-2021 - To Follow

   Ian Bennett (Deputy Director of Quality and Safety for South Tees Hospitals NHS Foundation Trust) will be in attendance to lead the presentation of the Quality Accounts document 2020-2021.

5. Health Inequalities Review - Health for Wealth — 9 - 38

   Dr Heather Brown of Newcastle University will be in attendance to provide an overview of Health Inequalities following the nhsa's publication of *Health for Wealth – Building a Healthier Northern Powerhouse for UK Productivity*.

6. Chair's OSB Update

7. Any other urgent items which in the opinion of the Chair, may be considered.

Charlotte Benjamin
Director of Legal and Governance Services

Town Hall
Middlesbrough
Monday 5 July 2021

MEMBERSHIP

Councillors D Coupe (Chair), D Davison (Vice-Chair), R Arundale, A Bell, A Hellaoui, T Mawston, D Rooney, C McIntyre and P Storey

Assistance in accessing information

Should you have any queries on accessing the Agenda and associated information please contact Scott Bonner, 01642 729708, scott_bonner@middlesbrough.gov.uk

HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on Tuesday 22 June 2021.

PRESENT: Councillors D Coupe (Chair), D Davison (Vice-Chair), A Bell, T Mawston, D Rooney, P Storey and T Higgins

OFFICERS: M Adams, S Bonner and C Breheny

APOLOGIES FOR ABSENCE: Councillors R Arundale, A Hellaoui and C McIntyre

20/73 **DECLARATIONS OF INTEREST**

There were no declarations of interest received at this point in the meeting.

20/74 **MINUTES - HEALTH SCRUTINY PANEL - 16 FEBRUARY 2021**

The minutes of the Health Scrutiny Panel meeting held on 16 February 2021 were submitted and approved as a correct record.

20/75 **MINUTES- HEALTH SCRUTINY PANEL - 23 MARCH 2021**

The minutes of the Health Scrutiny Panel meeting held on 23 March 2021 were submitted and approved as a correct record.

20/76 **PROPOSED SCHEDULE OF MEETINGS DATES FOR THE 2021/2022 MUNICIPAL YEAR**

The Chair presented the Panel with prospective meeting dates for the forthcoming municipal year and sought any comments.

ORDERED: That the proposed meeting dates for the forthcoming municipal year be agreed.

20/77 **COVID-19 UPDATE**

The Chair welcomed the Joint Director for Public Health to the meeting and invited him to provide an update on the current Covid situation. During his presentation the Director made the following points:

- Infection rates in northern parts of the South Tees were growing in a similar way to areas such as Newcastle.
- The Teesside areas were experiencing lower rates than others in the North East, however rates were picking up in the North East generally.
- The upward trajectory of infections showed slow growth in Middlesbrough, but it was unlikely this rate would remain slow and plateau.
- Infections for those in the 0-19 age group had risen but plateaued whereas those in the 20-39 year age group had continued to rise.
- There was a clear impact of the vaccination programme given infection rates for those within the 60+ age group was much smaller.
- While there was less concern regarding hospital activity for younger people there were concerns regarding “Long Covid” in this age category as this was not fully understood.
- Previous trends had also shown that peaks starting in younger age groups worked their way through to older age groups, although the vaccination programme had slowed this.
- Positivity rates were picking up, but were still quite low.
- Infection rates were spread across the town with no specific area affected. However there was no need for surge testing at that point.
- With regard to hospital statistics; there were currently 12 in-patients in South Tees which was a slight increase.
- While these numbers were not causing immediate concern the numbers were being monitored.

- James Cook Hospital was standing up activity that was lost during the Pandemic, so any increase to patient numbers due to Covid would impact on this further.
- Northumberland had the highest vaccination rate nationally with 85.7%. This was reflected in other rural more affluent areas of the country. Middlesbrough and Newcastle were positioned at the bottom of the list for vaccinations as these areas were generally younger and had more problems with deprivation.
- Middlesbrough had a single dose vaccination rate of 67.5%.

A Member queried if the information being presented was current and what was being done to redress Middlesbrough's low vaccination rate. It was confirmed the information was up to the 21st June 2021 and that various initiatives were being undertaken with Primary Care Networks to increase vaccine take-up, and to raise awareness of the vaccine. Examples included the Covid MELISSA Bus and moving to drop-in rather than booking models for distributing vaccines.

It was noted that vaccine take-up numbers may not increase significantly initially as this was a longer-term strategy. Members were invited to suggest ideas to increase vaccine take-up.

A Member queried what messages could be transmitted across Social Media to increase awareness and dispel inaccurate information. It was clarified there were numerous initiatives being employed to communicate and promote the vaccination programme. This included the every concept counts approach whereby the message of vaccine take-up was transmitted to care givers who would be able to convince those in need of the vaccine better than distant officials.

A Member expressed concern that social distancing measures on local bus services, particularly with regard to school children, were not being adhered to as strictly as they previously were. It was confirmed that the Public Protection Service would be asked to look into this issue.

A Member queried how many vaccination pods were being used at the Riverside Stadium and if walk-in appointments would be possible. It was confirmed the number of pods had reduced from two to one but clarification was needed on the capacity of that pod. It was also clarified that vaccination provision was provided through Newcastle Hospitals. Therefore having the Riverside as a drop-in center was not something the Council could influence but it could be pursued. It was also confirmed drop-in facilities were available for over 40s using the AstraZeneca vaccine, as there were spares available. However, this was not available for younger people as there were no spare Pfizer vaccines outside of the booking system.

The Chair stressed that social distancing measures were still in place and that people of all ages should continue to adhere to them to prevent further infection rates.

A Member queried that, due to the correlation between deprivation and lack of vaccine take-up, could other initiatives be used to target those communities more effectively. It was confirmed that a range of initiatives, such as the MELISSA bus were being explored to address this.

A Member queried if Community Hubs were being used as vaccination centers. It was clarified that vaccination centers were administered by the NHS had were required to offer an 8am to 8pm service seven days a week. It was clarified that Stockton Council were exploring using empty retail space for this purpose and its progress would be monitored.

A Member queried if improvement were planned for the NHS vaccination booking website as it was sometimes directing people to distant vaccination centers which were barriers to access. It was confirmed that greater understanding of how the website operated was required, as returning shortly after an initial search usually provided closer centers.

The Director continued with his presentation and made the following points:

- Vaccination rates in over 50s stood at 91%.
- However there were 4,758 over 50s that were not vaccinated with 2,800 over 50s with a single dose. It was for the former that caused most concern as they were more susceptible to the Delta Variant of the virus.
- To encourage vaccination take-up GPs supplied names to Public Health who found approximately 33% of those names seemed to have a BAME background. It was clarified that a number of factors may have contributed to this statistic, such as language barriers, but further work was required to understand this fully.

ORDERED:

1. That the Public Protection Service work with local bus operators to ensure social distancing measures remain robust and
2. That the drop-in vaccination model at the Riverside be pursued.
3. That the information presented be noted.

20/78 **OVERVIEW OF SERVICE AREAS**

The Joint Director of Public Health provided an overview of his service and made the following points:

- The position of Director for Public Health was statutorily mandated since the passing of the Health and Social Care Act 2012.

- The statutory duties if the Public Health Service were often wrapped up in other legislation which meant there was often no clear distinction between Public Health services the services supported by Public Health.

As the National Childhood Weight Management Programme was a mandated service a Member queried the accuracy of that programme as they felt it could be stigmatic for children to be labelled as obese. It was clarified that while the system for measuring children's weight via the BMI index was not perfect it was something that could not be changed locally as it was a national programme. The Chair stated that it was an issue that could be brought back to the Committee as part of its work programme.

The Director continued with his presentation and made the following points:

- The service was also required to be part of the Health and Wellbeing Board and to create Joint Strategic Needs Assessment which fed into the Joint Strategic Health and Wellbeing Strategy which ran until 2023, as well as creating the Pharmaceutical needs assessment.

A Member queried how the Joint Strategic Needs Assessment was being made available. It was confirmed that the JSNA was more accessible via web formats given the nature of its content. It was also clarified the JSNA needed to be updated going forward.

- One of the principles that Public Health operated to was the offer of service across all areas but to target those services at some groups, so called "proportionate universalism". Public Health's job was to understand and appreciate different needs and how those needs were expressed.
- Some of the key issues that Public Health were addressing were inequalities in life expectancy and health outcomes; reducing mortality and morbidity from preventable causes; and ensuring local population health is protected from infectious and communicable disease.
- One of the approaches used by Public Health was the population intervention triangle, which it was hoped would allow a more focused approach to Service, Civic and Community interventions and services. Ultimately, this model tried to move away from simply providing a service.
- Public Health's values were based on a model of five Programmes, five Business Imperatives and three Levels of intervention across the life course.

A Member queried what successes the Heroin Assisted Treatment had seen. It was clarified that the evidence suggested the programme had been successful with the small number of participants involved. It was also clarified that the Police and Crime Commissioner was supportive of treatment being provided through the ADDER programme although his primary objective was to address the issue of drugs as a crime rather than as a public health issue. It was also confirmed that there was no immediate threat to the funding available to the programme.

- The key issues and priorities facing Public Health centered around Relationships; Capacity and Capability as well as Uncertainty. The Covid Pandemic had demonstrated how the Council could work as a single unit for the betterment of the

people of Middlesbrough. It was important to try and replicate a similar sense of unity for other issues such as childhood obesity or substance misuse.

- The profile of the Public Health Team had grown during the Pandemic and it was intended that the Health and Wellbeing Board was more mission driven.
- There were difficulties with regards to recruitment and retention in Public Health roles due to a drift to NHS positions.
- There was a move to build the Live Well Centre concept into Town Centre Plans, especially in light of a shrinking retail offer in the town.
- Public Health needed to build on their public perception to deliver on important issues.

The Chair and Panel expressed their thanks to the Public Health team for their efforts during the Pandemic.

ORDERED: That the information presented be noted.

20/79 **REVIEW TOPIC OUTLINE - HEALTH FOR WEALTH**

The Chair and Democratic Services Officer advised the Panel that this review had been planned during the previous municipal year, but given the Panel's different composition for the municipal year 2021-2022 it was prudent to outline the rationale and methodology for the review and invited comments from Members.

A Member suggested that, as part of the review, previous statistics relating to life expectancy rates across Middlesbrough be revisited to understand if any change had taken place. It was also suggested that representatives from the Health and Wellbeing Board be asked to attend to provide evidence.

A Member suggested that regular updates be provided to the Panel regarding progress in respite care at Aygarth and Bankfield.

A Member also suggested inviting the Clinical Directors of the Primary Care Networks to introduce themselves to the Panel.

ORDERED:

1. That the Health Inequalities review as presented to the Panel be undertaken;
2. That previous life expectancy statistics across Middlesbrough be fed into the Health Inequalities review;
3. That representatives of the Health and Wellbeing Board be invited to provide evidence in pursuance of the Health Inequalities review;
4. That regular updates be brought to the Panel regarding respite care at Aygarth and Bankfield and;
5. That the Clinical Directors of the Primary Care Networks in Middlesbrough be invited to the Panel by means of general introduction and service overview and

20/80 **SETTING THE SCRUTINY PANEL'S WORK PROGRAMME FOR 2021/2022**

The Chair outlined the proposed work programme for the Municipal Year 2021-2022.

From the proposed work topics the Panel were keen to explore:

- Health Inequalities – accessibility to Health Care
- PFI Schemes at James Cook Hospital
- Women's Health and Infant Feeding and
- Dental Health

A Member queried if it was possible to understand which NHS PFI contracts had been paid back.

In addition to the topics cited in the report the Panel were keen to receive information relating to the impact the Covid Pandemic has had on Mental Health.

In addition to the updates cited in the work programme report, and following a recommendation from the Adult Social Care's Scrutiny Panel report into the LGBT+ community, the Panel were also keen to receive information from various Health providers relating to how those identifying as LGBT+ accessed health care.

ORDERED: That the topics identified from the work programme report and Member discussion be examined in the Municipal Year 2021-2022.

20/81 **ANY OTHER URGENT ITEMS WHICH IN THE OPINION OF THE CHAIR, MAY BE CONSIDERED**

None.

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Inequalities in health and wealth

13th July 2021

Heather Brown
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From Newcastle.
For policy makers.

Inequalities in health and wages

1)Health and social mobility locally, regionally, and nationally.

2) Geographical inequalities in health and employment

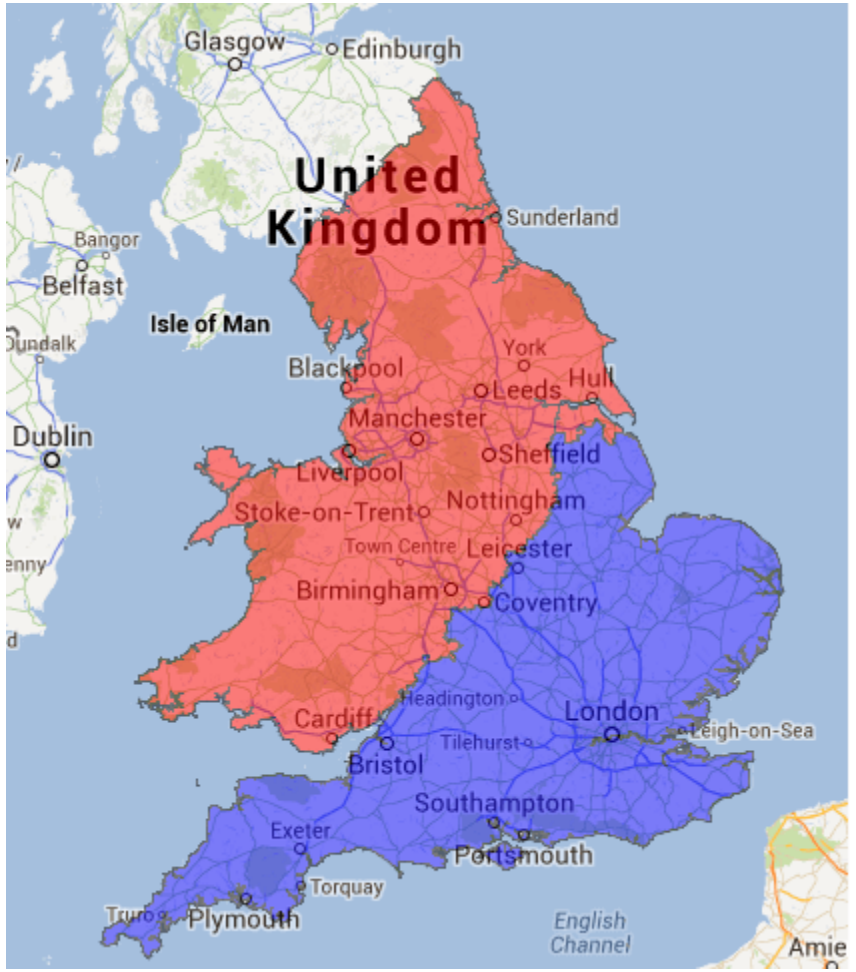
3)Policy responses to inequalities

4)Our research

5)Key findings

6)Recommendations

7)Challenges



*Map created by reddit user atrainmadbrit :*https://brilliantmaps.com/england -north-south/

Deprivation in the North East

Just under half of all LSOAs in Middlesbrough are in the 10% most deprived in the country.

Between 2015-2019 deprivation has been increasing in the North East.

Fig. 3 - LSOAs in North East Local Authorities in the most deprived 10%, 2019

Local Authority Area	IMD 2019 (LSOAs amongst 10% most deprived)		Change from IMD 2015	
	Number	Proportion of all LSOAs in Local Authority Area	Change in Number of LSOAs	Percentage Point Change (proportion of all LSOA's)
Middlesbrough	42	48.8%	0	0
Hartlepool	21	36.2%	2	3.4
Newcastle upon Tyne	45	25.7%	6	3.4
South Tyneside	25	24.5%	3	2.9
Redcar and Cleveland	21	23.9%	2	2.3
Sunderland	42	22.7%	6	3.2
Stockton-on-Tees	25	20.8%	3	2.5
Darlington	12	18.5%	2	3.1
Gateshead	21	16.7%	6	4.8
Durham County	39	12.0%	3	0.9
Northumberland	23	11.7%	9	4.6
North Tyneside	12	9.2%	3	2.3

Table from: https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Northumberland-Knowledge/NK%20place/Indices%20of%20deprivation/Indices-of-Deprivations-2019-Summary-Report.pdf

Poverty in the North

- Poverty rates over 5 percentage points higher
- Child poverty rates 29% in the North East, compared to 21% in the South East.
- Fuel poverty rates are also higher
- 21% in the North East compared to 11% in the South East

Projected impact of Brexit

Table 13: Summary of economic resilience indicators

REGION	Labour Productivity, GVA per hours worked		Gross Value Added per head		Business density			Business growth		Economic inactivity rate				Fiscal balances		Average Rank
	Compared to UK average, 2016	Rank	2016, £	Rank	Businesses per 10k adults	Region/ UK Ratio	Rank	Annual growth, 2010-16, %	Rank	Total pop 16-64, %	Rank	Total pop over 16, %	Rank	Average 1997-2016, £	Rank	
London	133.3	1	45,046	1	1,464	1.41	1	5.9	1	21	4.5	30	1	-1,767	1	1
South East	106.1	2	28,506	2	1,243	1.2	2	3.5	3	18	2	35	2	-1,185	2	2.2
South West	90.7	6	23,548	5	1,144	1.1	3	3.7	2	18	2	36	3.5	1,068	4	3.9
East of England	94.7	4	24,488	4	1,130	1.09	4	2.9	6	18	2	36	3.5	-173	3	4.1
East Midlands	85.7	9	21,502	8	972	0.93	5	3.4	4	22	7	38	8	1,331	5	6.5
North West	92.6	5	22,899	6	896	0.86	6	3	5	22	7	38	8	2,571	9	6.5
Scotland	99.4	3	24,876	3	728	0.7	11	2.2	11	21	4.5	37	5.5	1,531	6	6.6
West Midlands	87.3	8	22,144	7	892	0.86	8	2.4	10	22	7	37	5.5	2,078	8	7.8
Yorkshire and Humber	84.8	10	21,285	9	895	0.86	7	2.8	8	23	9.5	38	8	2,061	7	8.2
North East	88.9	7	19,542	11	679	0.65	12	2.9	7	25	11	41	12	3,357	10	9.8
Wales	83.1	12	19,200	12	872	0.84	9	2.5	9	23	9.5	40	10.5	3,805	11	10.6
Northern Ireland	83.2	11	20,435	10	845	0.81	10	0.6	12	28	12	40	10.5	4,417	12	10.9
UK	100		26,584		1,040			3.5								

Why is the North falling behind?

De-industrialisation changing the geograph

economic growth and employment

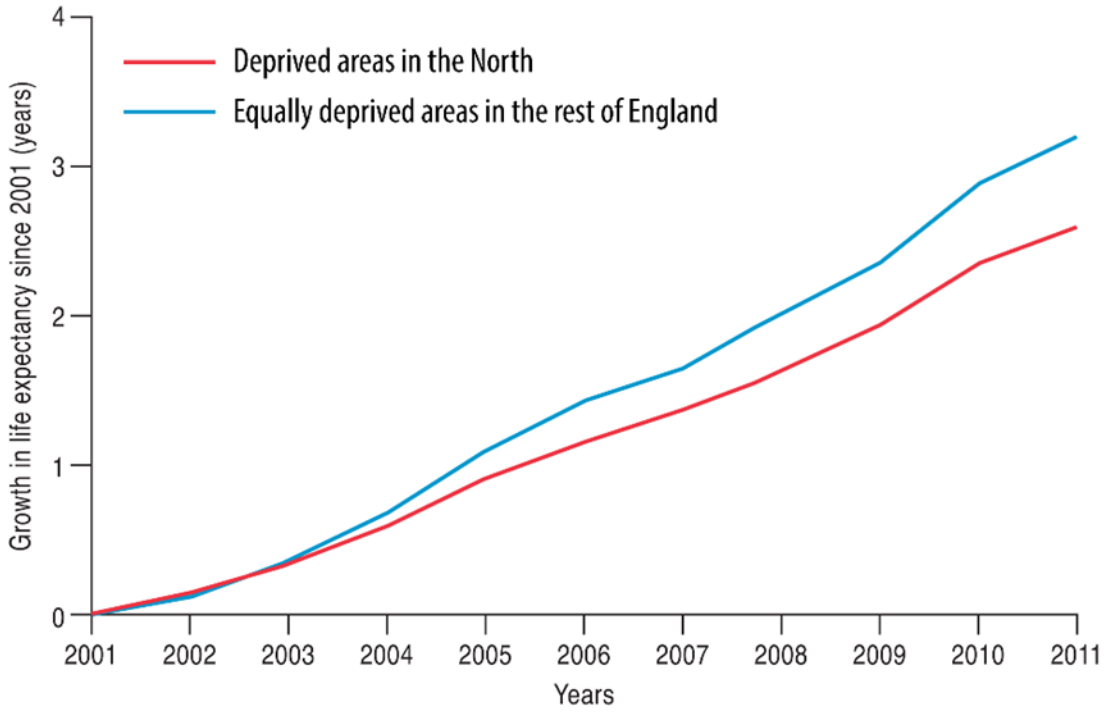
Disinvestment in peripheral former industri

areas

Austerity

Health Inequalities in the North

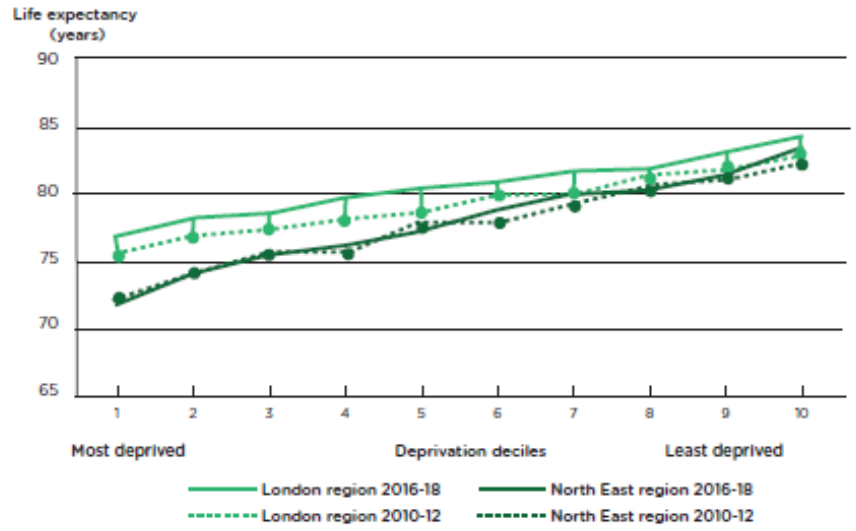
- Regional health divide has been widening in recent years.
- Between 1965 and 1995, there was no health gap between younger Northerners aged 20-34 years and their counterparts in the rest of England.
- Mortality is now 20% higher amongst young people living in the North.



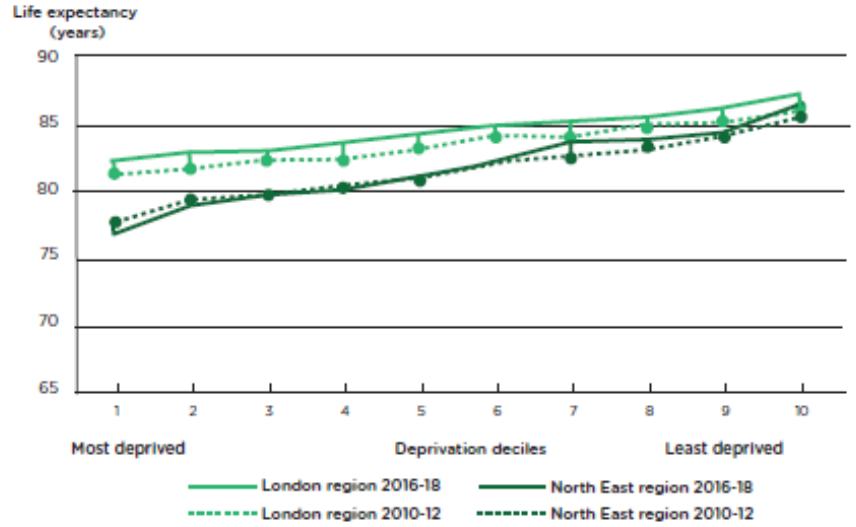
Health Inequalities

Figure 2.7. Life expectancy at birth by sex and deprivation deciles in London and the North East regions, 2010-12 and 2016-18

a) Males

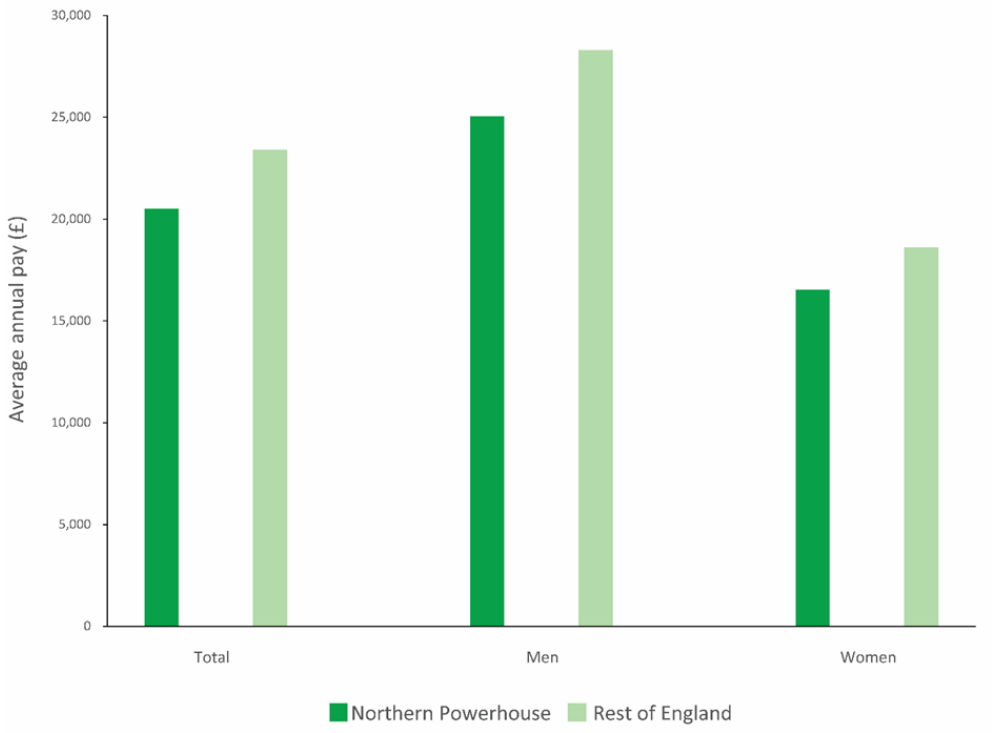


b) Females



Source: Based on PHE, 2020 (18)

Earnings and Economic Activity



Earnings are more than 10% lower than the rest of England

Economic activity rates are also lower

Higher unemployment, economic inactivity and worklessness

Covid and the North East

- Tipping point for many families at the edge
- Rising levels of child poverty
- Rising levels of food poverty
- High Covid rates

Health Inequality Policy

Three policy periods:

1) 1991-1998 (Increasing Neo-liberalism)
2) English Health Inequalities Strategy (1999-2010)
3) Austerity (2010-2017)

Our research

(1) Explore how different policy approaches to health inequalities impacts on geographical differences in mobility in health and wages for young people

(2) Estimate impact of poor health on productivity gap between the North and Rest of England

(3) Who is likely to become food insecure because of the pandemic?

Data

- BHPS was an annual household survey of approximately 5500 households and 10,300 individuals which ran from 1991-2008.
- 6700 of 8000 participants joined the Understanding Society Survey and participated from wave 2 (2010-2011) onwards
- Understanding Society Survey collects information on approximately 40,000 households.
- 7 waves of data are used in the analysis (2009-2016)

Data continued

- Understanding society Covid survey.
- Running from April 2020 to Summer 2021
- Approximately 17,000 individuals

Outcomes:

- Physical Health➔ SAH: 0) Very poor/Poor; 1)Fair; 2) Good/Very Good 3) Excellent
- Limiting Long Term Health Condition
- Mental Health➔ GHQ-12 (reverse Likert scale is used 0-worst mental health, 36 Best mental health)
- Wages➔ Log of Hourly wage
- Employment Gap

Food insecurity

1) Any person in household unable to eat healthy and nutritious food

2) Hungry but did not eat

Methods

- Compare influence of parents on young adult health and wages over the three policy periods between the North and Rest of England using regressions that control for time and family effects.
- Compare the influence of parents on health and wages between North and Rest of England by socioeconomic status:
  - ❑ Parents in professional and managerial occupations vs parents in manual occupations
  - ❑ Parents with a degree or higher vs parents with basic or no formal qualifications
  - ❑ Two parent vs single parent households

Methods: Statistical Analysis

Step 1:

- Employ decomposition methods to breakdown how much of the difference in the employment gap between the Northern Powerhouse and the rest of England can be explained by physical and mental health and a limiting long term health condition

Step 2:

- Estimate the association between mental and physical health and a limiting long term condition and employment.

Step 3:

- The coefficient from step 2 was divided by the total contribution of health to the productivity gap from Step 1 and multiplied by 10%.

Methods: Food insecurity

- We use logistic regression to determine the factors that influence the three measures of food insecurity.

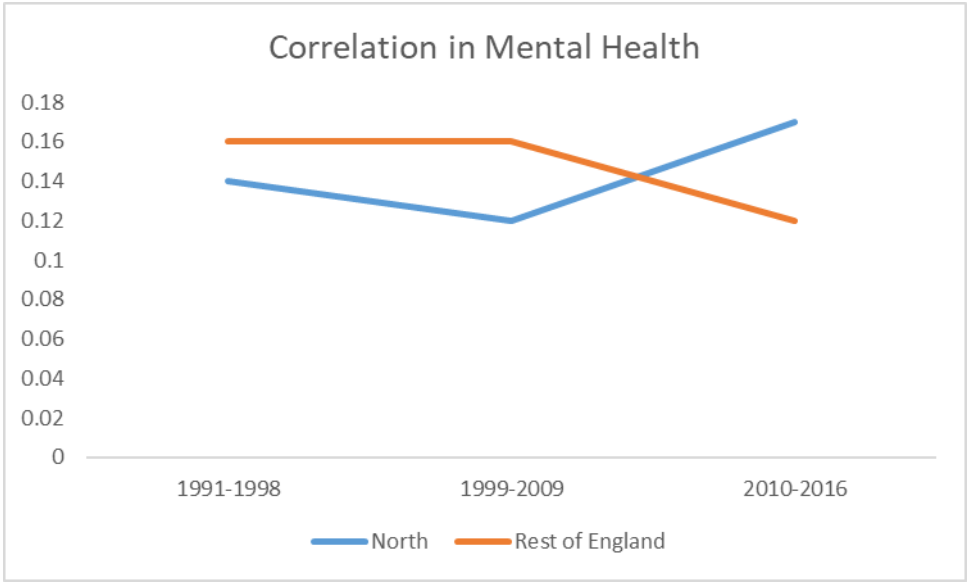
- Next, we use a decomposition approach to determine how much financial vulnerability and social support explain the likelihood of reporting the three measures of food insecurity.

Key Findings:

- There were regional differences on the role of health inequality policy on the influence of the family on young adult children's health and wages
- The English Health Inequality Period led to a larger decrease in the influence of parents and health and wages in the North (1%) compared to the Rest of England (0.03%)
- Austerity has been worse in the North than the Rest of England. Mobility is increasing at a slower rate in the North than the rest of England .

Key Findings

- The influence of parents on mental health is increasing in the North of England compared to the rest of England where it is decreasing.



Key Findings

30% of the £4 per person per hour gap in productivity (or £1.20 per hour) between the Northern Powerhouse and the rest of England is due to ill-health. Reducing this health gap would generate an additional

£13.2bn

in **UK GVA**

Key findings: Food insecurity

- People who had basic or no educational qualifications; who were unemployed in April 2020; were disabled; or had lower household incomes were significantly more likely to report all three measures of food insecurity.

- Financial vulnerability explains approximately half of the likelihood of being food insecure for those families with children of lower socioeconomic status, as measured by educational attainment.

- Eligibility for free school meals, being furloughed and receiving help from grandparents explains approximately 30% of the likelihood of being food insecure for those with lower socioeconomic status, as measured by educational attainment. Free school meals being the most important of these three measures.

Recommendations for local and regional stakeholders

1) Local authorities, local enterprise partnerships, local authorities, and Health and Wellbeing boards systems should scale up their family centred place based public health programmes to invest more in interventions that reduce social and environmental inequalities.

2) Local enterprise partnerships, schools, third sector organisations, local authorities, and devolved Northern regions should develop locally 'tailored' programmes for young people providing both health and employment support to help them into the world of work as well as staying healthy at work.

3) Coordinated responses between local health services to identify at risk families and individuals at a time of disrupted health service delivery

Recommendations to Central Government

1) To improve health and social mobility in the North there should be increased investment in place-based public health in Northern local authorities. Increasing health and social mobility in the North requires the Central government to increase the public health budgets in Northern local authorities to facilitate the development and delivery of effective place-based public health.

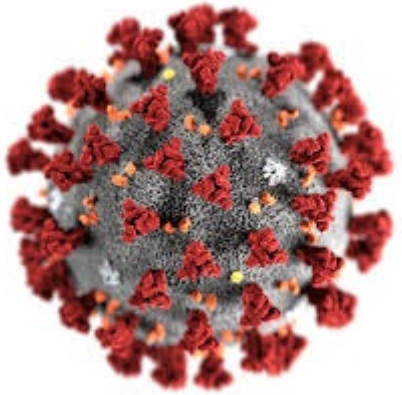
2) There should be increased investment in Northern schools especially secondary schools to reduce inequalities in educational attainment and the impact that it has on family mobility in the North.

3) To reduce inequalities, there should be increased spending on economic growth and development in 'left-behind' communities. This growth strategy should be environmentally sustainable and socially inclusive.

Recommendations to Central Government

- Increase generosity of benefits (continue additional £20 of universal credit payment
- Additional funding for local authorities who are tasked with supporting people who fall in the cracks of central government safety nets.
- Remove excessive financial and practical barriers (e.g. partner's income/savings) to obtaining universal credit, and reduce delays in delivery of funds
- Targeted job creation in economically vulnerable areas (e.g. Lighthouse scheme)
- Increasing eligibility and amount for food voucher schemes-(e.g. healthy start)

Challenges



Get ready for Brexit

- Exiting the European Union is a challenge in terms of future economic growth, NHS staff levels, and uncertainties around post-Brexit NHS and local authority public health budget settlements.
- Budget cuts at the local authority level impacting on the provision of services to children and young people
- The lagging behind of public health and prevention expenditure compared with treatment of existing conditions.
- Innovative and inclusive growth to ensure that economic growth in the North is environmentally sustainable and is targeted at all individuals/communities in the region.
- Covid

Cash-strapped North East councils slashed youth service spending by up to 96% in under a decade

Conclusions

- Deprivation is rising in the North East of England
- Health Inequalities are increasing between the North and Rest of England
- Health and Social Mobility for families in the North of England increased during the Health Inequality Strategy Period but has been decreasing since Austerity was introduced in 2010.
- Improving health in the North can reduce the employment gap
- Investment is needed in education, public health, employment opportunities, and the NHS.
- Challenging Climate

Questions and discussion

Newcastle University

The things we do here make a difference out there.

ncl.ac.uk