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

Monday, 4 July 2022

PRESENT: Councillor Caffrey (Chair) (Gateshead Council)

Councillor(s): Hall, and Wallace (Gateshead Council), Taylor and Pretswell (Newcastle CC) Jopling, Haney and Kellet (Substitute) (Durham CC) Kilgour and Malcolm (South Tyneside Council) Butler, Chisnall and McDonough (Sunderland CC) Kirwin, Mulvenna and O'Shea (North Tyneside Council) and Ezhilchelvan (Northumberland CC)

151 APPOINTMENT OF CHAIR

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

152 APPOINTMENT OF VICE CHAIR

In line with the terms of reference of the Joint Committee, the Joint Committee agreed to appoint Councillor Wendy Taylor of Newcastle City Council, as Vice Chair for the 2022-23 municipal year.

153 PROTOCOL / TERMS OF REFERENCE

The Joint Committee agreed the proposed revisions to the Protocol/ Terms of Reference arising from the move to a statutory ICS as of 1 July 2022.

It was noted that local authorities and health partners had been consulted on the current arrangements as set out in the Terms of Reference and Protocol and all parties were content that these were fit for purpose.

The arrangements would be reviewed annually to ensure that they remained fit for purpose.

154 APOLOGIES

Apologies were received from Councillor(s): Charlton-Laine (Durham CC), Ellis (Newcastle CC) Nisbet and Jones (Northumberland CC) and McCabe (South Tyneside Council)

155 DECLARATIONS OF INTEREST

Councillor Kirwin (North Tyneside Council) declared an interest as an employee of a national Cancer Charity.

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

Councillor Hall (Gateshead Council) declared an interest as a member of CNTW Foundation Trust's Council of Governors.

Councillor Haney (Durham CC) declared an interest as a member of Tees Esk and Wear Valley Foundation Trust's Council of Governors.

Councillor Butler declared an interest as an employee of North Cumbria Integrated Care

156 MINUTES

The minutes of the meeting of the Joint Committee held on 21 March 2022 were approved as a correct record

Matters Arising

The Chair noted that at the last meeting of the Joint OSC there had been a discussion in relation to the style of scrutiny adopted at the meetings. The Chair reminded members that robust scrutiny was the product of good preparation and she advised that if members had questions that they wished to have raised at the meetings it would be helpful to have these sent through to the scrutiny officer in Gateshead in advance so that arrangements could be made for relevant attendees at the meeting to be able to provide a response.

Councillor Mulvenna advised that it would be helpful for councillors to receive the reports and presentations a little earlier to assist members in sending questions through in advance.

Councillor O'Shea noted that the Joint Committee appeared to have a full work programme outlined for the year and queried whether the whole Joint Committee would be involved in scrutinising the matters outlined or whether some of this would be carried out in smaller groups and report back to the main Committee.

The Chair advised that the Joint Committee had not previously asked smaller groups to examine issues and report back. However, there was nothing to prevent the Joint Committee taking this approach going forwards if it felt in due course that members were able to commit the time and there were advantages to this approach that could not be gained from the whole Committee meeting. However, the Chair explained that it was only in the last six months that the Joint Committee had received some clarity on the details of how the ICS, ICB and ICP would be progressed and there was still a lot of detail yet to emerge particularly in relation to the linkages with Place as this

would be a transitional year The Chair also noted that going forwards there would be a need to focus at some point on work at an ICP sub level. In addition, the focus of the Joint Committee had up to this point been on health but the work undertaken going forwards would be in partnership and there needed to be greater clarity in relation to local authorities role in that Partnership.

157 UPDATE ON NEXT STEPS FOR THE ICS

Mark Adams, Area Director for the North provided the Joint Committee with a presentation on the above.

Mark advised that a huge amount of work had gone into the position we are now at with the new statutory ICS coming into being last Friday. The ICB Operating Model now takes over from the CCG's that local authorities previously worked with and this sets out how the ICB delivers its objectives within the integrated care system, how decisions are made and who makes them and how the ICB assure itself that its objectives are being met.

Principles of ICB development have been progressed to establish joint working and governance structures which have had involvement not just from the NHS but also local authorities and other partners ie the voluntary and community sector so that the ICB can have a clear focus going forwards on its four strategic aims of improving outcomes in population health and healthcare, tackling inequalities in outcomes, experience and access, enhancing productivity and value for money and helping the NHS support broader social and economic development.

Mark outlined the key functions of the new ICB and noted that a new function would be that of being a category 1 responder for emergency scenarios.

Mark outlined the position in relation to ICB governance and the new leadership team and advised that the Board had met last Friday for the first time.

Mark detailed the Board and Committee structure and provided an overview of those functions which would be carried out at scale and which at place, acknowledging that some of these might overlap. Mark advised that those functions carried out at scale across the ICB would mirror what was previously seen in CCG's.

Mark advised that the ICB covers 14 geographical areas "places" and the ICB wants to make as many decisions as it can as close as possible to "place".

Mark referred to the formal establishment of the North East and North Cumbria (NENC) FT Provider Collaborative which is a formal partnership of all 11 NHS Foundation Trusts (FTs) in the region and advised that currently the work of the collaborative is focused on addressing the challenges of service delivery.

Mark highlighted that there would be one whole system ICP built up from four smaller locally sensitive ICPs and the Chair of the ICB Sir Liam Donaldson had agreed the approach of how the ICPs would work in practice over a series of meetings with partners. The whole system ICP would therefore meet on a bi-annual basis and the four smaller ICPs would meet more frequently and would involve

representatives from Local Authorities, FTs and Primary Care Networks. The ICP would sign off the Integrated Care Strategy and how this is translated into the four areas.

Mark shared the system governance arrangements for the ICS and how the strategies and plans link together and he outlined the phase approach which would be adopted during 2022-23 which is a transitional year with business continuity being a critical focus.

Mark indicated that key to developing local place - based priorities was co-production and he highlighted the overarching common priorities arising from the ICS survey of places.

Mark highlighted the outputs from the NENC Joint NHS and LA workshop which had taken place on 24 June as a key starting point for identifying the areas which the ICB would delegate to Place and for developing a framework for minimum governance requirements. Mark stated that conversations would continue with each local authority area and the aim was to have initial proposals for each place based area by September. The plan was then to have the new ways of working in place from January 2023 and trialled for three months.

The Chair thanked Mark for his presentation and asked for clarification as to whether everyone on the Joint Committee was aware of the workshop on 24th June.

The Chair felt that if the workshop was the starting point for discussions then there was a need to ensure the involvement of relevant councillors from the twelve places as they are the decision makers. The Chair stated that in Gateshead the invitation had gone to a mix of councillors and officers but in the end none of the councillors had attended due to a lack of understanding as to why they were being asked to be involved.

The Chair therefore felt that if the workshop was intended to kickstart the process it had not worked and she felt a step back was needed.

Councillor Butler agreed with the Chair and that it was likely new councillors may not have been clear and he indicated it would be beneficial if the workshop was run again with representation from councillors.

Councillor McDonough noted that Sunderland had a couple of representatives who had attended the workshop but he felt that some of their questions had been skirted over and not fully answered. Councillor McDonough stated that his biggest concern was that there was currently no elected representation at the top of the ICB structure. Councillor McDonough stated that he was aware that national legislation was part of the problem but he still felt there had not been an adequate response to this issue.

Councillor McDonough also considered that it was not clear what the benefits would be on the ground as a result of having the new model in place. For example how would it make access to services better or the journey through health services easier. Councillor McDonough considered it was important to have responses to

these questions.

Mark advised that they did not have answers to this until they had completed the discussions with everyone in relation to place based working.

Councillor Jopling stated that she agreed with the points made by other colleagues but also wanted to know whether there was a plan to achieve standardised care across all areas within the ICS so that there is no postcode lottery in respect of operations etc. Councillor Jopling stated that if this is something which was an outcome from the statutory ICS then it would be a big achievement.

Mark confirmed that one of the areas of focus of the ICS was to tackle inequalities in all guises and therefore one of the key tasks would be to progress work in this area but this would not happen overnight.

Lynn Wilson suggested to Mark that going forwards it would be helpful if Leaders and Chief Executives were placed on the distribution list for ICS events.

Lynn highlighted how everyone had come together as system partners to provide an effective response to Covid and stated that tackling health inequalities is also an area which would greatly benefit from this type of approach.

Councillor Taylor advised that she also had been unaware of the workshop on 24 June and she felt this was an event which all councillors should have been made aware of.

Councillor Taylor stated that she thought it was encouraging to see the proposals in relation to maintaining business continuity and trusts working together. However, Councillor Taylor queried whether any progress was being made in relation to the integration of health and social care and how this is to be managed.

Mark advised that at the moment the focus was on funding the NHS as this was a huge change moving this from the CCGs to the ICB. Mark stated that the ICB was in a good place this year and going forwards consideration would be given to what this might mean for different levels of funding opportunities and the steps which might need to be taken. Mark stated that the plan would be to look at this collectively.

Councillor Kilgour stated that if would be helpful for the Joint Committee to know who the attendees were at the workshop on 24 June.

Councillor Kilgour stated that alongside the areas of responsibility that are being identified for local authorities at place it was key that funding was provided to tackle these. Councillor Kilgour stated that local authorities cannot take on these responsibilities without appropriate funding.

Councillor Kilgour stated that tackling changes to infrastructure in terms of housing etc would need to be incorporated into any assessment around funding.

Mark stated that at present officers in the CCGs and ICB were working with the funding that they have at the minute. Going forwards they will be consulting in

different ways with each place as to funding and how it can be used. Mark acknowledged that there is a role for the ICS in tackling the wider determinants of health eg job creation etc and he advised that these are the conversations that officers within the ICB want to have with each place.

Councillor Ezhilchelvan noted that there had been a reference to GP closures, which were previously the responsibility of the Primary Healthcare Boards, now being the responsibility of the ICB and he queried what stage the ICB was at in relation to having appropriate machinery in place to deal with these where feedback can be provided.Councillor Ezhilchelvan stated that he had attended the workshop on 24 June but was not aware of any explicit mechanism for information exchange except through the four ICP subs.

Mark advised that there is a process in place for the ICB to deal with GP closures although this is not something the ICB wishes to see. In terms of links between place based working and the ICB where feedback can be provided, Mark advised that Directors of Place based working were in place and there would be staff within the ICB who would work in each place and build links.

Councillor Kirwin indicated that he was really pleased to see continuity of care highlighted. However, Councillor Kirwin noted that previous presentations had referred to new powers to help place based working but he had not seen anything further as to what this would entail and he queried when this was likely to be known.

Mark advised that the workshop was really the start of that process and further discussions would subsequently be held in each place.

Councillor Mulvenna expressed concern that currently it is planned that the ICB will only have four members who are councillors. Councillor Mulvenna considered this was insufficient given the huge geography covered. Councillor Mulvenna considered that unless there was increased representation from grass roots councillors the ICB would face difficulties in progressing its objectives. Mulvenna advised that councillors in each respective place needed to be engaged and involved although he acknowledged that there may be a need for a couple of councils to come together but he considered that greater representation was needed.

Mark thanked Councillor Mulvenna for his comments and stated that he would like to explore how, at a place - based level, that might work.

The Chair noted that there is no political input in relation to the ICB and so considered that as councillors know what is happening in their areas there needed to be a bottom - up approach with local authorities coming together to discuss.

The Chair thanked Mark for the very informative presentation.

158 ONCOLOGY SERVICES BRIEFING

The Joint Committee was provided with a briefing paper and a presentation on this matter from representatives from NHS England, who are responsible for commissioning oncology services, Newcastle Hospitals as the provider of the

services and the Northern Cancer Alliance and the newly formed Provider Collaborative, which represents all the FT's in the region.

The Joint Committee was advised of the need for Newcastle Hospitals NHS FT to temporarily reconfigure non – surgical oncology in response to current significant workforce challenges which were reflective of the national picture.

The Joint Committee was informed that the decision to temporarily reconfigure services had not been taken lightly and that if the proposed changes were not put in place it would mean patients in some areas would be disadvantaged in how quickly they could be seen by the appropriate expert oncologist compared to other parts of the region leading to delays in their cancer treatment which was not an acceptable position.

The Joint Committee was informed that Newcastle Oncologists currently travel across the north of the region to deliver multiple outreach clinics at several local hospital sites (as well as Newcastle sites): Currently, Newcastle Hospitals was short of 6 full time Consultant Oncologists due to a combination of vacant posts, planned retirements and sickness absence coupled with a growing demand and complexity in non-surgical oncology treatments.

In order to ensure continued safe delivery of specialist oncology services and equitable access in the north of the region it was proposed to have a phased approach to establishing fewer outreach clinics which would act as hubs with two to three consultant oncologists working together to allow consultant oncologists in post to see as many patients as possible on the breast, lung and colorectal (bowel) cancer pathway. The intention was that this would increase resilience within the existing workforce and mean that consultants would no longer be lone workers which it was hoped would make recruitment to vacant consultant oncologist posts more attractive.

The Joint Committee was advised that there would be no changes to how patients would access their systemic treatment. 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. Clinic co-ordinator roles would be employed by Newcastle Hospitals to ensure efficient and effective use of all available appointments and virtual appointments would continue to be offered and maximised where this was appropriate.

The Joint Committee was informed that recruitment was ongoing and other appropriate staff groups who could provide support were being involved but given scale of challenge it was not clear how quickly the current workforce position would be resolved. The Joint Committee was informed that nationally there is a predicated consultant oncologist shortage of 28% by 2025 and regionally a predicated shortage of 43% over next 5 years.
The Joint Committee was advised that the proposed changes would begin to take effect in July and would be monitored for twelve months and during this time work would take place to look at a more sustainable model for the longer term.

The Joint Committee noted that approximately 114 patients would be impacted per week (approximately 18% of activity) and was informed that it was recognised that the proposed change would cause some disruption for patients but the primary concern was to ensure that all patients have timely access to the cancer care they need and that there is clear communication with patients.

Consideration had been given to patient transport requirements and Daft as a Brush patient transport had indicated they were keen to provide services regionally. North-East Ambulance Service were also supportive of temporary changes for patients who require patient transport.

Work was also taking place with the Northern Cancer Alliance to gather patient feedback from those affected by the temporary changes.

The Joint Committee was advised that whilst the temporary changes had been requested by Newcastle Hospitals NHS FT, they were supported in principle by regional NHS England Specialised Commissioners, the Northern Cancer Alliance, the Integrated Care System Leadership team for the North East and Cumbria and the wider hospital network that are part of this system.

Councillor McDonough queried whether a clinic in his area which provides breast cancer surgery would be affected.

Ian Pedley Consultant Oncologist, Newcastle Hospitals FT advised that there would be no impact on surgery as a result of the proposed changes.

Councillor Butler asked whether the proposed consultant hubs would run at reduced capacity if one consultant was sick.

Ian advised that work had been taking place to ensure that the hubs would be robust and responsive. This had involved examining whether long term follow ups could be carried out potentially via primary care and looking at ensuring there would be slots for emergencies. Ian also advised that specialist nurses would also work in the hubs.

Councillor Malcolm noted that Ian had indicated that the south of the country was able to achieve 100% student whereas the north was only achieving 50% and he queried why this was the case.

Ian explained that junior doctors who are successfully recruited are able to choose where they wish to work and the problem at present is that there is a heavy preponderance for opportunities in the south of the country to be chosen. Ian advised that his team have organised an open evening and invited junior doctors of one or two years qualification to attend so that they can promote their speciality.

Councillor Malcolm queried whether Brexit had impacted recruitment. Ian advised that there had been an impact on recruitment across the NHS. In relation to oncology some non-UK consultants had been appointed from outside of Europe. However, as far as specialist nurses and radiographers were concerned there had been a massive impact.

The Chair noted that the Joint Committee may need to have another briefing on the impact of Brexit on the workforce.

Councillor Jopling queried how the changes would affect patients as far as Teeside.

Ian advised that the temporary changes only applied to the North Durham to Berwick geography ie the north of the ICS . Currently James Cook Hospital is better staffed as a result of having to address workforce challenges a few years ago. However, the longer term work would also cover the south of the ICS.

Councillor Malcolm noted that the changes were highlighted as temporary and he queried what the timeframe for these would be. Councillor Malcolm stated that he presumed that this Joint Committee would be consulted on the proposals at the appropriate time.

Phil Powell advised that the changes would be in place for a finite period and run until 31 March 2023. In the meantime, work was taking place around what might need to be put in place after that and options were starting to be developed and these would be brought back to this Joint Committee once feedback from the temporary changes had been examined. It was anticipated that the options would be presented to the Joint Committee in six months time.

AGREED – The Joint Committee agreed to receive a further report in relation to Oncology Services in six months' time.

159 COVID RECOVERY PLAN

Matt Brown, Managing Director of the NENC Provider Collaborative provided the Joint Committee with a presentation on this matter.

Matt explained that prior to Covid 19 there were more than a quarter of a million people on the NHS waiting list for the ICS geography at any point. Now there were 300,000 people on that waiting list. Due to lockdowns in Covid referrals had reduced and so the waiting list had gone down. However, it was always recognised that post Covid the waiting list would subsequently increase and acknowledged that many people who had waited longer would have conditions which would have deteriorated as a result of waiting longer.

Matt shared information on the numbers of patients waiting 52 weeks or more and explained that prior to Covid 19 it was rare that any patient in the region would have waited this length of time. However, as a result of the impact of Covid 19, there were now over 20,000 patients waiting this length of time. Matt advised that due to the excellent work being progressed Trusts were starting to reduce the patient numbers on the waiting lists but it was a very challenging situation for the NHS as referrals are increasing.

Matt advised that in relation to the waiting list for patients waiting 104 weeks, again pre-Covid it was rare for anyone in the region to have waited this long. Post - Covid this waiting list had been reduced to approximately 50 patients who require very

specialist services due to their complex needs. Numbers of patients waiting 78 weeks had now reduced from 4000 to 1000 and were continuing to reduce.

In order to tackle the waiting lists work was focusing on increasing health service capacity; prioritising diagnosis and treatment and transforming the way elective care is provided along with providing better information and support to patients. Workstreams had been set up focusing on waiting list management, productivity, capacity and outpatients. The aim was to implement Getting it Right First Time (GIRT) principles in these areas and data was being shared across all the Trusts in relation to all aspects of performance with a view to sharing good practice and achieving consistency.

The Chair thanked Matt for the information provided and stated that it was reassuring to learn of the good work being progressed.

Councillor Hall queried what the position was in relation to patients waiting for out of area appointments.

Matt advised that he did not have the figures to hand but the number of patients waiting for out of area appointments was very small. Matt advised that he would organise for this information to be circulated to the Joint Committee in due course.

Councillor Jopling queried whether Trusts measured any negative impact on patients as a result of the model being progressed. Matt indicated that each Trust receives feedback on whether there is any deterioration in patients. Matt advised that the biggest issue related to health inequalities.
Councillor Ezhilchelvan stated that it was good to see the long term waiting list reducing but queried whether the list excluded those patients who had sadly died. Matt confirmed that the list excluded those patients.

Councillor Kirwin acknowledged the excellent work taking place but asked Matt what good looked like in terms of recovery given that the waiting list was at an all - time high at pre Covid levels.

Matt advised that in terms of what good looks like the ideal would be no waits. However, whilst this region was one of the best performing in the country in terms of reducing its waiting lists it was going to take a long time to get on top of the backlog. Matt advised that previously the aim was to have 92% of patients seen within 18 weeks and the aim would be to get back to that point. However, Matt advised that it was likely that it would be a long tome before that position could be achieved although some Trusts were getting closer.

Councillor Taylor noted that Newcastle Hospitals NHS FT has recently established a new centre for cataract operations and she queried how work was progressed to ensure that areas other than Newcastle benefitted.

Matt advised that the funding for the new Centre in Newcastle was from a national pot and so other Trusts in the region had to support funding being allocated to Newcastle for the Centre. Matt stated that it was then his job to ensure the best use of resources across the patch. This was achieved by ensuring that all Chief Officers

at specific Trusts learn about the work of other Trusts and where they are doing well / share good practice etc. Matt stated that all the Trusts are clear that they need to recover together.

Councillor Wallace noted that the presentation provided showed that the overall waiting list appeared to have peaked at around 300,000 early last year and the Joint Committee had been previously informed that the population in the region is approx. 3 million. Councillor Wallace therefore queried whether it was the case that 1 in 10 of the population was waiting for elective surgery.

Matt clarified that 1 in 10 of the population would be waiting for something on the pathway – which could include things like a first diabetes check and various out-patient procedures not just surgery – which is why the waiting time figures can be misleading.

Councillor Wallace queried if a person needed say a new hip and then also needed a new knee whether they would show in the figures one or twice.

Matt stated that he thought the numbers of patients in the figures several times would be small.

Councillor Haney queried whether it was monitored as to where people were on a pathway in terms of priority.

Matt advised that there was a clinical validation process for the pathway which included a prioritisation process. Matt stated that they look at the CCG areas and who they have / how many they have on the waiting lists by speciality so that they are clear where everyone is. The challenge is to bring this as level and equitable as they can. Matt advised that those Trusts who performed better pre-Covid in terms of waiting times are still usually better post Covid.

160 WORK PROGRAMME 2022-23

The Joint Committee agreed that the below issues should be rolled forward from the previous work programme to the Joint Committee's 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 Joint Committee agreed that the below issue should be included in the work programme:-

- Update on ICS Mental Health Collaborative

The Chair reminded the Joint Committee that if councillors had any other issues

which they would like included in the work programme they should forward these to the scrutiny officer for Gateshead.

161 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.

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

Chair………………………..