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NORTHUMBERLAND TYNE & WEAR & NORTH DURHAM STP HEALTH SCRUTINY COMMITTEE

Meeting on Monday, 17 June 2019 at 1.30 pm in the Bridges Room - Civic Centre

Agenda

1 Appointment of Chair (Pages 5 - 10)
In line with the attached current terms of reference of the Joint Committee, the Joint Committee is asked to appoint a Chair for the 2019-20 municipal year.

2 Appointment of Vice Chair
In line with the current terms of reference of the Joint Committee, the Joint Committee is asked to appoint a Vice Chair for the 2018-19 municipal year.

3 Apologies

4 Declarations of Interest

5 Minutes (Pages 11 - 22)
The minutes of the meeting of the Joint Committee held on 25 March 2019 are attached for approval.

6 Matters Arising

7 Optimising Services
Keith Bremner, Chief Executive of South Tyneside and Sunderland NHS Foundation Trust will provide the Joint Committee with a presentation on the above.

8 Primary Care - (Focus on Primary Care Networks and how GPs will be working together)
Denise Jones, Head of Primary Care for NHS England and NHS Improvement will provide the Joint Committee with a presentation on the above.

9 Development of ICS - Progress Update
Alan Foster Lead for North East and North Cumbria ICS and Mark Adams Chief Officer NewcastleGateshead, North Tyneside and Northumberland CCG will provide the Joint Committee with an update on the above.

10 Work Programme

Meeting Date	Issue
17 June 2019 – 1.30pm	• Development of ICS – Progress Update • Optimising Services • Primary Care – Focus on Primary Care Networks and how GPs will be working together
23 Sept 2019 – 1.30pm	• Development of ICS – Progress Update • Clinical Engagement and Proposed Clinical Priorities for ICS • Partnership Arrangements • Communication and Engagement – Progress Update
25 Nov 2019 – 1.30pm	• Development of ICS – Progress Update • Workforce – Progress Update • Urgent and Emergency Care – Progress Update
20 Jan 2020 – 1.30pm	• Development of ICS – Progress Update • Digital Care
23 March 2020 – 1.30pm	• Development of ICS – Progress Update • Population Health Management

Issue to slot in

- Mental Health – Progress Update

The proposed provisional work programme for the Joint Committee for 2019-20 is set out above.

The views of the Joint Committee are sought.

11 Dates and Times of Future Meetings

It is proposed that future meetings of the Northumberland Tyne and Wear and North Durham STP OSC are held at Gateshead Civic Centre on the following dates and times:-

- 23 Sept 2019 at 1.30pm
- 25 Nov 2019 at 1.30pm
- 20 Jan 2020 at 1.30pm
- 23 March 2020 at 1.30pm

Membership

Gateshead Council
Councillor L Caffrey
Councillor M Hall
Councillor R Beadle
Substitutes
Councillor M Charlton
Councillor P Foy
Councillor J Wallace

Newcastle City Council
Councillor W Taylor
Councillor F Mendelson
Councillor A Schofield
Substitutes
Councillor O Avery
Councillor Ali Avaei

North Tyneside Council
Councillor T Mulvenna
Councillor K Clark
Councillor J Mole
Substitutes
Councillor T Brady
Councillor E Parker-Leonard
Councillor J Kirwin

Sunderland City Council
Councillor D MacKnight
Councillor D Dixon
Councillor S Leadbitter

Durham County Council
Councillor J Robinson
Councillor J Stephenson
Councillor O Temple

Northumberland County Council
Councillor E Armstrong
Councillor JG Watson
Councillor EM Simpson
Substitute
Councillor RR Dodd

South Tyneside Council
Appointments to be confirmed.

Contact: Angela Frisby - Tel 0191 4332138 **Date: 3 June 2019**

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Protocol for a Joint Health Scrutiny Committee

Northumberland, Tyne and Wear and North Durham STP

1. This protocol provides a framework under the Local Authority (Public Health, Health and Wellbeing Boards and Public Health) Regulations 2013 for considering and providing a formal consultation response in relation to the Northumberland, Tyne and Wear and North Durham Sustainability and Transformation Plan and any associated proposals for substantial development and variation to health services contained therein or resulting therefrom. The proposals affect the Northumberland CCG, Tyne and Wear CCGs and the North Durham CCG area of County Durham. They are being proposed by the following:

   - Newcastle Gateshead CCG
   - North Durham CCG
   - North Tyneside CCG
   - Northumberland CCG
   - South Tyneside CCG
   - Sunderland CCG

2. The terms of reference of the Joint Health Scrutiny Committee are set out at **Appendix 1**.

3. A Joint Health Scrutiny Committee ("the Joint Committee") comprising Durham County Council; Gateshead Council; Newcastle City Council; North Tyneside Council; Northumberland County Council; South Tyneside Council and Sunderland City Council ("the constituent authorities") is to be established in accordance with the Regulations for the purposes of formal consultation by the relevant NHS Bodies in relation to the matters referred to at paragraph 1. In particular in order to be able to:-

   (a) respond to the draft STP consultation and any associated proposals for substantial development and variation to health services contained therein or resulting therefrom;

   (b) require the relevant NHS Bodies to provide information about the proposals;

   (c) require members/employees of the relevant NHS Bodies to attend before it to answer questions in connection with the consultation.

4. The Joint Committee formed for the purpose of the consultation outlined at paragraph 1 will, following approval of this protocol and terms of reference at its first meeting, circulate copies of the same to:-

   Local Authorities

   Durham County Council; Gateshead Council; Newcastle City Council; North Tyneside Council; Northumberland County Council; South Tyneside Council and Sunderland City Council;

   Clinical Commissioning Groups

   Newcastle Gateshead CCG
   North Durham CCG
   North Tyneside CCG

Northumberland CCG
South Tyneside CCG
Sunderland CCG

NHS Foundation Trusts

City Hospitals Sunderland NHS Foundation Trust
County Durham and Darlington NHS Foundation Trust
Gateshead Health NHS Foundation Trust
Newcastle-upon-Tyne Hospitals NHS Foundation Trust
Northumbria Healthcare NHS Foundation Trust
South Tyneside NHS Foundation Trust
Northumberland, Tyne and Wear NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
North East Ambulance Foundation Trust

Membership

5. The Joint Committee will consist of equal representation, with three representatives to be appointed by each of the constituent authorities on the basis of their own political balance.

6. The term of office for representatives will be for the period from the date of their appointment by their constituent authorities until their relevant authority's next annual council meeting. If a representative ceases to be a Councillor, or wishes to resign from the Joint Committee, the relevant council shall inform the joint committee secretariat and the replacement representative shall serve for the remainder of the original representative's term of office.

7. To ensure that the operation of the Joint Committee is consistent with the Constitutions of all the constituent authorities, those authorities operating a substitution system shall be entitled to nominate substitutes.

8. The Joint Committee may ask individuals to assist it (in a non-voting capacity) and may ask independent professionals to advise it for the purposes of the consultation process.

9. The quorum for meetings of the Joint Committee shall be a minimum of one member representative from each of the constituent authorities.

Chair and Vice-Chair

10. For the purposes of the consideration of the Sustainability and Transformation Plan (Draft and Final) the Chair and the Vice-Chair of the Joint Committee will be appointed annually at the first meeting of the Joint Committee following the relevant authorities' Annual Council Meetings. The Chair will not have a second or casting vote.

11. If the agreed Chair and Vice-Chair are absent from a meeting, the Joint Committee shall appoint a member to chair that meeting from the representatives present who are members of the same constituent Council as the Chair.

12. For the purposes of the consideration of any proposals for substantial development and variation to health services contained within or resulting from the Sustainability and Transformation Plan (Draft and Final) that affect at least two but not all of the

constituent authorities, the Committee will be chaired from one of the affected local authority areas.

Terms of Reference

12. The Joint Committee will be the formal consultee under the Regulations and the Directions for the purposes of the consultation by the relevant NHS Bodies concerning those matters outlined at paragraph 1. Terms of reference are set out at Appendix 1.

Administration

13. Meetings shall be held at the times, dates and places determined by the Chair in consultation with each of the constituent authorities.

14. Agendas for meetings shall be determined by the secretariat in consultation with the Chair.

15. Notice of meetings of the Joint Committee will be sent to each member of the Joint Committee at least 5 clear working days before the date of the meeting and also to the Chairs of the constituent authorities' relevant overview and scrutiny committees (for information). Notices of meetings will include the agenda and papers for meetings. Papers "to follow" should be avoided where possible.

16. Minutes of meetings will be supplied to each member of the Joint Committee and to the Chairs of the constituent authorities' relevant overview and scrutiny committees (for information) and shall be confirmed at the next meeting of the Joint Committee.

Final Report and Consultation Response

17. The relevant NHS body is required to notify the Joint Committee of the date by which its consultation response is required, and the date by which it intends to make a decision. The Guidance highlights that it is sensible for the Joint Committee to be able to consider the outcome of public consultation before it makes its consultation response.

17. The Joint Committee is independent of its constituent councils, executives and political groups and this independence should not be compromised by any member, officer or relevant NHS bodies. The Joint Committee will send copies of its final report and formal consultation response to the relevant NHS Bodies and the constituent authorities.

18. The primary objectives of the Joint Committee will be to reach consensus, but where there are any aspects of the consultation as regards which there is no consensus, the Joint Committee's final report and formal consultation response will include, in full, the views of all of the constituent authorities, with the specific reasons for those views, regarding those areas where there is no consensus, as well as the constituent authorities' views in relation to those matters where there is a consensus.

Voting

19. Wherever a vote is taken, this will be done on the basis of a simple majority.

Following the Consultation

20. Any next steps following the initial consultation response will be taken with due reference to the 'Local Authority Health Scrutiny: Guidance to support Local Authorities and their partners to deliver effective health scrutiny' (Department of Health; June 2014).

Principles for joint health scrutiny

21. In scrutinising the proposals, the joint committee will aim to consider the proposal from the perspectives of all those affected or potentially affected by that proposal.

22. The constituent authorities and the relevant NHS Bodies will be willing to share knowledge, respond to requests for information and carry out their duties in an atmosphere of courtesy and respect in accordance with their codes of conduct. Personal and prejudicial and/or disclosable pecuniary interests will be declared in all cases in accordance with the code of conduct and Localism Act 2011.

23. The Joint Committee's procedures will be open and transparent in accordance with the Local Government Act 1972 and the Access to Information Act 1985 and meetings will be held in public. Only information that is expressly defined in regulations to be confidential or exempt from publication will be able to be considered in private. Papers of the Joint Committee may be posted on the websites of the constituent authorities as determined by them.

24. Communication with the media in connection with the Joint Committee's views will be handled in conjunction with each of the constituent local authorities' press officers.

Appendix 1

Joint Health Scrutiny Committee

Northumberland, Tyne and Wear and North Durham STP

Terms of Reference

1. To consider the Northumberland, Tyne and Wear and North Durham Sustainability and Transformation Plan (hereafter called STP)

2. To consider proposals for substantial development and variation to health services as contained in and/ or developed from the STP and as proposed by the following:

   - Newcastle Gateshead CCG
   - North Durham CCG
   - North Tyneside CCG
   - Northumberland CCG
   - South Tyneside CCG
   - Sunderland CCG

3. To consider the following in advance of the formal public consultation:

   - The aims and objectives of the STP;
   - The plans and proposals for public and stakeholder consultation and engagement;
   - Any options for service change identified as part of the STP including those considerations made as part of any associated options appraisal process.

4. To consider the STP's substantive proposals during the period of formal public consultation, and produce a formal consultation response, in accordance with the protocol for the Joint Health Scrutiny Committee and the consultation timetable established by the relevant NHS Bodies.

5. In order to be able to formulate and provide views to the relevant NHS bodies on the matters outlined above, the Joint Committee may:-

   a) require the relevant NHS Bodies to provide information about the proposals the subject of the consultation with the constituent local authorities and the Joint Committee; and

   b) require an officer of the relevant NHS Bodies to attend meetings of the Joint Committee, in order to answer such questions as appear to them to be necessary for the discharge of their functions in connection with the consultation.

6. To ensure the formal consultation response of the Joint Committee includes, in full, the views of all of the constituent authorities, with the specific reasons for those views, regarding those areas where there is no consensus, as well as the constituent authorities' views in relation to those matters where there is a consensus.

7. To oversee the implementation of any proposed service changes agreed as part of the STP process.

8. The Joint Committee does not have the power of referral to the Secretary of State as this will be retained by individual local authorities.

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GATESHEAD METROPOLITAN BOROUGH COUNCIL

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

Monday, 25 March 2019

PRESENT: Councillor L Caffrey (Gateshead Council) (Chair)

Councillor(s): Taylor, Mendelson and Schofield (Newcastle CC) Armstrong and Dungworth (Northumberland CC), Flynn and Hetherington (South Tyneside Council), Spillard (North Tyneside Council - substitute) Robinson, Stephenson, and Temple (Durham CC), Dixon (Sunderland)

66 APOLOGIES

Councillors Beadle and Hall (Gateshead Council , Watson and Dodds (Northumberland CC), Huntley (South Tyneside Council), Leadbitter and Snowdon (Sunderland CC).

67 DECLARATIONS OF INTEREST

Councillor Taylor (Newcastle CC) declared an interest as an employee of Newcastle Hospitals Foundation Trust.

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

68 MINUTES

The minutes of the last meeting of the Joint Committee held on 21 January 2019 were approved as a correct record.

69 MATTERS ARISING FROM THE MINUTES

Development of ICS – Progress update

The Joint Committee noted that Amanda Hulme proposed to come back to a future meeting of the Committee to seek views on the proposed arrangements / membership of the proposed Independently Chaired Partnership Board.

It was also noted that an update on the ICS would be provided at today's meeting and be a standing item for future meetings.

The Chair noted that at the last meeting the Committee had understood that an expression of interest for a shadow ICS had needed to be submitted for the NE and Cumbria by 1 April 2019 and she asked if the Committee could be updated on progress.

Alan Foster explained that the process to become an ICS was still ongoing. However, as NHS England and NHS Improvement were now coming together, and appointments were being made to the regional team, progress in relation to the development of the ICS was slower than originally expected.

Alan also advised that there was now no longer a requirement to submit a document setting out an expression of interest by 1 April 2019. The process for developing an ICS would be an ongoing development process and this approach was being adopted across the country.

The ICS was all organisations working within a system and this would continue to be developed across NE and Cumbria. It was not a case of creating separate statutory organisations.

Alan stated that he had recently attended a Social Prescribing Conference in Newcastle and updates were being provided to Health and Wellbeing Boards and scrutiny.

Alan stated that further updates would be provided to future meetings of the Committee.

NEAS – Integrating the Ambulance Service in the STP

Councillor Taylor queried the timeframe for having all the additional paramedic appointments in place and asked that this information be provided at a future meeting.

Workforce update

It was noted that members of the Joint Committee had asked for further information on the below issues and this information would be provided in a future update on workforce as part of the new work programme.

- Numbers of nurses coming into the NHS in NE as well as figures related to student nurses / compared to national position.
- Numbers of NHS staff in NE due to retire
- Proportion of other foreign nationals forming part of the NHS workforce.
- Work around developing workforce across health and social care
- How unions are being involved in work progressed / training initiatives at regional and local level.
- Reassurances that workforce will not be provided via private companies
- Further detail on work to retain NHS staff
- Work to retain GPs in particular and info on whether national policies are impacting on changes to pension cap and making it uneconomic for GPs to continue.

70 PREVENTION - PROGRESS UPDATE

Dr Pilkington, Vice Chair, Newcastle Gateshead CCG and SRO Prevention Board provided a high - level summary of collective work in relation to prevention within the ICS.

Dr Pilkington reminded the Committee that although there are very high standards of healthcare across the patch our population still does less well due to poverty and inequalities in health. The key focus of prevention work was therefore to target activities that aim to close the health inequality gap and the NHS was committed to exploring with local authorities' potential areas which could deliver the most impact for our population.

Dr Pilkington explained that in September 2018 senior leaders on the Prevention Board attended a Systems Leadership and Large - Scale Change two - day Masterclass which had focused on the future direction and priorities for the Prevention Board and developed a new model focusing on a few key priorities. This work was then shared with senior NHS leaders at a Prevention Board workshop in November 2018 and feedback helped refine the developing strategy and the key priorities.

The Prevention workstream would be working more closely with the mental health workstream and supporting its ambition for zero suicides and the Care Closer to Home Workstream as well as collaborating with other workstreams.

Dr Pilkington advised that going forwards the Prevention Board focus will be to:

- support work at ICS level, maximising the benefits of working at scale across the region
- energise the NHS to scale up its contribution to prevention
- deliver work programmes focused in areas where the greatest difference can be achieved in the shortest amount of time in the NHS

However, this does not detract from work delivered by the local system and there may be a time where ICPs come together to deliver at scale on some pieces of work.

Dr Pilkington stated that in relation to population health and inequalities of outcome a community asset - based approach was critical to success as was social prescribing and work with the third sector.

Dr Pilkington advised that the Prevention Board agreed that its two highest priorities were:-

- Treating tobacco addiction as part of a whole NHS smoke-free model
- Reducing alcohol related harm

Dr Pilkington stated that there was a need to accelerate work on tobacco control and how nicotine replacement was supported to ensure that they reached targets. A major piece of work was therefore underway to drive this forward. Dr Pilkington explained that the health gains for the NE population could not be matched by any other health intervention if the target was achieved. Reducing alcohol related harm

was almost equal in terms of priority status as the NE has one of the highest hospital admissions for alcohol misuse.

Dr Pilkington stated that the Prevention Board had also agreed 3 enabling workstreams:

- Workforce (MECC, Increasing Public Health Capacity in Trusts, Health of the Workforce)
- Communication and engagement at ICS level (supporting the implementation of the prevention approach across the ICS system)
- Community asset- based approach (including social prescribing)

The Prevention Board would report on progress to the ICS Health Strategy Group and Health and Wellbeing Boards.

Dr Pilkington advised that the work of the Prevention Board had already managed to have some impact and was being promoted at the highest level by both Alan Foster and Mark Adams. Dr Pilkington explained that NECS had managed to generate a surplus and so the Prevention Board had bid for the one million pound surplus and had been successful. The additional money would now be used to increase Public Health capacity in key places across the system and an advert was going out for three public health posts which would be embedded in NHS trusts. The work proposed was based on a model in Northumbria and it was considered that it would have a huge cultural impact. It was hoped that it would be possible to create another couple of posts going forwards and so expressions of interest were being sought.

Dr Pilkington stated that as part of the work they were also looking to get Public Health expertise at the centre of the system and were looking to second a part-time Director of Public Health/Senior Consultant in Public Health to lead the regional Population Health Management work with NECS. It was also proposed to develop and implement an ICS wide Communications and Engagement strategy to change the NHS narrative around prevention.

Dr Pilkington advised that the first meeting of the newly constituted Prevention Board was being held on 1 May 2019.

Dr Pilkington explained that the aim was to implement a Smoke Free NHS by March 2020.

Councillor Mendelson thanked Dr Pilkington for the information which she considered was really positive and highlighted excellent work taking place. However, Councillor Mendelson noted the extent to which cuts had been made in local authority Public Health spending and queried what representations were being made in relation to these cuts. Dr Pilkington acknowledged that the cuts did represent a significant risk to the ambitious plans / work outlined and stated that representations were being made via Public Health England. In the shorter term, consideration was being given to system challenges and the potential scope for NHS budgets to fill gaps where funding had traditionally been provided via local authorities.

It was noted that there had been information in the BMJ that 30% of local authorities are no longer investing in smoking cessation and support and Dr Pilkington

considered that this would be clearly detrimental for the developing ICS.
Dr Pilkington stated he was not suggesting that the NHS would be able to fund all smoking cessation / support but the NHS might be able to assist in some areas. Joint working was essential to achieving progress.

Councillor Robinson queried who the elected members were on the Prevention Board and the evidence base for stopping smoking and reducing alcohol related harm as the key priorities as opposed to work to prevent dementia or heart disease or health and wellbeing of young people.

Dr Pilkington explained that there is strong evidence that if individuals stop smoking there is an immediate impact on their health in terms of a reduction in risk of heart attacks etc and the evidence in relation to alcohol harm and the increasing need to tackle this has been highlighted in the NHS for a long time. Dr Pilkington agreed that one of the most important places to make change happen is with young people but stated that the benefits of prevention work in relation to smoking and alcohol related harm were not lost with age. Dr Pilkington stated that in this region smoking rates had reduced faster than any other region and that whilst further work would require significant investment it is considered that there is scope to continue to achieve a dramatic and beneficial impact on population health by prioritising this work.

Dr Pilkington also confirmed that tackling heart disease continues to be a key driver and the Cardiovascular Network has a prevention stream led by NHS England and this works closely with the Prevention Workstream / Board.

Dr Pilkington advised that at this time there is not an elected councillor member of the Prevention Board as this was not something that had been considered.

Councillor Robinson considered that if a local authority Cabinet member with responsibility for health and wellbeing was involved in the Board this would send a very positive message.

Dr Pilkington stated that in principle he was not averse to this suggestion. Alan Foster stated that he also had no objections to the suggestion in principle. However, Alan stated that as the developing ICS progressed joint working there was a need to develop the system bottom up and as part of that there was a need to think about the best way of engaging with stakeholders at all levels. Alan stated that Health and Wellbeing Boards which are statutory bodies and have elected members as part of their membership are part of this bottom up approach and the important factor will be getting the right engagement with elected members at the right level.

Dr Pilkington advised that he was happy to discuss the issue further if councillors felt this was a significant opportunity to enhance joint working.

Councillor Taylor queried whether there were any other evidence - based interests if more funding became available.

Dr Pilkington advised that another area which was hugely important was in relation to local people becoming more active and the benefits of exercise - based interventions for individuals with vascular/ diabetes and musculoskeletal issues. Dr

Pilkington considered that there was scope for these to be more clearly articulated.

Councillor Taylor considered that obesity was also clearly another such area and Dr Pilkington acknowledged that this was the case and explained that action was being focused via an asset - based approach which looks at understanding what is important to individuals and then helping them to understand what they can do to change their weight.

Councillor Taylor noted the approach and highlighted that any public campaigns progressed in this area should be evidence based to ensure public monies were not wasted.

Councillor Schofield noted that the Committee had previously received information on the potential impact of Brexit on the NHS workforce and given that alongside this there were also issues in relation to cuts to local authority budgets and capacity issues within the third sector she considered that there was potential for this to have a significant impact on the prevention agenda.

Councillor Schofield also noted that the Prevention Board would need to be mindful of diversity and queried how this was being factored in.

Dr Pilkington explained that the Primary Care Networks in local geographies would be key as these Networks have to think about how to respond to the health and wellbeing needs of the local population.

Dr Pilkington also explained that in terms of workforce it was clear that the NE needed to carry out work to grow its own and he highlighted the work in relation to Sunderland Medical School which was developed in part to create and retain local staff.

Dr Pilkington also stated that consideration needed to be given to anchor institutions such as NHS Health Trusts and GP practices taking responsibility for apprentice opportunities to provide a better chance of having a workforce capable of meeting population needs.

Councillor Spillard noted the contracts put in place in relation to communication and engagement work and queried whether there was any danger of duplication and a failure to spend money wisely given that local authorities have already been working with organisations such as Fresh and Balance for a number of years. Councillor Spillard noted that illicit tobacco was a major factor in some of the most deprived areas where prevention was most needed and where local authority trading standards teams were now smaller and she queried whether this had been considered in relation to future funding.

Dr Pilkington advised that the local authority approach in creating regional bodies had been very helpful and indicated that Fresh and Balance have always been active members of the Prevention Board. However, the Board was not at the stage where plans had been developed in this area and work was yet to take place in relation to how those organisations would continue to feed in.

71 CARE CLOSER TO HOME

Janet Probert, Care Closer to Home Senior Responsible Officer, Dr Jenny Steel, Clinical Lead Care Closer to Home Network CNE provided the Committee with an update on this issue.

The Committee learned that the over-arching scope of the Care Closer to Home (CCH) programme of work is to support the local delivery of outcomes which look to ensure the provision of an improved range of Out of Hospital Services (including statutory, independent and voluntary sectors) with consistently high standards and improved patient satisfaction, that provide earlier intervention, better coordinated care, support independence and reduce the length of hospital stays.

The Committee noted that the CCH work-stream has prioritised 'frailty' as an area of focus as the presence of frailty, and its severity, correlates with poor outcomes, such as poor quality of life, institutionalisation, mortality and increasing cost to health and care systems.

Looking after the frail elderly is one of the biggest challenges facing primary care: GPs, dentists and community pharmacists. Caring for the frail elderly also presents huge challenges to social care, housing and residential care providers and the whole spectrum of third sector services.

There is a spectrum of frailty from mild to moderate through to severe, ultimately leading to end of life. Frailty is common amongst older adults, with the overall prevalence of frailty in people aged over 60 estimated to be around 14%. In England, there are 1.8 million people aged over 60 and 0.8 million people aged over 80 living with frailty. The prevalence of frailty increases with age, resulting in 5% of people aged 60-69 living with frailty and up to 65% of people aged over 90 living with frailty. Frailty is also considered more common in women (16% versus 12%).

The Committee was also provided with information around a frail person's journey in the health and social care system.

In terms of progress so far, the Committee learned that :-

- A regional frailty Toolkit is being developed (incorporating evidence-based approaches to care across the frailty journey, key resources and local examples of good practice). The toolkit is aimed at preventing frailty and supporting older people, families and communities living with frailty. The ambition is to work more collaboratively across the wider health and care system to improve the quality of life for our aging population, whilst exploring the significant economic case for change.
- The Toolkit is underpinned by a dashboard of key outcome metrics.
- Local health and care economies will be able to benchmark existing care provision and metrics against others in the region, identify their priorities and then draw on the Toolkit to introduce new initiatives and improve the care and support they offer.
- A regional frailty 'Community of Practice' (CoP) has been established to drive the work forward, bringing together a wide range of professionals from across

the regional health and care system, who understand frailty and older people's services.

- A Workforce competency framework has been developed for registered and non-registered staff working anywhere in the care system and plans are afoot for testing it in a variety of settings in the coming months. A longer - term vision is for the development of an apprenticeship. A workforce lead 'CoPper' has been identified, supported by clinical leads and linked to the regional ICS workforce programme.
- The programme is also collaborating with local Universities as part of an ARC bid where Frailty has been chosen to be one of the key themes supported by 'evaluation CoPpers.
- Academics and librarians have agreed to support the evaluative methodology surrounding the toolkit and strengthen the presentation of supporting evidence.
- A simple web-based digital platform for the Frailty Toolkit has been set up.
- Working in partnership with Newcastle Hospitals Trust, funding has been secured from Health System Led Investment in Provider Digitisation over the next 3 years to support digitisation of the Frailty ICARE work. Three digital projects are underway which look to support our regional CoP, the Frailty ICARE website and a patient-facing pathway.
- Work is also ongoing to support the regional digital access portal.

The Committee was informed that next steps included:-

- Continuing to develop the Frailty Toolkit to offer a region-wide common understanding of frailty and establish a supportive way for learning and sharing best practice to support local health and care system planning.
- Continuing to facilitate and support a region-wide CoP, where initiatives are shared, learning and recommendations agreed, plans made for wider sharing through local forums and the Toolkit kept iterative.
- Taking advantage of digital solutions to further enhance the technological platform for the Frailty Toolkit and frailty CoP to better facilitate access through the implementation of the DCJS-funded Projects.
- Supporting the reduction in financial costs, time spent and resource utilisation across the health and care system by: improving current practice, streamlining and aligning services to avoid duplication, thereby working more efficiently and cost effectively whilst improving patient experience.
- Working across the whole health and care system: to support carers and family members taking a 'whole family' approach and to support people with daily living tasks, promoting independence and the ability to live at home for as long as possible.
- Exploring potential integration of services and shared pathways of care.

The Committee was advised that the approach to this work and specifically the Frailty Toolkit and Community of Practice has real potential to support and facilitate both local and 'at scale' transformation.

Ian Kitt, the Chair of Healthwatch North Tyneside considered that the information was helpful but felt that the name of the Frailty Project was problematic as work carried out by Age UK highlighted that the term frailty might generate negative

reactions amongst older people and put them off engaging with the programme. Ian queried the extent to which older people were already engaging with the programme and whether the description of the project had been discussed with them.

Dr Steel advised that there had been lengthy discussions and whilst there some who were not comfortable with the term, generally it was considered that frailty does not necessarily mean older people and is based around individuals and their specific needs. Dr Steel stated that they had talked to older people and held a summit which was attended by those who actively work with older people eg Age UK who fed in their views and were listened to.

Dr Steel stated that through the Community of Practice there was an offer to all Healthwatch to hold discussions and feed in views with the aim of developing an iterative process. Dr Steel stated that this was the start of a conversation and if the feedback going forwards was that frailty was not the right term they would listen and make changes.

Janet stated that they had not tried to provide a local solution rather they had tried to pull together an evidence base that can then be used locally. Janet envisaged that those in the Community of Practice would provide the local link and the expectation would be that the local system would engage with the local population.

Councillor Taylor congratulated everyone on the tremendous work carried out so far but had concerns in relation to funding. Councillor Taylor queried how invest to save funding was sorted out.

Janet stated that better joined up local systems lead to better outcomes being achieved. Janet stated that she could provide some good examples from across the patch. For instance, there was a lot of good work around housing to keep people well and safe and areas where GPs can bring housing into the conversation with patients.

Alan stated that a key policy aim for the NHS was to invest more in out of hospital care. Alan also advised that the new GP contract and Primary Care Networks will be incentivised. Alan indicated that there may be additional funding going to primary care which could facilitate the development of new roles in primary care and work with community services and local authorities.

Alan advised that the work being progressed in relation to frailty was recognised nationally and may provide a blueprint for a national frailty programme.

Councillor Flynn advised that he had always felt uncomfortable about care provided at home but had recently viewed some of the assistive technology available for individuals requiring certain adaptations and had been very impressed and was very supportive of this type of work.

Janet confirmed that this type of technology was at the forefront of the work they were doing but they did need to support people to feel more comfortable having care provided at home.

Councillor Dungworth highlighted that there were also issues around individuals who acted as carers and then became frailer themselves as a result of their caring role. Janet noted that this was a good point and advised that the key would be to look at the whole situation relating to an individual and ensure that early conversations led to support networks being put in place.

Janet stated that in her area they were offering frail patients Developing Crisis Plans which were very new.

72 DIGITAL MINOR ILLNESS REFERRAL SERVICE (DMIRS) - UPDATE

Andre Yeung, LPN Chair North Cumbria and North East England provided the Committee with an update on the progress of the Digital Minor Illness Referral Service (DMIRS) which had started in August 2014.

Andre explained that the service targets those individuals with a self - limiting illness via contact through NHS 111. As a result of the technology put in place between pharmacies and NHS 111 and training in call handling 16,500 individuals had now been referred through to pharmacy services where previously this had not happened.

In terms of the issues being referred through to Pharmacy as a result of the service, respiratory issues provided the largest number of referrals with coughs being the highest area of referrals and colds and flu next. Andre stated that all the issues referred were lower level issues which would previously have been addressed at GP surgeries and predominantly individuals using the service needed only advice or advice and an over the counter product. Andre explained that a lot of the calls received had been at night or over the weekend and referrals to Pharmacy had meant that individuals had avoided having to go to out of hours facilities. Andre stated that DMIRS aims to support general practice by providing an option before general practice is needed.

Andre stated that the benefits of this approach had been an increase in capacity and reduction in costs and that individuals were receiving information and education in relation to self - care and care was being provided closer to home.

However, Andre highlighted that a challenge had been that pharmacists had not been used to providing advice on managing conditions and it had taken time for pharmacists to get used to this change in approach. Andre stated that further training for Pharmacists would be beneficial to bolster the learning already achieved.

Andre also highlighted that it would be useful if Pharmacy had access to certain medicines and for improved technology to assist them in carrying out a more thorough job.

Andre stated that the service had proven so successful that it had now been implemented in three other areas, Devon and Sommerset, London and East Midlands and discussions were taking place regarding the potential for a national service to support primary care.

The Chair thanked Andre for his update and stated that the role of pharmacy was a really important part of the mix.

Councillor Mendelson queried whether there were cost issues in relation to the service.

Andre stated that most of the NE had minor ailments services which allows Pharmacies to give out some medicines for free. This scheme was introduced in the late 1990's in order to address health inequalities. Andre stated that there was now a driver to remove this scheme but it does have an important role. However, Andre advised that he was not aware of pharmacies reporting that patients were indicating that there were major issues in paying for medicines.

Councillor Hall noted that Andre had indicated that the service was considered successful and queried whether there was data from a patient perspective which supported that position. Andre advised that there was twelve months of available data which included information from a patient's point of view and highlighted high levels of satisfaction with the service. Andre stated that the data was not available currently as it was being consolidated to include the data for the three new areas covered by the service. However, Andre advised that there would be an evaluation of the service going forwards.

Councillor Hall indicated that it would be helpful for the data to be provided to the Committee when it became available.

73 DEVELOPMENT OF WORK PROGRAMME 2019-20

The Committee considered and agreed its provisional work programme for 2019-20 as follows:-

Meeting Date	Issue
17 June 2019	• Development of ICS – Update • Optimising Services • Primary Care – focus on Primary Care Networks and how GPs will be working together in a new way)
23 Sept 2019	• Development of ICS – Update
25 Nov 2019	• Development of ICS – Update
20 Jan 2020	• Development of ICS – Update
23 March 2020	• Development of ICS – Update

Issues to slot In

- Development of ICS – Partnership Arrangements
- Communication and Engagement – Progress Update
- Workforce – Progress Update
- Urgent and Emergency Care – Progress Update
- Primary Care – focus on Primary Care Networks and how GPs will be

working together in a new way)

- Population Health Management
- Digital Care
- Clinical Engagement and Proposed Clinical Priorities
- Mental Health – Progress Update

74 PROPOSED DATES AND TIMES OF FUTURE MEETINGS

It was noted that future meetings of the Joint Committee were scheduled for the following dates and times at Gateshead Civic Centre:-

- 17 June 2019 at 1.30pm
- 23 Sept 2019 at 1.30pm
- 25 Nov 2019 at 1.30pm
- 20 Jan 2020 at 1.30pm
- 23 March 2020 at 1.30pm

Chair……..