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

Meeting on Monday, 20 March 2023 at 2.30 pm in the Council Chamber, Civic Centre, Gateshead

Agenda

1 APOLOGIES

2 DECLARATIONS OF INTEREST

3 MINUTES (Pages 3 - 24)
The minutes of the meetings of the Joint Committee held on 21 November 2022 and 30 January 2023 are attached for approval.

4 DRAFT REVISED ICS-ICP JOINT OSC ToR & PROTOCOL (Pages 25 - 32)
Document attached. The Joint OSC is asked to approve a change to the quorum as set out in red and italics at paragraph 9 of the attached Tor and Protocol for practical considerations to ensure the continued efficient and smooth running of the Joint OSC as the current ToR and protocol has been identified as too restrictive.

5 NEXT STEPS FOR ICS
Dan Jackson, Director of Governance and Partnerships, NE&NC ICB will provide the Joint OSC with an update on this matter.

6 WINTER PLAN EVALUATION AND LEARNINGS
Siobhan Brown, Transformation Director, System Wide, NE&NC ICB will provide the Joint OSC with a presentation on this matter.

7 EMERGENCY PLANNING
Marc Hopkinson, Director, NE&NC ICB will provide the Joint OSC with a presentation on this matter.

8 WORKFORCE INTERIM UPDATE
Marc Hopkinson, Director, NE&NC ICB will provide the Joint OSC with a presentation on this matter.

9 WORK PROGRAMME
The Joint OSC was informed that the below issues had been identified during 2022/23 which it had not been possible to progress as part of that work programme and which the Joint OSC may wish to roll forward to the 2023-24 work programme:-

- Digital Strategy - Update

- Children's Mental Health Provision – update on current performance and future provision

In addition to the above the Joint OSC has previously agreed that the following matter should be a standard item for each meeting.

- Next Steps for ICS

The Joint OSC has also agreed to consider the following:-

- the Strategic Options for Non - Surgical Oncology Services and an update on Gynae Oncology Services
- the Integrated Care Strategy Implementation Plan

The views of the Joint OSC are sought on the above and any additional issues it may wish to consider as part of the 2023 -24 work programme.

10 DATES AND TIMES OF FUTURE MEETINGS

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

- Monday 3 July 2023 at 1.30pm
- Monday 25 Sept 2023 at 1.30pm
- Monday 20 Nov 2023 at 2.30pm
- Monday 22 Jan 2024 at 1.30pm
- Monday 18 March 2024 at 2.30pm

Contact: Angela Frisby Tel 01914332138 Date: 6 March 2023

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

Monday, 21 November 2022

PRESENT: Councillor M Hall (Chair) (Gateshead Council)

Councillor(s): J Green (substitute) and Wallace (Gateshead Council) Taylor and Pretswell (Newcastle CC) Chisnall (Sunderland CC) Ezhilchelvan and Nisbet (Northumberland CC) Jopling (Durham CC) Kilgour, Malcolm (South Tyneside Council) Mulvenna and O'Shea (North Tyneside Council)

APOLOGIES: Councillor(s): Butler (Sunderland CC), Kirwin (North Tyneside Council) and McCabe (South Tyneside Council)

171 APPOINTMENT OF CHAIR

In line with the terms of reference for the Joint Committee, the Joint Committee agreed to appoint Councillor Maria Hall of Gateshead Council as Chair for the remainder of the 2022 - 23 municipal year.

172 APOLOGIES

Apologies were received from Councillors Kirwin (North Tyneside Council), Butler (Sunderland CC) and McCabe (South Tyneside Council)

173 DECLARATIONS OF INTEREST

Councillor Hall (Gateshead Council) declared an interest as a Director of Prism Care NECIC and as a member of CNTW FT's Council of Governors

Councillor Taylor (Newcastle CC) declared an interest as an Honorary Consultant at the Freeman Cancer Centre.

174 MINUTES

The minutes of the meetings of the Joint Committee held on 4 July 2022 and 17 October 2022 respectively were approved as a correct record.

175 HEALTH INEQUALITIES UPDATE

Professor Edward Kunonga, Director of Population Health Management at NECS and Public Health Consultant at CDDFT and TEWV provided the Joint OSC with an update on the above.

Professor Kunonga provided the Joint OSC with information on the difference between health inequalities and healthcare inequalities and the causes of death that drive disparities in life expectancy by deprivation.

Professor Kunonga advised that the impact of the Covid 19 pandemic had widened the life expectancy gap. For males there was now a 10.4 year gap across the region with variations in each local authority area and for females there was now an 8.1 year gap across the region again with variations in each local authority area.

The Joint OSC learned that in males, the gap in life expectancy between the least and most deprived areas in the region was mostly due to higher mortality in circulatory disease, followed by external causes, cancer, respiratory disease* and Covid-19. In females, higher mortality in cancer in the most deprived areas contributed to the life expectancy gap most, followed by circulatory disease, respiratory disease and Covid 19.

Professor Kunonga provided the Joint OSC with information on what was contributing to the health inequalities gap and it was noted that almost 10% was as a result of Covid 19. Therefore, Professor Kunonga considered that there was still a need to encourage uptake of Covid 19 vaccinations.

Professor Kunonga also highlighted that the proportion of premature deaths by external causes in males, which includes deaths from injury, poisoning and suicide, was higher in the North East than in any other region and was affecting males in the prime of their life and really needed to be addressed. The pattern was different for females where external causes was less of a contributing factor.

Professor Kunonga stated that there was some positive news with significant progress in reducing infant mortality rates in the region being made.

The Joint OSC was advised of the national approach and the Core 20 plus programme approach. Core 20 focused on the 20% most deprived communities nationally. Professor Kunonga advised that a third of the NE&NC ICS population lives in the 20% most deprived communities and half of the population lives in the 30% most deprived communities and 70% lives in the 40% most deprived communities so the scale of the challenge in terms of reducing health inequalities was huge. The Plus element of the programme focused on giving special attention to certain disadvantaged population groups such as those with severe mental illness and homeless individuals.

Professor Kunonga stated that joint work was taking place with local authority Directors of Public Health to establish where the ICB could make a difference at a regional level to make a significant difference through economies of scale and identify what work should occur at place level.

Professor Kunonga set out the vision for the NE&NC ICB and highlighted that feedback on an outline framework for the ICP Integrated Care Strategy was due to be received at the end of the week. The aim was for the Integrated Care Strategy to be published before Christmas. Professor Kunonga stated that they were not starting from scratch in developing the Strategy and were building on a range of assets, progress which had already taken place and partnership working.

Professor Kunonga highlighted the draft key commitments in the developing Integrated Care Strategy and set out the high - level timeline and advised that the finalised strategy would be shared with the Joint OSC in due course.

Councillor O'Shea thanked Professor Kunonga for the extensive presentation and noted that the NHS has significant and ambitious plans aimed at reducing health inequalities. However, Councillor O'Shea queried whether these plans might be impacted by the Autumn Budget and austerity which will affect many classes of people and will be particularly likely to damage disadvantaged communities.

Professor Kunonga stated that they were making the case for resources to tackle health inequalities in the NE&NC ICB area as strong as they possibly could and had established a small working group to look at the national formula for resourcing and what action might be taken where it does not reflect the level of need in the region. Professor Kunonga stated that where the NHS is working more closely with local authority colleagues to progress work in this area this would provide the opportunity for the Joint OSC to examine these and offer challenge. With regard to the broader policy issue this was for others involved in policy to challenge.

Councillor Ezhilchelvan stated that some of the statistics provided were compelling for action and the data was impressive. However, Councillor Ezhilchelvan asked what information was needed so that priorities could be developed to make a difference on the ground and establish whether the causes of health inequalities were realistic. Councillor Ezhilchelvan stated that it would not be realistic to expect that if there was no austerity tomorrow that everyone would be equally well off. Councillor Ezhilchelvan stated that for example he would like to know the underlying reasons for the figures in relation to cardiovascular which were high in some areas and low in others. Councillor Ezhilchelvan considered that if this information was available then it would be possible to inform the manner in which people seek to change behaviour.

Professor Kunonga thanked Councillor Ezhilchelvan for raising a very good point and explained that this was one of the programmes that they were working on within the ICB. Professor Kunonga stated that he would be happy to come back to the Joint OSC to talk about how they were using the wealth of information to do what Councillor Ezhilchelvan had highlighted. Professor Kunonga stated that as an example they were looking at how individuals were admitted as emergencies for diabetes and linking that with data in primary care in relation to engagement with a view to then sharing information on potential actions with community leaders. Professor Kunonga stated that the presentation today was to provide the Joint OSC with the bigger picture.

Councillor Ezhilchelvan thanked Professor Kunonga for the clarification and queried what he classed as “external causes”. Professor Kunonga stated that this was an ONS classification of causes of death and relates to drug related deaths, suicides and deaths the coroner is unable to make a determination on and they were trying to unpick this data further.

Councillor Jopling asked whether resources were being targeted at certain areas to get more value for money and make a difference given that budgets were tight. She also queried whether they had any plans which identified what they intended to tackle first.

Professor Kunonga stated that this was an important question and he acknowledged that tough decisions/choices would have to be made. However, Professor Kunonga advised that decisions/choices around what should be prioritised would not be made in isolation and would be agreed as a system and at place level and then collectively. The ICS ambition to improve the health of the population and reduce health inequality gaps would require tough decisions which would be made in partnership. Other joint work would involve consideration as to how assets would be utilised across the system and the important contribution of the voluntary and community sector and partnership work with local authorities to help the population understand the narrative.

Professor Kunonga stated that a recent small survey which asked whether the public would be willing to prioritise access to elective recovery had shown that the appetite for this was not high. However, Professor Kunonga stated that in order to narrow the health inequalities gap there may be a need to bring forward surgery for some groups before others and such decisions would require both public and local authority support. Professor Kunonga stated that currently they were in discussions with local authorities around whether surgery for the 2,900 patients with learning disabilities needs to be prioritised.

Councillor Taylor thanked Professor Kunonga for the excellent presentation but noted that much of what had been presented was not new and had been put forward over the last forty years. Councillor Taylor acknowledged that there had been one big success in reducing smoking but she queried how a difference could be made in other areas when the pandemic had made matters worse.

Professor Kunonga acknowledged the points made by Councillor Taylor and stated that what was new was the scale of the challenge. However, Professor Kunonga stated that there are areas where progress is being made such as in cardiovascular diseases which were being dealt with faster than the England average and this was not down to just one part of the system. Professor Kunonga stated that they wanted to learn from examples such as this to see how they could utilise these going forwards.

Professor Kunonga stated that the ICB was aware that there was potential for the cost of living crisis to wipe out the last ten years of improvements if matters were not addressed. Professor Kunonga stated that this was why the ICB wanted to work closely with local authorities to protect what has already been achieved and use this as a springboard for further improvements.

The Chair thanked Professor Kunonga for the excellent presentation but expressed concern that health inequalities for children and young people might increase as a result of the cost of living crisis particularly for those living in the most deprived communities and children with life limiting conditions from birth. The Chair noted that the Marmot Review had referenced the importance of the first 1000 days in a child's life and yet the presentation had only referred to the first 28 days and she was concerned about the depth of focus.

Professor Kunonga advised that when they started to develop the Integrated Care Strategy one of the consistent themes which came through was Children having the best start in life. Professor Kunonga noted that work had taken place around the first 1000 days of a child's life within the ICB and there was compelling evidence as to adverse childhood experiences which they were looking to address but there were no short-term fixes. Professor Kunonga stated that at the region wide Children's Health Network, which was attended by Head Teachers, Directors of Children's Services and representatives from the voluntary sector, there was overwhelming feedback that the ICB was not pushing far enough in its strategies and this would therefore be reflected in the next iteration of the Strategy. However, Professor Kunonga stated that progress in tackling health inequalities across the patch might still be affected by national policy and could still be wiped out.

The Chair noted that a major issue in terms of tackling health inequalities was the ongoing issue of resources.

176 WINTER PLANNING UPDATE

Siobhan Brown, Transformation Director System Wide, NENC Integrated Care Board, provided the Joint ICS OSC with an update on the next steps in increasing capacity & operational resilience in urgent & emergency care ahead of winter.

Siobhan advised that a key point to note was that the healthcare system is now under sustained pressure all year round not just during winter and therefore choices in relation to priority areas of work were being taken in partnership. Whilst there is a lot of focus on what the NHS was doing they were working with local authorities and local communities.

Siobhan stated that there had been a lot of modelling work in relation to disease and there had been an early peak of flu and Covid and a respiratory disease which affects children. Siobhan stated that it was expected that there would be a second peak early in the new year.

Siobhan advised that wider challenges included the cost of living crisis; energy and fuel challenges; inequalities already inherent in communities that they did not want to worsen; year round pressure on all areas of the system that outstrip capacity to deliver as well as industrial action and the interplay of human behavioural patterns and access to services.

Siobhan noted that there were 13 places within the ICS, soon to be 14, and she stated that a lot of the winter planning agenda was very local although some work

was system wide.

Siobhan advised that the ask to have a 24/7 System Control Centre linked regionally and nationally by 1 December 2022 was well on the way to being achieved and they would use what works well and build on from there.

The need had also been identified to build on the surge model and agree escalation triggers for place, area, system level interventions as required as well as being prepared for variants of Covid-19 and respiratory challenges and this had been based on the work of local resilience forums and the learning from Covid along with constant horizon scanning and a major focus on vaccinations.

In terms of flu vaccinations, in Care Homes and amongst over 65's they had achieved a take up of 73% and 75% respectively and for Covid vaccinations a take up of 80% and 83% respectively. Front line workers were also being offered Covid and Flu vaccinations and there was also constant promotion of vaccines being offered to health and care staff via a range of pharmacies and GP practices.

Siobhan stated that in relation to clinical triage, clinical advisors at call centres were doing significant work in pointing patients towards alternative pathways, such as two hour community response services at a local level, which meant that ambulances did not need to be dispatched. Siobhan stated that they had also added in extra capacity to help reduce call times for 111 and these were improving although there was still a lot to be done.

On the issue of Hospital Discharges five hundred million pounds was to go to Better Care Funds to tackle this issue and each local authority would be meeting with the Chief Nurse to determine how work on this should be progressed.

Siobhan also advised that as part of the planning process for our ICS each area had been tasked with implementing two virtual ward pathways, Acute Respiratory and Frailty. This model would support early discharge and provide alternative pathways to early discharge. The NENC Respiratory Network, working closely with Acute Trust Clinicians were leading on this work. Siobhan stated that the aim was to have 350 virtual ward beds up and running by Christmas with up to 800 by March 2023.Siobhan stated that initially the virtual beds would be focused on respiratory with the next layer focused on frailty and falls. Siobhan advised that acute respiratory hubs were also looking at having increased numbers of beds and the aim was to have 292 new beds by December.
To support the most vulnerable patients during the challenging winter months Siobhan advised that the Chief Executive of the ICB had written to Ofgem and asked that the very vulnerable should not be punished and cut off from services and had received a favourable response.

Siobhan advised that in terms of risks to the plans, the ICB was operating in a very challenging environment which felt unprecedented. A significant concern was around workforce in view of planned industrial action and the top priority was to keep patients safe. Siobhan stated that the ICB was also very conscious of capacity issues within Social Care and was looking at joint ways to tackle matters where this was possible.

In terms of measuring success, Siobhan noted that the ICB is assured by NHS England and the ICB's Board Assurance Framework sets out the progress it is making each month against key metrics.

Siobhan stated that as far as the key metrics were concerned the ICB was doing really well in relation to 111 call abandonment rates. In terms of mean 999 call answering this was still an issue for medically optimised patients but they were performing well in England in relation to category 2 response times. However, in some areas there were significant problems in relation to handover response times and next week a community practice event was being held to examine what more could be done to tackle this. Siobhan advised that bed occupancy in both care homes and the NHS was currently really high and this situation becomes really challenging when beds are occupied by those who are medically fit.

Siobhan advised that the ICB was just about to launch its winter communications campaign which would focus on supporting health and wellbeing (keeping people well), signposting people to the right service for their needs - as well as some of the key issues being faced by health and care partners such as high need and times of surge.

Siobhan advised that she was happy to update the OSC on winter planning issues as and when it wished to receive these.

Councillor Pretswell thanked Siobhan for an excellent presentation and stated that she just wanted to comment on Siobhan's point about patient safety being a priority in light of industrial action. Councillor Pretswell stated that no trade union would put patient safety at risk and they would work with the employers to ensure that was the case.

The Chair queried what the ICB was doing in terms of tackling fuel poverty for CHC funded patients and whether the ICB was looking to give more to older people who might suffer from hypothermia.

Siobhan stated that the ICB had inherited 13 systems in relation to CHC and as a result was in the process of carrying out a review and the issues raised would be part of that review.

The Chair considered that the focus appeared to be mainly on adult health and she queried the position in relation to childhood illness. The Chair stated that she was aware that nationally there were 308 critical beds for children and young people but the ICB area only has 14 and she asked what was being done in terms of step down for them. The Chair was concerned that currently some children and young people might have to be transferred to Southampton and Manchester and families would find this hard to cope financially.

Siobhan stated that the ICB would do all it could to prevent that situation occurring and would protect tertiary centres so when there was a surge they would know the number of critical care beds and take pressure from them.

The Chair queried whether numbers of critical care beds had increased as demand had.

Siobhan stated that she did not have information on the volume but the virtual wards must include children and the respiratory hubs.

Councillor Taylor thanked Siobhan for her excellent presentation. Councillor Taylor considered that the biggest challenge was workforce and she noted that one of the urgent treatment centres in Newcastle had recently closed due to staffing issues.

Councillor Taylor stated she was also pleased to see End of Life Care highlighted as she was aware of a case where an individual had been admitted to hospital instead of a hospice and this had been inappropriate.

Councillor Taylor queried how virtual wards would work. Siobhan confirmed that patients would be supported by technology in their home combined with a multi-disciplinary team who would wrap around the patient and contact the patient to see how they were doing.

Siobhan stated that in terms of workforce the ICB was working with Provider Collaboratives to encourage them to collaborate more and share staff.

The Chair queried whether there was an End of Life Plan.

Siobhan stated that this was in the emergency care space where it was identified that there should be no inappropriate or unnecessary journeys or admissions. Siobhan also advised that understanding care plans and ensuring these were communicated well and ensuring sufficient hospice provision was also identified.

Councillor Kilgour thanked Siobhan for an excellent and realistic presentation. However, Councillor Kilgour considered that whilst the ideas and aspirations outlined were the right ones the problem was resources and she did not know where the resources were coming from to progress the work that was needed.

Siobhan acknowledged that a pragmatic approach was needed in relation to resource allocation.

Councillor Ezhilchelvan stated that he was pleased to see that cost of living, fuel poverty and industrial action were part of winter planning as they may continue to be issues due to the ongoing war in Ukraine.

Councillor Ezhilchelvan also noted that he had received a letter signed by all Chief Nursing Officers in England and Scotland, in relation to Social Care, seeking agreement to a deviation from normal practice to help the current situation. Councillor Ezhilchelvan queried whether Siobhan was aware of this and what the deviations were that were referred to.

Siobhan stated she was unaware of the letter.

The Chair considered that everyone recognised that if there was a buoyant Social

Care System this would solve many of the issues which the NHS was currently facing. However, the Chair advised that she was not aware of any conversations at a regional level with providers in relation to home care provision and the way it is currently commissioned. The Chair stated the local authority commissioners' budgets are being continually squeezed and within the NHS people are remaining in hospital for longer and agency staff are costing more. The Chair stated that she believed that if some NHS funding was diverted to Social Care for care provision this would solve some of these issues but this needs those conversations to happen.

Siobhan stated that, in terms of the joint planning and investment that the ICB and system partners needed to do, conversations were starting with Directors of Adult Social Care. Siobhan also stated that she would be happy to make sure that the points raised were fed back.

Councillor Chisnall queried whether most of the calls to the NE Ambulance Service could be prevented if individuals accessed their GP.

Siobhan stated that from a 111 perspective 42% of calls required primary care to speak to the individual so she stated that the answer was yes. Siobhan stated that they were looking to build capacity in all GP practices as well as looking at overflow models.

Councillor Jopling stated that she felt that there was a bit of a disconnect between the 111 system and GP's and she queried how many GP appointments were wasted.

Siobhan stated that this was a good point and something they were looking at. Siobhan stated that 111 slots in primary care were well used but there was something about how primary care were signposting with 111 that they were looking to address with a view to improving people's experience.

Councillor Taylor asked Siobhan whether the Joint OSC would receive an update on lessons learned.

Siobhan stated that she would be happy to come back to a future meeting of the Joint OSC to provide this.

177 WORK PROGRAMME 2022-23

The Joint Committee agreed its work programme should now include an item on the Integrated Care Strategy for its January 2023 meeting and that the item on Emergency Planning should be moved to its March 2023 meeting as set out below :-

Meeting Date	**Issue to Slot In**
30 January 2023	• Next Steps for ICS • Oncology Services – Proposed Service Changes and briefing on Gynae Oncology Services • Integrated Care Strategy
20 March 2023	• Next Steps for ICS

	• Progress of the Digital Strategy • Winter Plan Evaluation and Learnings • Emergency Planning

Issue to Slot In
Children's Mental Health Provision – Update on Current Performance and Future Provision

178 DATES AND TIMES OF FUTURE MEETINGS

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

- 30 Jan 2023 at 1.30pm
- 20 March 2023 at 2.30pm

Chair……..

GATESHEAD METROPOLITAN BOROUGH COUNCIL

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

Monday, 30 January 2023

PRESENT: Councillor M Hall (Chair) (Gateshead Council)
Councillor(s): Taylor (Newcastle CC) Jones (Northumberland CC), Kilgour and McCabe (South Tyneside Council), Butler and McDonough (Sunderland CC), O'Shea and Shaw (substitute) (North Tyneside Council

179 APOLOGIES

Councillor J Green (Gateshead Council), Councillors Pretswell and Ellis (Newcastle CC), Councillors Mulvenna and Kirwin (North Tyneside Council), Councillors Ezhilchelvan and Nisbet (Northumberland CC), Councillor Malcolm (South Tyneside Council) Councillors Jopling, Haney and Charlton-Laine (Durham CC) Chisnall (Sunderland CC)

180 DECLARATIONS OF INTEREST

Councillor Hall (Gateshead Council) declared an interest as a Director of Prism Care NECIC and as a member of CNTW FT's Council of Governors

Councillor Taylor (Newcastle CC) declared an interest as an Honorary Consultant at the Freeman Cancer Centre.

Councillor Butler declared an interest as an employee of NC Integrated Care.

181 MINUTES

The minutes of the meeting of the Joint Committee held on 21 November 2022 were deferred until the next meeting as this meeting was inquorate.

182 NEXT STEPS FOR ICS

Dan Jackson, Director of Governance and Partnerships, NE & NC ICS, provided the Joint OSC with an update on this matter.

Dan provided an overview of the latest position in relation to the development of the

proposed governance arrangements for the ICB, Executive Committee and place-based options, following consultation with local authorities.

Dan advised that it was anticipated that ICB place arrangements would be in place by April 2023.

Councillor Butler thanked Dan for the helpful update and queried whether the non-ICB members which could be included in the membership of the Committees would be similar to non – executive members on other bodies.

Dan advised that the non – ICB members were there to provide a broader membership than the NHS and could include the voluntary sector and local authorities. Dan indicated that guidance was currently being sought on voting and accountability.

Dan stated that in terms of how the meetings would be formally constituted it may be the case that they have tripartite meetings where one part is devoted to ICB business, another part is devoted to S.75 business and the final part is devoted to wider partnership issues. Currently they were exploring whether some members should have different voting rights for each part of the meeting.

Councillor Butler queried whether there would be private providers with voting rights on the Committees.

Dan stated that there would not be private providers on ICB place committees, just as there were not any private providers on the ICB's main board

Councillor Butler asked if the Joint OSC could see where this was set out and Dan advised that it was set out in the ICB Constitution which could be accessed online via the ICB's website

Councillor Butler queried who the core voting members on the Place based Committees would be and whether these would be officers or councillors.
Dan advised that place committee membership would likely comprise ICB and executives but they would work to deliver the local priorities set by elected member-led Health and Wellbeing Boards

Councillor Taylor queried what the position would be if the option of a Place Committee was progressed.

Dan advised that the majority of the voting members would be ICB staff.

John Costello asked if he understood correctly that from April 2023 there would be an ICB Place Committee in place for each area and there would then be a move to a Joint Committee for some.

John stated that he had not realised that both could be in Place and he asked for clarification.

Dan stated that it was not a case of having one or the other and it was probable that

both would be in place particularly given the need to transact S.75 arrangements and they would probably run concurrently.

Councillor Hall noted that in terms of S.75 matters there were still significant issues with staffing and arrangements put in place needed to be responsive and get funding out to make sure the workforce was being supported.

Councillor Hall queried whether there was going to be a hold up in getting Better Care funding to staff.

Dan stated that one of the key priorities was to avoid any disjuncture / destabilisation and he advised that Nicola Bailey had ICB responsibility for Gateshead.

Councillor Hall stated that she was concerned that there might be a time lag in money coming through. Councillor Hall stated that she wanted to make sure that each local authority representative on the Committee was satisfied that funds would be coming through and they would not be disadvantage.

Dan stated that he was not aware of any disadvantage.

183 UPDATE ON NON - SURGICAL ONCOLOGY WORKFORCE CHALLENGES IN NE & GYNAE ONCOLOGY SERVICES ACROSS NENC

Ashraf Azzabi, Clinical Director, Cancer Services & Clinical Haematology, Newcastle Hospitals NHS FT, reminded the Joint OSC of the temporary arrangements which had been put in place for non – surgical oncology services and the workforce challenges which had led to this position.

Ashraf highlighted that the Hub at the Queen Elizabeth Hospital in Gateshead dealing with breast cancer in South of Tyne had not yet been put in place and had been delayed due to I.T. access and workflows and the need for honorary contracts to allow movement between Trusts as well as workforce availability. As a result, they were linking with all Trusts to address I.T. barriers and were ensuring honorary contracts were in place as well as using new clinic co-ordinators to ensure appointments/travel booked for patients. Ashraf stated that it was hoped that the temporary measures for breast cancer would be in place by the beginning of March.

Ashraf indicated that it had been acknowledged that there would be an impact on patients who would have to travel further as a result of the temporary arrangements. However, Ashraf, highlighted the data which had been collected in relation to this issue and noted that the impact on patients had been less than expected.
Ashraf stated that work was continuing to recruit consultants working with NHS England and the Northern Cancer Alliance with a view to developing a sustainable solution going forwards. Ashraf stated that they were keen to have patient and public engagement in order to achieve the right solutions.

The Chair asked if it were possible to recruit the consultants needed that arrangements would go back to how they had been previously.

Ashraf advised that there would not be a return to the previous arrangements.

Ashraf stated that he had been practising in the region for 25 years and had been practising as a sole practitioner during that time. This was a problematic arrangement as it meant that it was difficult to provide cover if needed. Feedback from oncologists generally was that they considered that it was beneficial to work with colleagues as they could provide cover better where issues arose.

Councillor Taylor asked if Ashraf could confirm that there would be no changes for patients having chemotherapy in their own unit.

Ashraf confirmed that there would no changes for these patients.

Councillor O Shea noted the workforce challenges which had been outlined and queried why there appeared to be significant problems in the region as opposed to the rest of the country.

Angela Wood, Clinical Director of the Northern Cancer Alliance advised that there were national shortages and these were being reflected in the NE region it was not the case that the NHS in the NE were poor recruiters. Angela stated that generally, when they trained someone to be an Oncologist, they stayed in the area but they had been restricted nationally as to the number of oncologists that they could train so they had to look at other parts of the workforce to provide support. In addition, in this region they have an older demographic of Oncologists and there was also a current workforce crisis in terms of resilience.

Councillor O'Shea noted that Angela had indicated that the NENC are limited to the number of trainees they can train in the region and this is due to the national allocation of training numbers and asked if she was saying that it was government policy which was restricting the numbers they could train.

Angela confirmed that was the case. National training numbers were given by Health Education England. However, more recently they had managed to work with Health Education England to increase the training numbers for Oncology up to 7. However, whilst they would have more Oncologists coming through it takes five years to train Oncologists.

Councillor O'Shea asked if government was supressing funding.

Angela stated that the government's position was not helping the situation.

Phil stated that in Newcastle they were very successful in their training programme and had a number of talented registrars and had appointed all that had come through the training programme as consultants. Unfortunately, they did not have enough.

Councillor Jones noted that the Wansbeck site had been removed and this meant that there was no site in Northumberland. Wansbeck covers the north and west of Northumberland. As a result, Councillor Jones, considered that this would mean a very difficult journey for patients from Northumberland. Councillor Jones noted that there had been a high response rate in the consultation from Wansbeck and she believed that this was probably the reason for that.

Councillor Jones queried whether arrangements were being put in place to help people travel to the sites. She also noted that Healthwatch Northumberland was not part of the list or organisations consulted on the temporary arrangements and she suggested that it would be beneficial for NHS colleagues involved in progressing the temporary arrangements to gain their views.

It was highlighted that Daft as a Brush had indicated that they were happy to support transport arrangements as were NEAS via their Patient Transport arrangements.

It was also clarified that patients still had access to treatment in Wansbeck.

In terms of Healthwatch it was highlighted that mechanisms were in place to bring all Healthwatch representatives together to gain their views and consultation with organisations such as Healthwatch was part of the next steps it was planned to take forward.

Councillor McDonough queried whether recruitment from overseas was being considered as an option and the Joint OSC was advised that it was and a piece of work was taking place with colleagues in Yorkshire around this with a view to training people as part of a cohort.

The Joint OSC was advised of the engagement carried out so far in relation to the temporary measures and was informed that further work was now needed with service users via surveys and focus groups. Further information would be gathered between now and June with a view to developing a plan for a final round of engagement in relation to a proposed service model and external support would be sought to progress this. South Yorkshire Cancer Alliance had been asked to provide a level of challenge to the proposals developed and it was planned to engage further with the Joint OSC in July 2023 in relation to the proposals. The aim was to share the longer term plan in the autumn and then think about how they would implement the plans.

It was noted that the proposals would have a positive impact on patients including early appointments with oncologists.

Councillor Butler noted that over the years he had seen many complaints come via Healthwatch in relation to a number of services but he had not seen these in relation to cancer services which had been timely with pleasant staff. Councillor Butler stated he wanted to say a big thank you to all the staff involved.

Councillor Jones advised that she had understood that cancer treatment was ongoing at Wansbeck but her concern was that individuals would not attend their first appointment with the consultant.

Ashraf stated that they had not seen any evidence of that being the case and if patients did not attend then they would follow this up.

Ashraf noted that all those individuals with prostate cancer from the border to Newcastle have to come for their appointments to Newcastle and this has been the

case for years and there have been no problems with patients attending.

Ashraf noted that they are engaging with Daft as a Brush and NEAS in relation to patient transport in order to address patient transport issues.

Councillor McDonough noted that one of the reasons for staff shortages related to staff retirements and he asked if plans were being put in place so that this situation could be avoided in future.

It was highlighted that even if there was a clear picture around the staff who are retiring there was not a great deal that could be done as the team did not have the number of oncologists being trained coming through – although it was acknowledged that they now had a few extra these were still not going to be sufficient. Therefore, consideration was being given to how other clinical specialists might provide support and operate at the level of a trainee registrar with a view to taking on some of the work previously carried out by consultants. A training programme was therefore being developed for Advanced Clinical Practitioners (ACP's) and it was hoped to have 16 in place
over time which would make a big difference and help to fill the workforce gap.

Consideration was being given to nurse specialists as many were coming up to retirement and so a recruitment plan is being developed. There was also a major programme for pharmacists to become prescribing pharmacists sitting with oncologists in the Hubs.

Councillor Shaw stated that she thought the work being progressed to plug workforce gaps was fantastic and she wanted to thank the teams for innovative ways of thinking which were being progressed in such difficult times. However, Councillor Shaw was interested in whether the age profile of workforce was known and whether this information was being fed to government so they were aware when considering issues such as training numbers.

The Joint OSC was advised that the difficulty was that there was not a national workforce strategy in place. It was very clear that nationally there is a shortage in this speciality however getting additional resources / training numbers had proved very difficult. Ashraf stated that people are living longer and different types of treatment are being developed which means that the oncology population is growing but they are still being told there is no funding.

Councillor Shaw asked whether having the ICS in place was considered helpful in allowing innovations to be shared more widely.
The Joint OSC was advised that yes it was considered helpful as the Cancer Alliance was able to be on the front foot and working across the ICS.

The Chair queried whether there were any shortages of drugs and was advised that there were not.

The Chair also queried whether there were any issues as a result of poor internet access for patients.

The Joint OSC was advised that patients come to them for a discussion in relation to their treatment options and the pandemic changed many attitudes and many patients were now happy with just a phone call as a follow up.

Angela Wood and Alison Featherstone, Managing Director, Northern Cancer Alliance and Julie Turner Head of Specialised Commissioning NENC, NHS England advised the Joint OSC of the proposed way forward for developing a regional clinical model for Gynae Oncology Services across NE&NC.

The Joint OSC was advised that since July 2021 South Tees NHS Foundation Trust had significantly reduced numbers of specialist gynae-oncology surgeons as they did not have enough consultants for all surgery. Gateshead, and other hospital colleagues have supported the service and 94 patients had moved to Gateshead from South Tees for treatment in 15 months.
Gynae – oncology level three tertiary (specialist) surgical services provided at South Tees NHS FT and Gateshead Health FT were therefore the focus of the proposed changes.

The Joint OSC was informed that the capacity and service delivery challenges had brought the clinical teams closer together to review the patient pathways there was a need to build on this collaboration to build resilience into the current service model and improve services.

The Northern Cancer Alliance were leading work on behalf of NHS England Specialised Commissioning to consider a regional gynae oncology service which accounts for the workforce challenges but strengthens the service and ensures it is clinically driven from the bottom up and improves pathways to help patients have access to surgery more quickly.

To date the Clinical Teams have developed a vision and principles for a regional service and the below proposed future clinical model :-

- One Regional Lead Provider with a Managed Clinical Network.
- One regional service, Two centres with three specialist operating sites.
- Surgeons work across the three operating sites as one team as demand/capacity requires
- One clinical pathway into one MDT for decision making (over a number of days)
- Strong co-ordination and navigation of patients across the region

Informal feedback has so far been positive although it was acknowledged that travel may be an issue for some patients which may requires some mitigating actions to be put in place. Over the next few months, it was planned to agree the high- level clinical model and develop a communication and engagement plan and seek patient feedback. The Joint OSC was advised that this was not a major change to the way the service has been carried out but would make the service more resilient and effective.

Councillor Taylor noted that multi-disciplinary teams (MDT's) would usually have between 60 and 70 patients and she queried whether staff from other hospitals

would be brought in.

The Joint OSC was advised that they were changing the process and remodelling it using radiology/pathology and streamlining MDT's. There was a big piece of work to improve MDT working.

John Costello noted that reference had been made to one regional lead provider and he asked whether the lead provider had been identified yet or whether this was still a matter for discussion.

Julie advised that a lead provider had been identified and it was Gateshead Health NHS FT and all parties were comfortable with that and there will be a lead provider supported by a managed clinical network.

The Chair stated that she was aware that there were also shortages of surgeons and clinicians in other areas and she asked what was happening to deal with this.

Julie advised that she understood that a number of initiatives were ongoing but she did not have any knowledge as to the details.

The Chair stated that she understood that there were shortages in radiology, pathology and cardiology and she considered that this may be an area for the Joint OSC to receive an update on at a future meeting.

The Chair thanked everyone for their excellent presentations.

184 UPDATE ON INTEGRATED CARE STRATEGY

Peter Rooney, Director of Strategy and Planning, provided the Joint OSC with an update on this matter.

Peter advised that all integrated care partnerships (ICPs) were required to publish an initial integrated care strategy which should demonstrate how the health and care needs of the population would be met. The North - East and North Cumbria had agreed to publish the strategy on December 15 with a fuller launch including accessible versions in late January.

The NE & NC had been the first ICP in England to publish a draft strategy for feedback and had received over 400 responses through an online survey and additional responses.

ADASS, Directors of Children's Services and Directors of Public Health had been consulted as had Health and wellbeing boards and each of the four local ICP meetings. First ICP in England to publish a draft strategy for feedback. In addition, comments were received from NHS England, Office for Health Improvement and Disparities and the UK Health Security Agency. Key themes were shown in the Engagement Feedback Report produced.

As a result of the feedback received, the following changes were made to the

strategy:-

- Inclusion of a Best start in life goal: maternity, children and young people.
- Commitment to co-production as a key enabler.
- Realism: where we are now and revised the medium-term ambition in the goals.
- Broader prevention focus: substance misuse, healthy weight, social isolation.
- Stronger recognition of housing and economic/social development.
- Inclusion health, rural and coastal, older adults, long term conditions & end of life.

Peter highlighted the vision, goals and key enablers for delivery of the strategy and noted that a copy of the finalised Integrated Care Strategy had been circulated to the Joint ICS OSC.

Peter advised that there was a national requirement for Integrated Care Boards and NHS Trusts covering 2023/24 – 2028/29 to produce a 'Delivery plan' for the ICP integrated care strategy and would include the 14 local authority place plans and thematic plans. A Draft plan would be produced by the end of March with a final plan by the end of June. Engagement with partners on the draft plan would take place between March and June.

Councillor O'Shea thanked Peter for the presentation and noted the significant aspirations and asked how these would be measured going forwards and how the Joint OSC could be assured that the targets put forward were stretching the ICB.

Peter confirmed that the Strategy document included measures and comittments and the ICB would transparently publish progress on an annual basis.

Councillor McCabe considered that the content of the Strategy was admirable and the document was well written and it would be excellent if what was outlined could be achieved. However, Councillor McCabe was concerned as to how it could be achieved.
Councillor McCabe stated that previously Health OSCs in South Tyneside and Sunderland listened to health colleagues in relation to plans around the Path to Excellence and for maternity and neonatal services and now maternity services in South Tyneside no longer exist as they are all provided in Sunderland. As a result, Councillor McCabe questioned how he could have confidence in the measurable commitments outlined in the Strategy, especially given current workforce challenges.

Peter acknowledged that many health colleagues were operating in highly pressurised environments without sufficient staff in some areas and services could not continue to be run in this way. The ICB was looking to tackle the workforce challenges by encouraging staff to stay by looking at the working environments they are operating in and potential financial rewards and in terms of recruitment was looking at new models and skill mixing. However, Peter considered that ultimately national help would be needed to address the situation.

In terms of assurance Peter advised most of the document related to population health outcomes and these did not just relate to the NHS but were a collective

challenge and included partners and were also societal. Peter reiterated that the ICB would publicly and transparently publish progress.

Councillor McCabe advised that he remained sceptical as he still felt it was unclear how the outcomes outlined would be achieved.

The Chair asked if the Delivery Plan for the Strategy could be brought to the OSC and Peter confirmed that it could.

Councillor Taylor queried whether in terms of addressing the determinants of health it was possible that the ICS would put in place schemes where they paid for heating to prevent them from being admitted to hospital.

Peter advised that they were looking through the guidance to see if these were the types of work which were feasible. Peter stated that only a quarter of the outcomes would be determined via healthcare and the rest were related to the social determinants of health / economic.

Councillor Kilgour stated that she was also sceptical and felt that much of what was outlined was reinventing the wheel. She was unable to see how different outcomes could be achieved if the same things were being put in place and she felt any real benefits might only be achieved way into the future.

Peter stated that tracking life expectancy it could be seen that this had risen consistently in the UK and then in 2012 it had stopped growing. Inequalities are also increasing Therefore, collectively there is a need to see what can be done differently. and the Strategy is set against this backdrop.

The Chair stated that the sentiments set out in the Strategy were ones that everyone could agree with. However, there have been significant changes within the NHS before which have been costly and to outward appearance the changes establishing the ICS could appear to be change for change's sake. The Chair referenced the Marmott Review and expressed concern that we are now worse off than we were and she noted that much blame was being placed on Covid but she considered that years of under resourcing was also a significant factor. The Chair hoped that having the the Strategy in place would ensure a level of national commitment to addressing the issues.

Peter stated that he had met Prof Marmott who was angry at the current position and he agreed that we shouldn't be at this position but unfortunately we are. Peter acknowledged that there had been previous reorganisations but he advised that they always provided some opportunities and they would look to do the best possible and take advantage of these.

The Chair stated that the NHS needs to work much more closely with Social Care to address some of the key issues. Peter agreed and stated it was recognised that the two were deeply entwined

Councillor Butler stated that what would be important was to develop a communications strategy which explained the changes to local people in a

meaningful way. Councillor Butler also agreed that unless there is a shift in approach a rise in healthy life expectancy would not be possible.

Peter agreed that credible delivery plans were needed and these would need to be developed collectively as a group of partners.

185 WORK PROGRAMME 2022-23

The Joint Committee agreed its work programme should now include an interim update on workforce, focusing particularly on how the ICB has been managing workforce issues to ensure effective service provision / access to services during periods of industrial action by NHS staff, and consideration of the Integrated Care Strategy Draft Implementation Plan – at its next meeting if this was feasible and that the item on the Progress of Digital Strategy should be moved to its July meeting in its 2023-24 as set out below :-

Meeting Date	Issue to Slot In
20 March 2023	• Next Steps for the ICS • Winter Plan Evaluation and Learnings • Emergency Planning • Integrated Care Strategy Draft Implementation Plan • Workforce – Interim Update

Issues to slot in – 2023-24 work programme

- Progress of Digital Strategy – July 2023
- Children's Mental Health Provision – Update on Current Performance and Future Provision – July 2023

186 DATES AND TIMES OF FUTURE MEETINGS

It was agreed that the next meeting of the Joint OSC is held at Gateshead Civic Centre on the following date and time:-

- 20 March 2023 at 2.30pm

Chair……..

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Revised Protocol for Joint Health Scrutiny Committee

Joint OSC for the NE & NC ICS and North of Tyne and Gateshead and Durham, South Tyneside and Sunderland area ICPs

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 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 area ICPs covering the geographies of Northumberland, Tyne and Wear and Durham and the below mentioned groups and bodies:-

North of Tyne and Gateshead area ICP

- Primary Care Networks within the North of Tyne and Gateshead area ICP geography
- Northumbria Healthcare NHS FT
- Newcastle Hospitals NHS FT
- Gateshead Hospitals NHS FT
- Gateshead Council
- Newcastle City Council
- North Tyneside Council
- Northumberland County Council

Durham, South Tyneside and Sunderland area ICP

- Primary Care Networks within the Durham, South Tyneside and Sunderland area 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

Plus the following bodies which cover both area 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 and areab ICPs covering Northumberland, Tyne and Wear and Durham (currently the " North of Tyne and Gateshead " and " Durham, South Tyneside and Sunderland " area 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;

- **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 of Tyne and Gateshead and Durham, South Tyneside and Sunderland area ICP geographies**

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 seven members from five local authorities except where there is a formal consultation process in relation to a proposal for a substantial variation and development where the quorum shall 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 area ICPs 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 area ICPs covering Northumberland, Tyne and Wear and Durham (currently " North of Tyne and Gateshead " and "Durham, South Tyneside and Sunderland" 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 of Tyne and Gateshead and Durham, South Tyneside and Sunderland area ICPs

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 area ICP covering the geographies of Northumberland, Tyne and Wear and North Durham (currently the "North of Tyne and Gateshead " and "Durham, South Tyneside and Sunderland" ICPs)

2. 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. 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. 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. 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. 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 of Tyne and Gateshead " and "Durham, South Tyneside and Sunderland " area Integrated Care Partnerships.

7. 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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