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JOINT OSC FOR THE NE & NORTH CUMBRIA ICS & NORTH & CENTRAL ICPS

Meeting on Monday, 4 July 2022 at 1.30 pm in the Bridges Room - Civic Centre

Agenda

1 Appointment of Chair
In line with the terms of reference of the Joint Committee, the Joint Committee is asked to appoint a Chair for the 2022-2023 municipal year.

2 Appointment of Vice Chair
In line with the terms of reference of the Joint Committee, the Joint Committee is asked to appoint a Vice Chair for the 2022-2023 municipal year.

3 Protocol / Terms of Reference (Pages 5 - 12)
The Joint Committee is asked to endorse the proposed revisions to the Protocol / Terms of Reference arising from the move to a statutory ICS as of 1 July 2022.

Revised Draft Protocol attached.

4 Apologies

5 Declarations of Interest

6 Minutes (Pages 13 - 26)
The minutes of the meeting of the Joint Committee held on 21 March 2022 are attached for approval.

7 Update on Next Steps for the ICS
Mark Adams, Area Director for the North, will provide the Joint OSC with an update on this matter.

8 Oncology Services Briefing (Pages 27 - 30)
Briefing attached.

Representatives from NHS England, who are responsible for commissioning oncology services, Newcastle Hospitals, as the provider of these services, and the Northern Cancer Alliance, alongside the newly formed Provider Collaborative, which represents all FTs in the region, will provide the Joint OSC with a presentation on this matter.

9 Covid Recovery Plan

Matt Brown, Managing Director of the NENC Provider Collaborative, will provide the Joint OSC with an update on this matter

10 Work Programme 2022-23

The below issues have been rolled forward from the previous work programme to the 2022-23 work programme:-

- Next Steps for ICS (standard item)
- Workforce – Progress Update
- Inequalities – Update
- Emergency Planning
- Progress of the Digital Strategy – (regular updates)

In addition to the above, the below issue has been suggested for inclusion in the programme:-

- Update on ICS Mental Health Collaborative

The views of the Joint OSC are sought on the above and any additional issues it may wish to consider as part of the 2022-23 work programme

11 Dates and Times of Future Meetings

It is proposed that future meetings of the Joint OSC are held at Gateshead Civic Centre on the following dates and times:-

- 19 Sept 2022 at 1.30pm
- 21 Nov 2022 at 2.30pm
- 23 Jan 2023 at 1.30pm
- 20 March 2023 at 2.30pm

Membership

Gateshead Council
Councillor L Caffrey
Councillor M Hall
Councillor J Wallace
Substitutes
Councillor J Green
Councillor J McCoid
Councillor I Patterson

Newcastle CC
Councillor T Prestwell
Councillor L Ellis
Councillor W Taylor
Substitute
Councillor Ali Avaei

North Tyneside Council
Councillor J O'Shea
Councillor J Kirwin
Councillor T Mulvenna
Substitutes
Councillor P Richardson
Councillor E Parker-Leonard
Councillor J Shaw

Durham CC
Councillor R Charlton-Laine
Councillor P Jopling
Councillor D Haney
Northumberland CC
Councillor P Ezhilchelvan
Councillor K Nisbet
Councillor V Jones
Substitute
Councillor B Flux

South Tyneside Council
Councillor G Kilgour

Councillor J G McCabe
Councillor E Malcolm

Sunderland CC
Councillor M Butler
Councillor A Chisnall
Councillor D McDonough

Contact: Angela Frisby Tel 0191 4332138 Date: 24 June 2022

Revised Protocol for ~~a~~ Joint Health Scrutiny Committee

Joint OSC for the NE & NC ICS and North and Central ICPs OSC

1. This protocol provides a framework under the Local Authority (Public Health, Health and Wellbeing Boards and Public Health) Regulations 2013 for considering any proposed formal consultation in relation to the ~~establishment of an~~ Integrated Care System for the North East and North Cumbria and any subsequent proposals for substantial development and variation to health services arising from / as a consequence of the development / establishment of an Integrated Care System for the North East and North Cumbria and / or arising from / or as a consequence of the development of an Integrated Care Board, Integrated Care Partnership and sub ICPs~~s~~ covering the geographies of Northumberland, Tyne and Wear and Durham and the below mentioned groups and bodies:-

Sub ICP North

- ~~Northumberland CCG~~
- ~~North Tyneside CCG~~
- ~~NewcastleGateshead CCG~~
- Primary Care Networks within the ICP North geography?
- Northumbria Healthcare NHS FT
- Newcastle Hospitals NHS FT
- Gateshead Hospitals NHS FT
- Gateshead Council
- Newcastle City Council
- North Tyneside Council
- Northumberland County Council

Sub ICP Central

- ~~South Tyneside CCG~~
- ~~Sunderland CCG~~
- ~~North Durham CCG~~
- ~~*Durham, Dales, Easington and Sedgfield CCG*~~
- Primary Care Networks within the ICP Central geography?
- Sunderland Hospitals NHS FT
- South Tyneside Hospital NHS FT
- County Durham and Darlington NHS FT
- South Tyneside Council
- Sunderland City Council
- Durham County Council

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Plus the following bodies which cover both sub ICP geographies

- Northumberland, Tyne and Wear NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- North East Ambulance Foundation Trust

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

2. 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 above. In particular in order to be able to:-

(a) respond to any consultations in relation to proposals for substantial development and variation to health services arising from / as a consequence of the development of /establishment of an Integrated Care System for the North East and North Cumbria and / or arising from / or as a consequence of the development of an Integrated Care Board, Integrated Care Partnership~~s~~ and Sub ICPs covering Northumberland, Tyne and Wear and Durham (currently the " North" and " Central" ICPs as outlined in paragraph 1 above).

(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 purposes 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~~
~~Durham, Dales, Easington and Sedgfield CCG~~
~~North Tyneside CCG~~
~~Northumberland CCG~~
~~South Tyneside CCG~~
~~Sunderland CCG~~

- **NE & NC ICS**

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

- **Primary Care Networks covering the North and Central Sub ICP geographies**

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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, except in cases where a constituent authority exercises its right not to participate in a formal consultation process in relation to a proposal for substantial variation and development in which case the quorum will be made up from a minimum of one member representative from each of the constituent authorities electing to participate in the consultation process.

Chair and Vice-Chair

10. For the purposes of the consideration of the developing / established ICS for the NE and North Cumbria and the development / establishment of the Integrated Care Board Integrated Care Partnership and sub ICPs~~s~~ covering Northumberland, Tyne and Wear and Durham 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 arising from the development / establishment of an Integrated Care System for the North East and North Cumbria and / or arising from / or as a consequence of the development of an Integrated Care Board, Integrated Care Partnership and Sub ICPs~~s~~ covering Northumberland, Tyne and Wear and Durham (currently " North" and "Central" see para.1) 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 any 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 any 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 any 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 any 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

Joint OSC for the NE & NC ICS and North and Central ICPs OSC

Terms of Reference

1. To consider the development / establishment of an Integrated Care System for the North East and North Cumbria and any subsequent proposals for substantial development and variation to health services arising from / as a consequence of the development / establishment of an Integrated Care System for the North East and North Cumbria and / or arising from / or as a consequence of the development of an Integrated Care Board, and an Integrated Care Partnership and sub ICPs covering the geographies of Northumberland, Tyne and Wear and North Durham (currently the "North" and "Central" ICPs)

~~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~~
~~- Durham, Dales, Easington and Sedgfield CCG~~
~~- North Tyneside CCG~~
~~- Northumberland CCG~~
~~- South Tyneside CCG~~
~~- Sunderland CCG~~

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

- The aims / objectives / programme of work of the developing ICS for the NE and North Cumbria and ;
- The plans and proposals for public and stakeholder consultation and engagement in relation to the developing ICS for the NE and North Cumbria;
- Any options for service change identified as part of the development of the ICS for the NE and Cumbria including those considerations made as part of any associated options appraisal process.

3.~~4.~~ To consider any substantive proposals during any 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.

4.~~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.

5.~~6.~~ To ensure any 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.

6.~~7.~~ To oversee the implementation of any proposed service changes agreed as part of the development / establishment of an Integrated Care System for the North East and North Cumbria and / or arising from / or as a consequence of the development of the "North" and "Central" Integrated Care Partnerships.

7.~~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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JOINT OSC FOR THE NE & NORTH CUMBRIA ICS & NORTH & CENTRAL ICPS MEETING

Monday, 21 March 2022

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

Councillor(s): Berkley and Malcolm (South Tyneside Council), Flux (Northumberland CC) Jopling (Durham CC), McKnight, Mendelson (Newcastle CC) Mulvenna and Brady (North Tyneside Council) and N McKnight (Sunderland CC)

143 APOLOGIES

Apologies were received from Councillor (s): Hall (Gateshead Council), Taylor (Newcastle CC), D McKnight and McDonough (Sunderland CC), Mole (North Tyneside Council) and Jones and Nisbett (Northumberland CC), Charlton – Laine and Robson (Durham CC) and Kilgour (South Tyneside Council)

144 DECLARATIONS OF INTEREST

Councillor Neil McKnight declared an interest as an employee of NewcastleGateshead CCG

145 NOTES OF INFORMAL MEETING OF THE JOINT OSC

The notes of the Joint OSC's informal meeting held on 24 January 2022 were agreed as a correct record.

146 UPDATE ON NEXT STEPS FOR THE ICS

The Chair introduced Sam Allen, Chief Executive Designate, NE & NC ICS and noted that the Joint OSC had submitted a number of questions to her in advance of the meeting today which it was anticipated Sam's presentation would address.

The Chair noted that a number of the questions had been very specific to Durham and therefore it had been agreed that a separate written response would be provided to these.

Sam thanked the Chair and provided the Joint OSC with a presentation on the next steps for the development of the ICS.

The Joint OSC was advised that everything was still on track for the ICB to become statutory from 1 July 2022

The four main aims of the Integrated Care Board (ICB) would be to:-

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

The ICB would involve the 8 CCG's coming together into one organisation and would serve a population of approximately 3.2 million and cover the 13 local authority areas setting strategy and delivering on the four key aims.

However, within the ICS the prominence of place would be pivotal as each local area is unique and has its own priorities and so working with Integrated Care Partnerships will be very important.

Sam highlighted national expectations in terms of engaging with people and communities and advised that she was meeting with Healthwatch collectively later in the week. Consideration was also being given to citizen panels. Sam advised that she wished to build on the good work already taking place

In terms of engagement so far, an ICS-wide Network with a dedicated working group had been established looking at the development of a Community Engagement strategy.

3 key principles had been identified to shape the development of the strategy and went out to staff, partners, community groups and others for feedback which were:-

i) Carrying on the good work happening at place level
ii) Making sure we have the right structures in place to make it visible and meaningful
iii) Looking for ways to innovate, such as exploring ways of embedding lived experience and what we could gain from a citizens panel

Funding had also been secured for Healthwatch to develop a model for regional mobilisation to enhance and support place - based arrangements.
In addition, £10k had been secured from NHSEI to scope the work around developing a Citizens Panel and work was ongoing to identify a range of stakeholders – geographical and community of interest spread - to give a regional sounding board via a 3 month project.

Next steps would be for NHS engagement leads within existing CCGs to engage with partners and community groups to identify local priorities for the future strategy, and this co-development will shape a first draft to be shared in April. It was intended that there would be final sign off for the draft strategy by the end of May 2022, with ongoing review.

In terms of developing the Integrated Care Board arrangements the following seven key guiding principles had been agreed with partners:-

- Secure effective structures that ensure accountability, oversight and stewardship of our resources

- Create high quality planning arrangements to address population health needs, reduce health inequalities, and improve care
- Ensure the continuity of effective place-based working between the NHS, local authorities and our partners
- Recognise our ICP sub-geographies as a key feature of our way of working across multiple places
- Design the right mechanisms to drive improvements in geographical areas larger than place-level
- Highlight areas of policy, practice and service design where harmonisation of approach might benefit service delivery
- Maintain high and positive levels of staff engagement and communication at a time of major change

Sam advised that a number of appointments had now been made and most of the new Executive Team had been recruited with only the Executive Director of System and Strategy Oversight and the Executive Chief Nurse yet to be recruited and it was hoped these appointments would take place in the second week in April.

Sam highlighted that the appointment of the 8 partner members on the ICB (4 from Local Authorities, 2 from Foundation Trusts, 2 from Primary Care) along with Healthwatch and other non - voting members could only commence after the Bill receives Royal Assent.

Sam advised that they were waiting for further guidance in relation to partner appointments and it was expected that this would be received in late May.

Sam advised that there had been an amendment to the Bill dealing with the establishment of the ICB's which now allowed for elected politicians to sit on ICBs. Sam stated that the amendment would need to be addressed in a way that ensured that all 13 local authorities were represented and ensured that the Board had the number of members which would allow it to be effective. At the moment the Board already had 25 members.

Sam stated that she envisaged that ICP's would have strong elected member representation. The Joint ICS OSC was provided with a map giving an overview of the proposed ICB high level functions and decision making at both system and place - based levels and provided with an outline of the forward plan for place - based working and financial delegations to place.

Sam advised that one of the first tasks would be the development of a five - year plan. Sam stated that this would be developed at place and aggregated up. However, some matters would be reserved for the ICB alone such as specialised services. Directors of Place - based delivery would be key in forging/developing local relationships. Partnership forums were already in place at a local level and these would operate as part of the ICB.

Sam stated that safeguarding was a really critical area and local teams already in place would continue.

Sam advised that a number of White Papers had been published recently and they

were looking across these to guide the development of the ICS. The year ahead would be a year of transition. At the moment, some places were indicating that they wished to have a single point of accountability rather than a single person and work was taking place to look at where place - based delivery and decision making could be supported.

In terms of place - based working every local authority has a Health and Wellbeing Board and the relationship between these Boards and the ICP would be critical. These Boards would very much influence the ICP. Sam stated that she wanted to work with each place over the months ahead to explore how the Boards operate and what can be done to make sure they are effective and drive the strategy.

Sam noted that there had been questions raised as to whether budget allocations would be the same and she advised that for the year ahead they would remain the same as they were not proposing any changes. However, Sam advised that at some point consideration would need to be given to the position of equity and doing something extra for some parts of the community within the ICS. Sam noted that this was likely to be a key point of discussion going forwards.

Sam noted that the budget would be a needs - based budget and consideration would be given to productivity and efficiency so where there were opportunities to do things more efficiently work would be carried out to achieve this whilst at the same time ensuring effective governance.

Sam outlined the proposed accountability to the ICB which included an Executive Committee which was likely to meet monthly with other Committees such as audit and commissioning reporting to that Committee. Sam noted that delivery would be discharged through place and places were to be grouped into three ICB areas, ICB North and North Cumbria, ICB Central and ICB Tees Valley and these will work with the ICP to help shape strategy.

Sam advised that the ICP would oversee the development of an Integrated Care Strategy for our ICS. The ICP would help galvanise joint action and commitment needed to improve population health in our ICS and build on existing system-level work. The ICP would also complement the joint work of local authority Adults', Children's and Public Health Networks.

Sam advised that there would also be close working with all local and Combined Authorities to strengthen the NHS's contribution to regional economic growth.

Sam advised that it had been agreed with partners that there would be one Strategic ICP supported by 4 'Sub-ICPs'. This recognised the position that the NE &NC is the largest ICS area in the country and the long-established sub-regional partnership working arrangements between CCGs, Foundation Trusts and Local Authorities. The Sub-ICPs would build a needs assessment from each of their Health and Wellbeing Boards which would then feed into the Integrated Care Strategy setting process overseen by the strategic ICP.

Planning meetings were now taking place, ahead of first formal meetings of the ICP from July.

Sam stated that an ICP Chair and Vice Chair had yet to be appointed and there would be a number of statutory members and a number of other potential members eg Police and Fire authorities and they were waiting for further guidance.

As far as the next steps for the development of the ICP were concerned there would be strategic planning with local authorities on the practicalities of ICP formation (including chairing, membership, TOR, reporting framework to e.g. HWBs and relationships with key forums). A working group of senior stakeholders had also been convened to develop proposals on the development of the Integrated Care Strategy for approval by the ICP by December 2022.

This would build up from

- the JSNAs from each of the 13 Health and Wellbeing Boards
- the analytical work of the Office for Health Improvement and Disparities in the region
- performance management information from NHS England
- patient and service user feedback from HealthWatch and VCSE sector partners
- the strategic analysis and shared priorities of our DsPH, ADASS, and ADCS networks
- the economic development work of our Local and Combined Authorities.

The outputs of the ICP development work would then be considered alongside feedback on the draft ICB operating model first by the Shadow ICB, and then at a deliberative event for all key stakeholders in June 2022.
This would provide a holistic picture of how the system works, and how the governance fits together leading into the first formal meetings of the ICP from July onwards.

Sam advised that it was envisaged that the ICP would not meet more than between 2 and four times a year although it may meet more frequently initially.

Sam advised that they were engaging staff and key stakeholders on the proposed operating model with a further iteration to be developed by March/April 2022. This would include proposals on transitional place-based working arrangements, and work would be carried out with the 13 places to develop a route map to more formal place governance by 2023.

Sam advised that there had already been a lot of helpful feedback but they were still collecting views.

Sam stated that they would be sharing the feedback with participants and would also send a summary of the feedback to the Joint OSC and details of the response to the feedback and information on the proposals developed.

Sam advised that the first year would be very much a transitional year where the governance for place - based working was set up.

Sam hoped that the presentation provided had addressed the written questions

submitted in advance of the meeting and she advised that she would also be providing a written response, in addition to today's presentation, which would be circulated to the Joint OSC in due course.

The Chair thanked Sam for the presentation and advised that it had provided a very helpful steer on the development of the ICS and provided reassurance that for the first year it would be a case of business as usual whilst new ways of working were developed.

Councillor Jopling advised that having listened to what Sam had outlined the position seemed daunting given the size of the ICS. Councillor Jopling noted that in terms of place - based working and dealing with need there were many areas where there was a history of long - term unemployment and individuals on benefits and long - term illness and she queried how Sam saw the new system being put in place as having an impact given the plan to make efficiencies which often meant a scaling down of services. Councillor Jopling queried whether Sam envisaged better outcomes for individuals and improved longevity.

Sam highlighted that efficiencies within the system can lead to positive outcomes and she cited the example of the Great North Care Record which the Joint OSC would hear more about later on their agenda. Sam advised that this project had the potential for making a real difference to outcomes for healthcare.
Sam stated that the project has a real opportunity to increase not just years of life but also quality of life. Sam indicated that if the ICS gets things right then it would be able to make a difference but it relied on everyone working together.

Councillor Mendelson queried how the new ICS structure would fit with the national NHS. Councillor Mendelson stated that one of her concerns was that large scale boards such as the ICB would invite contracts from larger firms at the expense of smaller provision.

Sam advised that in terms of fitting into the NHS the ICB would be one of 42 Boards – the largest of which was Greater Manchester, as a result of population size and geography.

Sam stated that they were currently working with the Boards in the NE and North Yorkshire Region of which there were four and they were sharing their constitutions and details of how they planned to operate. This fit within the NHS England Improvement structure which has regulatory functions and also provides support to the ICS to deliver on national plans. Sam advised that from 2023 CQC would also have a regulatory role with regard to the ICS.

Sam indicated that there was to be a first national meeting of all the Boards in April 2022.

Sam advised that in terms of commissioning one of the benefits for the ICS was the relaxation of competition rules. Sam stated that there are a number of excellent local providers and the ICS wants to use local services and suppliers.

Councillor Berkley advised that she was from South Tyneside and on the Board of

Healthnet. Councillor Berkley stated that she was pleased to hear from Sam that for the first 12 months that funding would be maintained as this had been one of her concerns.

Councillor Berkley stated that they had a really good relationship with their CCG at a local level and their VCS and she considered that it was important to have a mechanism where they could have local contact with those responsible for funding and other key issues.

Councillor Berkley noted that in South Tyneside they have some of the highest levels of deprivation in the country linked to poverty and inequalities and so in terms of making a real difference she queried how funding would be allocated going forward to make sure that all areas within the ICS have their needs met.

Councillor Berkley also noted that in terms of addressing areas such as tackling mental health issues and isolation across the age profile their Health and Wellbeing Board had nearly produced their next plan and this had a lot of local involvement.

Sam indicated she supported Councillor Berkley's comments in relation to the community/voluntary sector and she advised that she was due to meet with them shortly.

Sam stated that she would take back to her team the ask about making sure local points of contact remain. Sam stated that she did not envisage much change but she would ensure the comments were fed back.

Sam advised that the ICS was one of only two ICS which were investing in a broader network of support via Vonne.

Councillor Malcolm noted that the ICS was being lauded as an equal partnership with local authorities but he was sceptical and he considered that the Joint OSC needed to scrutinise and hold health partners to account and at a place level within the system.

Sam indicated that she welcomed scrutiny by the Joint OSC and noted that the policies in relation to the development of the ICS were national policies which were being implemented. Sam acknowledged that currently Councillor Malcolm considered that the ICS was health driven but she advised that it would not be successful if that was the case and she hoped to redress the balance in terms of Councillor Malcolm's perception going forwards.

Councillor Neil McKnight from Sunderland noted that Sam had mentioned job creation and he also noted that there was a 30% increase in elective work and a 5% cut in revenue funding for staffing and he queried where Sam saw the ICB's role in working with acute trusts and Universities to address staffing issues.

Sam acknowledged that there is a vacancy gap and stated that she saw the role of the ICB as working with partners to further develop academic links and progress the apprenticeship levy to create training opportunities leading to rewarding careers.

Councillor McKnight noted that the Joint OSC was aware that they were approximately five years away from about 30% of GPs reaching retirement age and he queried whether any consideration had been given to this as part of joint commissioning arrangements with CCGs.

Sam advised that NHS England was responsible for commissioning GP services and this had been delegated to CCGs. However, NHS England would retain this responsibility once the ICB was in place.

Sam advised that a fuller stocktake of the position was being led by a GP in the south of England working with all ICS and was examining the role of Primary Care Networks and Primary Care and it would be important to be open to potential new ways of working. However, Sam advised that currently there were no changes planned in relation to the commissioning of primary care.

The Chair noted that Sam had referred to the ICS role in supporting jobs and wealth creation and using the budget to work in local communities to create employment opportunities. However, the Chair considered that the problem was the commissioning rules people were currently working to. The Chair stated that commissioning at scale was the issue many local authorities were struggling with as this was very difficult when limited by what you can do and how you can do it. The Chair stated that some of the financial regimes had not changed significantly to allow the flexibility needed to progress this.

Councillor Malcolm stated that there would never been true integration of budgets if health regulations and local authority regulations didn't match up and this was a real barrier.

The Chair hoped that there would be more flexibility in this area in the future and noted that Sunderland had been looking at this issue and discussions were due to take place in Gateshead between the Council and CCG.

The Chair stated that as someone who had previously been a non - executive director on a PCT Board for ten years she had seen how national priorities had impinged on local rather than acting as a lever to help and she hoped that this would not be the case with the new ICS structures and that there would be a bottom - up approach which would lead to improving the lives of local people.

The Chair noted that the Joint OSC brought together a range of perspectives all focused on that one aim of improving the lives of people within their local communities.

The Chair thanked Sam for the excellent presentation.

147 ONCOLOGY SERVICES BRIEFING

The Joint OSC agreed that consideration of this item should be deferred to a future meeting of the Committee.

148 REGIONAL DIGITAL STRATEGY - PROGRESS UPDATE

Professor Graham Evans, Chief Digital Officer, NE & NC ICS provided the Joint OSC with a presentation on this matter.

Professor Evans stated that the digital strategy was a key means of enabling improvements across the ICS. Drivers for digital transformation were that life expectancy is plateauing and in some areas is reducing along with unprecedented pressures on the health system as a result of the pandemic. Health inequalities were also widening with England lagging behind comparable nations on many key measures of health outcomes.

In addition, recruitment and retention of staff was a big challenge and technology is a good means of helping to attract the brightest and best. Finance was also a key challenge due the impact of an ageing population and the consequent burden on care services. Professor Evans stated that the current hospital - based model of care was not fit for purpose any longer and there was a need to work differently providing more care in people's homes and community and break down barriers between services such as GP's, local authorities, acute partners, voluntary sector etc to meet needs, prevent duplication and create efficiencies.

Professor Evans stated that technology was a key means of facilitating smarter working and the ambitions set out in the NHS Long Term Plan and the ICS has a major part to play in delivering these ambitions.

The Digital programme started life as one of six workstreams in the embryonic ICS and now that the ICS is to be statutory the Digital programme is one of 6 ICS priorities demonstrating the ICS commitment to transform where necessary and appropriate.

The first Digital Strategy was produced in 2019 but the pandemic demonstrated that this was not fit for purpose and so a new Strategy was developed virtually via Teams following a huge amount of collaboration.

Professor Evans stated that the Digital Strategy is a live document which will be iterative which focuses on five key themes; the essentials ie getting the basics right; connecting; improving; empowering and learning and highlights real life examples. The strategy has helped fast track the NHS ability to meet with patients during the pandemic.

Digital governance is in place and has been reviewed with a view to improvements being progressed. There is also an ICS Digital Roadmap which has already delivered a significant amount but there is still much more to do. The ambition is to have a single digital front door so that individuals can meet virtually with practitioners.

In terms of secondary care, the strategy is looking at how we can raise the bar in terms of sharing information between points of care as has been done with the Great North Care Record.

Professor Evans stated that levelling up was a really important feature of the

strategy as all parts of the system need to be able to talk to each other in the same language. However, Professor Evans noted that the pandemic had demonstrated that not everyone is able to access technology for a range of reasons and there is a need to make sure that there are no unintended consequences as a result of the strategy and that some people are not left behind. The issue of digital poverty was therefore an important consideration.

In terms of the strategy and supporting the patient/citizen, an important digital programme had been the development of the Great North Care Record which provided the ability to join together points of care from the GP practice. This programme was already making a big difference allowing clinicians to make more timely interventions. The next development would be to progress work to allow patients to engage through the NHS App with a secure log in profile to allow them to receive correspondence in relation to appointments etc. However, recognising that not all sections of the community will be able to access their personal information in this way there will continue to be paper based methods until the balance eventually tips.

In the area of Digital Pathology, Radiology share information across the entire system which is helping to transform how the workforce operates in an area where there are recruitment difficulties. In terms of patients self - managing their care, telemetry is supporting patients with diabetes to upload data from their primary care records. A great deal of work was also taking place in relation to digitising care homes and this was making a real difference. Work was also in the early stages in relation to the development of a regional laboratory which would lead to faster diagnostics and efficiencies of scale. Development of a single maternity record was also commencing.

In addition, as the ICS was becoming more digitally dependent, work was also taking place to strengthen digital defences to ensure that the ICS could respond quickly to any potential cyber attacks.

Professor Evans advised that they have put in place a design framework to establish what good looks like at a system and organisational level within the digital programme and have carried out an initial review and identified areas of future focus. This initial assessment has identified that the most important priority is to empower citizens. Following on from this an action plan has been developed linked to digital poverty and health inequalities.

Professor Evans stated that a close eye would be kept on potential future opportunities where technology may allow things to be done differently such as AI being used where appropriate to carry out mundane tasks to improve productivity and achieve better outcomes.

Professor Evans stated that going forwards the alignment of NHS E/I would streamline the digital transformation agenda in terms of lines of communication from the centre and the digital programme within the ICS was the opportunity to drive improvements and make a real difference.

The Chair thanked Professor Evans for an interesting update. The Chair noted that

the Covid pandemic had of necessity driven forward the digital programme but positive differences were being made as a result.

Councillor Malcolm advised that he was worried by the presentation as not everyone is able to grasp new technology and he was concerned some people may be left behind. Councillor Malcolm felt that true patient centred care needed to have a human element. Councillor Malcolm noted that Professor Evans had stated that the pandemic had opened up opportunities for the digital programme but he considered that it was not a satisfactory situation that local people were not able to see a GP face to face before having a telephone triage. Councillor Malcolm stated he was not anti-technology as he was aware that organisations need to progress. However, Councillor Malcolm stated he was concerned about the current pace of change and he queried what the timescales were for the digital strategy and the costs of implementation.

Professor Evans agreed that it was important that people were not left behind. However, he noted that the NHS and patient care within the ICS would be in a worse position if the improvements carried out through the digital programme had not occurred. Professor Evans highlighted that not everyone was able to physically attend a GP or consultant appointment. Professor Evans advised that the current strategy covered the next 3 years. In terms of costs and procurement, Professor Evans stated that competitive procurement processes were in place as there was not just one digital solution being delivered and he advised that they were working in a similar way to other ICS across the country.

Councillor Malcolm considered that this issue should come back to the Joint OSC in the future for further scrutiny.

The Chair indicated she was concerned as to how well - acquainted local people were with the Great North Care Record and she considered this should be promoted widely.

Councillor Jopling stated that she considered that the work being done to allow patients to take ownership of their own conditions such as diabetes sounded really positive and she queried how this was used to feed information in and make referrals as needed.

Professor Evans advised that if an individual's thresholds were exceeded as part of the data management process this would trigger an alert for a response. Professor Evans stated that many patients who are used to their condition know what an abnormal response will be and so this puts them more in control of managing their own condition. In the longer term, Professor Evans hoped that work in relation to prevention would take pressure off the system.

Councillor Berkley considered that there was an overdependence on national statistics and she hoped that more local statistics were being used and evaluated when seeking to make technical improvements. Councillor Berkley also highlighted the growing role of pharmacies and hoped that they were being built into the digital programme. She also noted that health records were extremely valuable and considered it important that priority was given to protecting such records to provide

local people with confidence.

Professor Evans stated that cyber security was really important and the work being progressed had to conform to certain security standards.

Councillor Flux advised that he was very pro – technology, however, he did worry that sometimes technology was being developed just for the sake of it and he queried how it could be ensured that this did not happen.

Professor Evans stated that for him the key starting point was to look at the problem they were trying to fix as in many cases technology many not be the answer although in some areas it did have a part to play.

Councillor McKnight stated that he was interested in seeing more included in the strategy around educating people about their health and how AI is being used in learning eg Vital Signs Work and how this is being rolled out and used.

Professor Evans stated that there is some detail in the strategy in relation to AI and machine learning eg the Pathologist at North Tees advised the Executive Group that Digital Pathology use AI to take out approximately 60% of the labour intensive work with a human quality check.

Councillor Mulvenna advised that he was interested in understanding how tests were carried out to check for cyber security threats.

Professor Evans advised that third party experts are contracted to test the system. He also advised that NHS mail filters out approximately a million potential hits and the firewall prevents a great many. Professor Evans stated that the biggest weakness in the system tended to be people.

Councillor Mendelson referred to previous references regarding the digital divide and asked whether the ICS would be funding and supporting people to access IT at pharmacies with a view to accessing services. Councillor Mendelson noted that in the past this had tended to be carried out in libraries.

Professor Evans stated that he was not sure of the position regarding funding but digital options which could be considered might be akin to a telephone box where a hub could be based either in a library, voluntary sector organisation or in a smaller hospital where they could be accessed by the local community.
Professor Evans stated that the Great North CARE Record which was the largest shared record in the world connects primary and secondary care and the ambulance service and 50% of local authorities in the region are now connected. Professor Evans stated that there was more work to do with authorities in the northern part of the region and they were looking to bring in hospices and community pharmacy and dentistry but they were making massive progress.

The Chair indicated that it would be helpful if Professor Evans could come back to the Joint OSC with regular updates on the progress of the strategy, particularly given the concerns raised about the potential for creating two tier access to services. The Chair stated that it was important to consider the issue of digital accessibility and the

differences in accessibility in rural and urban areas and the impact of severe weather on accessibility. The Chair highlighted that in west Gateshead electricity was off for two weeks in some areas as a result of Storm Arwen leading to a real disparity in digital access.

149 WORK PROGRAMME 2022-23

The Joint OSC agreed that the below issues which had been identified during 2021-2022 and which it had not been possible to progress as part of that work programme should be rolled forward to the 2022-23 work programme:-

- Workforce – Progress Update
- Inequalities – Update
- Emergency Planning
- Detail on Covid Recovery Plan

In addition the Joint OSC agreed that there should be regular updates within the 2022-23 work programme on the following:-

- Next Steps for ICS
- Digital Strategy – Progress

A discussion also took place in relation to the Joint OSC's role in scrutinising and providing constructive challenge in relation to the work being carried out to develop the ICS and around whether the Joint OSC considered that the terms of reference/remit of the Joint OSC might need to be amended in light of the developing arrangements for the statutory ICS.

The Chair advised that each of the local authorities represented on the Joint OSC would be consulted on the above and the outcome reported back to the next meeting.

150 DATE AND TIME OF NEXT MEETING

It was proposed that the next meeting be scheduled on Monday 4 July 2022 at 1.30pm and this would be confirmed in due course.

Chair……..……..

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Non-surgical oncology workforce challenges in the North East

June 2022

Current challenges

Workforce challenges in oncology services are being felt across the entire NHS and nationally there is a predicted consultant oncologist workforce shortage of 28% (401 whole time equivalents) by 2025. We expect to feel the impact of this even more within the North East region in the years ahead.

The immediate workforce pressures being faced locally are within the specialties of breast, lung and colorectal (bowel) cancer and over the coming months we expect a shortage of approximately six whole time equivalent (71.5 PAs) Consultant Oncologists at Newcastle Hospitals. This is due to a combination of vacant posts (compounded by an inability to recruit), planned retirements and sickness/absence. This is coupled with a growing demand and complexity in non-surgical oncology treatments with for example chemotherapy use increasing significantly.

NHS England Specialised Commissioning are currently discussing the best way to address these immediate workforce challenges to ensure the continued safe delivery of specialist oncology services. As we manage this difficult position, we want to ensure that key stakeholders are well sighted on the issues being faced and the likely temporary action that will need to be taken.

Background

Consultant oncologists from Newcastle Hospitals currently travel across the whole of the north of the region to deliver specialist outreach clinics at several local hospital sites.

Given the scale of the immediate challenge and gaps in the consultant oncologist workforce, we will need to change the number of local outreach clinics on a temporary basis to ensure that all patients still have fast access to staging diagnostics and treatment. This is in relation to breast, lung and colorectal (bowel) cancer only.

The exact detail of this required change is still being worked through, but in principle it will involve a phased approach to establishing fewer outreach clinics, that allow the consultant oncologists in post to see as many patients as possible who are on a breast, lung or colorectal (bowel) cancer pathway.

It is hoped this interim approach will increase resilience within the existing workforce as it will mean there are no longer lone workers and will also hopefully make recruitment to vacant consultant oncologist posts more attractive.

Without consolidating the number of outreach clinics, patients in some areas would be disadvantaged in how quickly they can be seen by the appropriate specialist Consultant Oncologist compared to other parts of the region. This means they would wait longer to agree their initial treatment plan and their cancer treatment would be delayed. This is not an acceptable position and the NHS is therefore working as swiftly as possible to ensure there is no detrimental impact on patient care as a result of these difficult workforce challenges.

Impact for patients

The vast majority of patient care will continue to happen locally from the initial diagnostic pathway with local MDTs, local surgery and chemotherapy at local hospital chemotherapy units. The only impact would be for patients having their first face-to-face outpatient

appointment with the consultant oncologist and for any necessary face-to-face follow up appointments with the consultant oncologist during their chemotherapy treatment. The NHS will continue to offer and maximise the use of virtual appointments where this is appropriate.

These first face to face outpatient appointments are generally followed up by multiple trips for radiotherapy and chemotherapy. We would like to stress that there will be no impact on local chemotherapy services or current radiotherapy services which will continue to operate as normal.

Whilst we recognise this will cause some disruption for patients, our prime concern is to ensure every person gets the timely access they need for cancer care and that there is clear communication with patients. We are also giving due consideration to patient transport requirements, with Daft as a Brush patient transport keen to provide services regionally.

Information provided by Newcastle Hospitals NHS Foundation Trust (June 2022)

Based on information provided by Newcastle Hospitals, indicative figures show that this temporary change will impact approximately 114 patients a week, see the breakdown below.

Predicted patient movements 'out of area' by locality

Locality	Impact
Northumberland to North Tyneside	8 patients a week
North Tyneside to Northumberland	9 patients a week
South Tyneside to Sunderland and Gateshead	13 patients a week
Gateshead to South Tyneside and Durham	28 patients a week
Sunderland to Gateshead and South Tyneside	42 patients a week
Durham to Gateshead	14 patients a week

Total impact is approx. 114 patients a week

NB there are over 630 cancer patient contacts every week in these specialities (breast, lung and colorectal)

This therefore reflects 18% of activity

Next steps

While these temporary changes have been requested by Newcastle Hospitals NHS Foundation Trust they are supported in principle by regional NHS England Specialised Commissioners, The Northern Cancer Alliance, the Integrated Care System leadership team for North East and Cumbria and the wider hospital network that are part of this system. The regional Provider Collaborative and the Cancer Board have also been briefed regarding the challenging workforce position in non-surgical oncology services and the likely need to consolidate the number of outreach clinics as a temporary measure.

Information at this stage remains indicative and work is ongoing at Newcastle Hospitals to finalise which patients will need to travel to a different place to attend an outreach clinic as

part of these necessary temporary measures. This is dependent on which consultant oncologist specialist the patient needs to see (breast, lung or colorectal (bowel) cancer).

We will continue to keep overview and scrutiny colleagues informed of progress with these changes . If you have any queries in the meantime, please do not hesitate to contact.

Alison Featherstone – Cancer Alliance Managing Director

Julie Turner – Head of Specialised Commissioning

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