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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