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North Tyneside Council

Adult Social Care, Health and Wellbeing Sub-Committee

Wednesday, 23 June 2021

Thursday, 1 July 2021 0.02 Chamber - Quadrant, The Silverlink North, Cobalt Business Park, North Tyneside, NE27 0BY **commencing at 6.00 pm**. (Due to Covid restrictions anyone wishing to attend should first notify the contact officer).

Agenda Item **Page**

1. **Apologies for Absence**

   To receive apologies for absence from the meeting.

2. **Appointment of Substitute Members**

   To be notified of the appointment of Substitute Members.

3. **Declarations of Interest**

   You are invited to declare any registerable and/or non registerable interests in matters appearing on the agenda, and the nature of that interest.

   You are also invited to disclose any dispensation in relation to any registerable and/or non-registerable interests that have been granted to you in respect of any matters appearing on the agenda.

   Please complete the Declarations of Interests card available at the meeting and return it to the Democratic Services Officer before leaving the meeting.

4. **Minutes** **5 - 8**

   To Confirm the minutes of the meeting held on 3 June 2021.

Members of the public are welcome to attend this meeting. However, in order to enable the meeting to be held in a Covid-secure manner, places for members of the public are limited. Please email democraticsupport@northtyneside.gov.uk or call 0191 643 515 if you wish to attend or require further information.

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Agenda Item		Page
5.	**Covid Update - Public Health and Adult Social Care** To receive an update presentation covering public health and adult social care.	
6.	**Financial Support for Adult Social Care providers in North Tyneside** To receive a report on the additional financial/grant support that has been made available to adult social care providers in the borough during the pandemic.	
7.	**Update Report from HealthWatch North Tyneside** To receive an update report from Healthwatch North Tyneside setting out their current work programme and priorities.	
8.	**Joint Overview and Scrutiny Committee for the North East and North Cumbria ICS - feedback from members** To receive a report from members who attended the recent meeting of the Joint Overview and Scrutiny Committee for the North East and North Cumbria ICS held on 28 June 2021. A copy of the papers from this meeting are attached for information.	**9 - 62**

Circulation overleaf …

Members of the Adult Social Care, Health and Wellbeing Sub-Committee

Councillor Joe Kirwin (Chair)
Councillor Jim Allan
Councillor Trish Brady
Councillor Margaret Hall
Councillor Pam McIntyre
Councillor Paul Richardson
Councillor Jim Montague (Deputy Chair)
Councillor Mrs Linda Arkley
Councillor Joanne Cassidy
Councillor Maureen Madden
Councillor Tommy Mulvenna
Councillor Jane Shaw

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Adult Social Care, Health and Wellbeing Sub-Committee

Thursday, 3 June 2021

Present: Councillor J Kirwin (Chair)
Councillors J Allan, Arkley, J Cassidy, M Hall, M Madden, P McIntyre, T Mulvenna, P Richardson, J Shaw and J O'Shea

In attendance:
Councillors A McMullen

Apologies: Councillors J Montague and T Brady

ASCH1/21 Appointment of Substitute Members

Pursuant to the Council's Constitution, the appointment of the following substitute members was reported:

Councillor J O'Shea for Cllr T Brady

ASCH2/21 Declarations of Interest

There were no declarations of interest.

ASCH3/21 Minutes

Resolved: That the minutes of the meeting held on 31 March 2021 be confirmed and signed by the Chair.

ASCH4/21 Covid Update - Public Health and Adult Social Care

The Sub-committee received a Covid 19 update covering public health and adult social care.

It was noted that the Delta/Indian variant of concern had been detected in the Borough. The Borough is currently an outlier for Covid rates and rates are high, but much lower than rates reached during previous peaks, and considerably lower than those areas with the highest rates such as Bolton and Blackburn. The case rate for the last 7 days is 71.2 per 100,000 based on 148 positive cases. It was noted that the infection rate for the 5-34 age group is double the rate for the borough overall, with young people under 20 driving the infection rate. This is a reflection of low vaccination rates in young people.

The Sub-committee noted the extra measures that had been put in place to address the issue, including surge testing facilities in three areas. It was noted that a small number of positive cases had been found as a result of surge testing and follow up action was being taken to provide advice on self isolation and to identify close contacts.

In relation to care homes, following 8 weeks with no positive cases, there are currently three cases with two of these asymptomatic and one resident who had symptoms but had not been vaccinated.

In relation to current outbreaks, it was noted that the majority of these related to schools, work places and sporting clubs. At the moment there has not been an impact on hospital admissions. It was noted that the current variant was providing to be more transmissible with a 100% transmission rate being experienced within households in the borough.

There was some discussion about the relevance of the R number. It was noted that the R number provides a picture of what is happening on a national level but is less useful at a local level and more real time data is now available to give a more accurate picture of what is happening at a local level.

A member raised an issue about the recent misunderstanding over travel restrictions in the borough. It was noted that this issue had been clarified after discussions with central government.

Members asked about the effectiveness of the in-house test and trace system. It was noted that the small team was acting in combination with Public Health England in relation to complex cases. It was noted that the local team had a completion rate of 95% which was higher than the national system, although the national system has improved. It was noted that using a local number to contact people can be more effective and also there was a final option to directly visit people if necessary.

There was some discussion about the isolation pilot. It was noted that there was an extended financial scheme which was available to anyone financially disadvantaged by the need to isolate, and also regular contact from the local team and the introduction of shopping vouchers for families.

In relation to Adult Social Care, the sub-committee received an update on support to care homes. It was noted that there is currently one care home in an outbreak situation and advice and support on infection control has been provided.

In relation to vacancy rates, it was noted that one home has recently closed with residents moved to its sister home.

It was noted that the Council continues to offer support to promote vaccinations to care homes and their staff. It was noted that there is currently a government consultation on whether vaccination should be a condition of employment for care homes and some care homes are making vaccination a condition for new staff. It was also noted that infection control, including vaccine rates, will be included in quality monitoring visits which are due to begin again in the near future.

It was noted that CQC registered providers are able to access free PPE through a government portal.

There was some discussion about additional financial support that has been made available to care providers, including the Infection Control Fund and funding to cover staff sickness. It was noted that funding has been made available on a periodic basis with allocations based on numbers of beds and linked to specific grant criteria. It was noted that infection control funding was specifically for infection control within the home and did not cover workforce

absence. A member raised concern about sick pay for staff in care homes. It was noted that individual terms and conditions will vary depending on individual employers but the Council would expect all employers to meet statutory requirements. Members asked if a report could be brought to the next meeting to set out the additional financial allocations via the various grants that have made to care providers in the borough

It was agreed:

That officers be asked to provide a report to the next meeting setting out the additional financial allocations that have been made to care providers in the Borough during the pandemic and an explanation of the various grants and grant conditions during this time.

ASCH5/21 Home care pilot - health and social care

The Sub-committee considered a presentation which set out proposals for a home care pilot which would combine some areas of work between health and social care. This would result in a combination of health and social care tasks being carried out by a single person during home care visits and reduce duplication requiring multiple visits from different teams. It was noted that the pilot built on previous work undertaken by this Sub-committee to consider options for delivering home care via in-house provision.

It was noted that work streams had been developed with the NHS and a pilot covering around 50 people would be launched in August/September 2021 and will last for around 12 months. This was originally envisaged to focus on the North West of the Borough but may now incorporate other areas in order to find the right cohort of people. The project would involve the pooling of budgets with a review of how funding can be used differently to better meet needs. The pilot will not involve the external sector but will be taken forward with staff from the NHS and social care.

There was some discussion about how the pilot will be managed. It was noted that the pilot had support from the senior leadership at both the Council and Northumbria Heathcare Trust and the project group was lead and supported by senior managers from both organisations. Members stressed the need for a clear management structure in order to ensure clear lines of responsibility to address any problems that may arise.

Members raised questions about the qualifications of the visiting professional and what this skill level will be in in order to deliver the necessary medical and social care support. It was noted that this pilot will cover home care and community nursing interventions only and will be separate from other professional support that may be needed eg social work or physiotherapy support.

Members highlighted the difficulty of bringing together health service and local authority services. Members were in favour of the sub-committee having a strong role in monitoring the project as it goes forward to ensure it is effective and is meeting the needs of customers. Members also raised questions about public involvement with those involved in the pilot and whether they have a choice whether to take part. It was suggested that other Councillors who are not involved in this Sub-committee should also be provided with information on the pilot as it is likely to impact on residents in their wards.

Officers highlighted that Northumbria was currently looking at using their existing workforce to staff the pilot and that monitoring would be in place to ensure that individual's needs are being met.

The Chair thanked Officers for the presentation.

ASCH6/21 Work Programme 2021-22

The Sub-committee considered the draft Work Programme for 2021-22.

The sub-committee expressed interest in receiving more information about the proposed changes to the NHS and also the Future Care Board. It was noted that the Health and Wellbeing Board would be receiving information about this at their next meeting and there was an intention to invite members of this Sub-committee to attend the meeting to avoid duplication of information, subject to adequate space being available in line with Covid restrictions. It was also noted that the Joint Regional Scrutiny Committee's role was to scrutinise the development of the Integrated Care System (ICS) covering the North East and North Cumbria and members would be feeding back to this sub-committee from the regional meetings.

The following additional suggestions were put forward for inclusion in the work programme:

- Commissioning of Dental Services
- Sheltered Housing – is adequate support being provided for residents?
- Recovery of hospital services and tackling the operations backlog

It was noted that a Study Group had been set up some time ago to look at Home Care Services. This group had been on hold since March 2020. The following suggestions were put forward in relation to sub-groups:

- Sheltered Housing
- Monitoring of the Home Care Pilot
- Continuation of the previously established Home Care Sub-group.

Members were asked to consider which one of the sub-group topics should be taken forward as a priority and to email comments to democratic services.

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

Meeting on Monday, 28 June 2021 at 1.30 pm in the Council Chamber, Civic Centre, Gateshead

Agenda

1 Appointment of Chair
In line with the attached current terms of reference of the Joint Committee, the Joint Committee is asked to appoint a Chair for the 2021-22 municipal year.

2 Appointment of Vice Chair
In line with the current terms of reference of the Joint Committee, the Joint Committee is asked to appoint a Vice Chair for the 2021-22 municipal year.

3 Protocol /Terms of Reference (Pages 5 - 12)
The Joint Committee is asked to note the attached Protocol / Terms of reference.

4 Apologies

5 Declarations of Interest

6 Minutes (Pages 13 - 26)
The minutes of the meeting of the Joint Committee held on 22 March 2021 are attached for approval.

7 Matters Arising (Pages 27 - 30)
OSC Written Questions Re White Paper on Future Direction of Health Service / Next Steps for ICS

It was agreed that a written response would be provided to the Joint Committee's twelve written questions which are set out at Appendix 1 to the minutes.

Attached is the Integrated Care System for the North East and North Cumbria response.

8 Update on White Paper on Future Direction of Health Service / Next Steps for ICS

Mark Adams, Chief Officer, NewcastleGateshead, North Tyneside and Northumberland CCG will provide the Joint Committee with a presentation on this matter.

9 Provisional Work Programme

10 Date and Time of Next Meeting

To be confirmed.

Membership

Gateshead Council
Councillor L Caffrey
Councillor M Hall
Councillor S Craig

Substitutes
Councillor M Charlton
Councillor P Foy
Councillor J Wallace

Newcastle CC
Councillor W Taylor
2 vacancies

Durham CC
Councillor P Jopling
Councillor R Charlton-Laine
Councillor K Robson

North Tyneside Council
Councillor T Mulvenna
Councillor T Brady
Councillor J Kirwin

Substitutes
Councillor J Mole
Councillor E Parker-Leonard
Councillor P Richardson

South Tyneside Council
Councillor G Kilgour
Councillor A Hetherington
Councillor R Berkley

Sunderland CC
Councillor D McDonough
Councillor D Macknight
Councillor N Macknight

Northumberland CC
Councillor K Nisbet
Councillor B Flux
Councillor J Reid

Contact: Angela Frisby Tel: 0191 4332138 Date: 18 June 2021

Protocol for a Joint Health Scrutiny Committee

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

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

ICP North

- Northumberland CCG
- North Tyneside CCG
- NewcastleGateshead CCG
- Northumbria Healthcare NHS FT
- Newcastle Hospitals NHS FT
- Gateshead Hospitals NHS FT
- Gateshead Council
- Newcastle City Council
- North Tyneside Council
- Northumberland County Council

ICP Central

- South Tyneside CCG
- Sunderland CCG
- North Durham CCG
- *Durham, Dales, Easington and Sedgfield CCG*
- 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 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 Integrated Care Partnerships covering Northumberland, Tyne and Wear and Durham (currently the " North" and " Central" ICPs as outlined in paragraph 1 above).

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

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

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

Local Authorities

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

Clinical Commissioning Groups

Newcastle Gateshead CCG
North Durham CCG
Durham, Dales, Easington and Sedgfield CCG
North Tyneside CCG
Northumberland CCG
South Tyneside CCG
Sunderland CCG

NHS Foundation Trusts

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

Membership

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

6. The term of office for representatives will be for the period from the date of their appointment by their constituent authorities until their relevant authority's next annual council meeting. If a representative ceases to be a Councillor, or wishes to resign

from the Joint Committee, the relevant council shall inform the joint committee secretariat and the replacement representative shall serve for the remainder of the original representative's term of office.

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

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

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

Chair and Vice-Chair

10. For the purposes of the consideration of the developing / established ICS for the NE and North Cumbria and the development / establishment of the Integrated Care Partnerships 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 Integrated Care Partnerships covering Northumberland, Tyne and Wear and Durham (currently " North" and "Central" see para.1) that affect at least two but not all of the constituent authorities, the Committee will be chaired from one of the affected local authority areas.

Terms of Reference

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

Administration

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

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

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

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

Final Report and Consultation Response

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

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

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

Voting

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

Following the Consultation

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

Principles for joint health scrutiny

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

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

23. The Joint Committee's procedures will be open and transparent in accordance with the Local Government Act 1972 and the Access to Information Act 1985 and

meetings will be held in public. Only information that is expressly defined in regulations to be confidential or exempt from publication will be able to be considered in private. Papers of the Joint Committee may be posted on the websites of the constituent authorities as determined by them.

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

Appendix 1

Joint Health Scrutiny Committee

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

Terms of Reference

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

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

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

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

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

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

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

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

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

6. To ensure 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.

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

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

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

Monday, 22 March 2021

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

Councillor(s):M Hall (Gateshead Council), Taylor, Mendelson and Schofield (Newcastle CC) Clark, Mulvenna and Mole (North Tyneside Council) Dixon, Macknight and Leadbitter (Sunderland CC) Beynon, Nisbet and Dodd (substitute) (Northumberland CC) Flynn (South Tyneside Council), Simmons and Stephenson (Durham CC)

IN ATTENDANCE: Councillor Joe Kirwin (North Tyneside Council)

117 APOLOGIES

Councillor (s) Armstrong (Northumberland CC), Beadle (Gateshead Council), Kilgour (South Tyneside Council) and Robinson (Durham City Council)

118 MINUTES

The minutes of the meeting of the Joint Committee held on 20 January 2020 were approved as a correct record.

119 DECLARATIONS OF INTEREST

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

Councillor's Hall (Gateshead Council) and Mendelson (Newcastle CC) declared an interest as members of CNTW Foundation Trust Council of Governors.

120 MATTERS ARISING

There were no matters arising to report.

121 WHITE PAPER ON FUTURE DIRECTION OF HEALTH SERVICE /NEXT STEPS FOR ICS

Mark Adams, Chief Officer, NewcastleGateshead,North Tyneside and Northumberland CCG provided the Joint Committee with a presentation on the above.

Mark provided the Joint Committee with a reminder of the ICS and how it works in the region and the ambition to support greater collaboration between partners in the health and care system to help accelerate progress in meeting the most critical

health and care challenges.

Mark highlighted that as at November 2021 the recommended next steps for the ICS included greater emphasis on:-

- Improving population health and healthcare
- Tackling unequal outcomes and access
- Enhancing productivity and value for money
- Helping the NHS to support broader social and economic development

Mark reminded the Joint Committee that the NE& NC ICS had the largest footprint in the country with a population of 3 million and covering thirteen places which brings a range of challenges and complexity. However, there has been a long tradition of the NHS and care organisations working together across that geography for the benefit of the population and Mark cited the areas of workforce and digital as examples of areas of such work.

Mark advised that going forward the ICS would be known as NHS North East and North Cumbria and

- ICSs will have a triple aim duty: to pursue better health and wellbeing, better quality of services, and the sustainable use of NHS resources.
- ICSs will be accountable for outcomes of the health of the population.

However, Mark stated that whilst the ICS would have overall accountability for health outcomes 80% of the work of the ICS would continue to be at place - based level within the thirteen places within the ICS.

Mark advised that the NHS and local authorities will be given a duty to collaborate but he reiterated that across the ICS geography there were already positive relationships between the NHS and local authorities and positive ways of working via Health and Wellbeing Boards and through joint funding, programmes and projects.

Mark indicated that:-

- Responsibility remains split between strategic planning/funding and care delivery
- The ICS NHS Body will be responsible for
    - setting the strategic direction for the system
    - the commissioning and allocative functions of CCGs (and some of those of NHS England) utilising a new provider selection regime. Work is taking place currently to look ay how the statutory functions allocated to CCG's will be mapped across the ICS.
    - plans for capital and revenue spending for NHS orgs in the system.
    - It will not have the power to direct providers, but NHSE will set financial objectives for ICSs, which providers must have regard to
- The ICS NHS Body will have the authority to delegate significantly to place level and to provider collaboratives.

Mark reiterated that 80% of the work of the ICS would be at place - based level and so he advised that there was an expectation that they would delegate ways of working to place based level. In this way it was hoped that the ICS would not lose

momentum or the strengthened relationships and ways of working.

Mark advised that going forwards key areas of focus would be to ensure:-

- Decisions taken closer to the communities they affect are likely to lead to better outcomes;
- Collaboration between partners in a place across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities, improve outcomes, and deliver joined-up, efficient services for people; and
- Collaboration between providers (ambulance, hospital and mental health) across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity.

Mark advised that ICSs also need to be able to ensure collectively that they are addressing the right priorities for their residents and using their collective resources wisely. They will need to work together across partners to determine:

- distribution of financial resources to places and sectors that is targeted at areas of greatest need and tackling inequalities;
- improvement and transformation resource that can be used flexibly to address system priorities;
- operational delivery arrangements that are based on collective accountability between partners;
- workforce planning, commissioning and development to ensure that our people and teams are supported and able to lead fulfilling and balanced lives;
- emergency planning and response to join up action at times of greatest need; and
- the use of digital and data to drive system working and improved outcomes.

Mark explained that in terms of emerging functions, ICSs were likely to become statutory NHS bodies , taking over CCG commissioning functions, alongside strategic planning and oversight of quality, performance and finance.

Alongside this it was expected that at Place level there would be a progressively deepening relationship between the NHS and LAs on health improvement and wellbeing which would involve:-

- Centrality of health and wellbeing boards, utilising JSNAs and public insight to inform decision-making
- A leading role for clinical primary care leaders through primary care networks, joining up services in neighbourhoods, linking to other public or voluntary services
- Greater use of population health management to target health and care services

In addition, Provider Collaboratives would come together in ways they have not done before to use resources more efficiently and effectively and will operate at both place and system level as follows:-

- Vertical integration within places (eg between primary, community, local acute, and social care, or within and between primary care networks) through

place-based partnerships
- Horizontal integration between places at scale where similar types of provider organisation share common goals - such as reducing unwarranted variation, transforming services, or sharing staff and resources.

Mark advised that the ICS would have its own constitution and governance would be via and ICS NHS Board and an ICS Partnership Board which would lead system prioritisation and engage partners and clinical leaders. Mark explained that there may also be a need for an NHS only decision making body to handle issues such as Path 2 Excellence" type reconfigurations and he highlighted other potential ICS functions.

Mark advised that the ICS NHS Board would be directly accountable for NHS spend and performance within the system and the ICS Partnership Board would act as the forum for agreeing co-ordinated action and alignment of funding on key issues, as well as providing direction on the early stages of the ICS formation. The membership of the Partnership Board would not be specified nationally but would be drawn from a number of sources including Health and Wellbeing Boards, Healthwatch,VCSE partners, social care and housing providers.

Mark stated that as the ICS had been in place across the NE and North Cumbria for some time place - based working was already well developed and he cited some examples and stated that there was a lot to build on going forwards.

Mark advised that prior to the White Paper the ICS had also made significant progress by appointing Sir Liam Donaldson, with his significant array of expertise and knowledge, as Chair of the ICS from 1 February 2021.

Mark indicated that in terms of next steps it was planned that the ICS would
- Continue to use our influence to shape the final legislation
- Work to influence the national workstreams and expected NHSE guidance on ICS governance, operating models, and assurance
- Complete a mapping exercise of current CCG and NECS staff
- Work with region to understand which NHSE/I functions will be devolved to ICSs
- Engage our local authority partners at both political & executive level
- Pause any joint appointments until we have agreed place model
- Develop a project plan that takes us up to April 2022 and beyond

Councillor Caffrey, thanked Mark for the presentation and advised that there were a number of questions which the Joint Committee would like answers to around the role of local authorities and relationships with local health and care systems at place level.

It was agreed that a written response would be provided to the Joint Committee's twelve written questions (attached at Appendix 1)

Councillor Caffrey highlighted some issues now and stated that a major concern was around who the system belonged to and what measures were going to be put in place to ensure it operated fairly and included everyone, including the people the

system was working to benefit.

Councillor Caffrey stated that the Joint Committee was also concerned to understand how it could be guaranteed that there would be no detriment to local communities and that work would still be delivered at place. The Joint Committee also wished to understand when they were likely to receive more clarity on the way forward for the ICS.

Councillor Caffrey asked Councillor Taylor if she wished to raise any issues.

Councillor Taylor stated that she shared many of Councillor Caffrey's concerns given the significant changes proposed for the ICS.

Councillor Taylor advised that she was concerned that the proposed Partnership Board would be too large to be effective. Councillor Taylor stated she recalled that when the regional health authorities were in existence they were bureaucratic and too large. Councillor Taylor also noted that whenever there has been a re-organisation of the NHS there has been disruption for a time afterwards.

Councillor Taylor also expressed disappointment that CCGs which have now got to a point where they are working well are to be abolished.

Councillor Taylor also queried how the Provider Collaboratives would work and queried whether this would involve a sharing of aims, goals and budgets. Councillor Taylor indicated she was also interested to know how resources would be distributed and who would decide on such distribution.

Councillor Taylor also advised that as far as emergency planning was concerned the last exercise she recalled taking place in Newcastle was 10 to 15 years ago and she queried whether it was proposed for this to take place more regularly in future and be considered in more detail.

On the issue of integration Councillor Taylor also queried who decides who integrates and how that would work.

Mark noted that Councillors Caffrey and Taylor had raised a number of important issues but advised that it was important to take a step back.

Mark advised that he had worked for the ICS for some time now and he wanted to reassure the Joint Committee that there was some degree of experience already in place to understand what was valuable to carry out across the ICS eg workforce and digital.

Mark noted that he had stated that 80% of the work of the ICS would still be at place - based level and he expected that this would endure and be built upon. As far as the duty to co-operate was concerned Mark noted that across the NE & North Cumbria ICS good relationships already existed and ways of working which the intention was to build on but this was not necessarily the case in other areas across the country. As far as the size of boards and how other structures / process would be tackled, at this point that was yet to be made clear. At the moment there were

outline proposals in the White Paper and Mark stated that he was aware of various commentaries from different organisations in relation to this. As a result, Mark advised that they were waiting for more detailed guidance and this was expected in the next month or so.

Mark advised that they were also particularly keen to understand the flexibilities available to ICSs to help ensure that what is being put in place does not cut across what the ICS has already been able to deliver.

Councillor Taylor queried whether there would be more of a focus on emergency planning going forwards.

Mark advised that there would be a focus on emergency planning and stated that there was a raft of learning arising from the pandemic.

Sir James Mackay advised that there had been two or three large ICS mock emergency planning exercise in the last few years and they were actively working on future planning scenarios and it was anticipated that another exercise would take place before Christmas.

Councillor Dixon stated that he was aware of and shared the concerns raised by the LGA regarding the proposals for the ICS and noted that the LGA had always called for decisions on the health of populations to be made as close to place as possible. However, it was Councillor Dixon's understanding that the proposals in the White Paper would lead to more central control, with regional teams having oversight at regional level. Councillor Dixon also noted that the White Paper indicates the removal of S75 of the Health and Social Care Act replacing a regulated market with an unregulated market and he asked for more information about that. Councillor Dixon also noted that there had been much reference to collaboration and yet the White Paper was imposing a legal duty to collaborate and binding local authorities to a plan written by ICS Boards. Councillor Dixon stated that it appeared to him that this would bring local authority resources relating to social care etc under the control of the NHS and outside of local government control.

Councillor Dixon stated he would also like more clarity on the relationship between the two proposed ICS Boards. Councillor Dixon stated he was particularly concerned about a letter which had been circulated on 11 February in relation to the composition of the proposed Partnership Board which appeared to suggest that representation from a single local authority might suffice when the ICS covers a number of local authority areas. Councillor Dixon stated he would like more information regarding local authority representation on the proposed Board. Councillor Dixon felt there were a number of areas where there were unanswered questions at this stage.

Mark noted the concerns raised by Councillor Dixon and indicated that the ICS was also waiting for answers on these issues.

Mark advised that in terms of regional responsibilities the ICS already carries out a raft of things on a regional / national basis such as contracts for GPs and specialised commissioning and he stated that it was not unreasonable that this should continue.

Mark reiterated that in general terms, much as now, 80% of the work of the ICS would be carried out at a place based with place-based colleagues. As far as S75 of the Health and Social Care Act was concerned they were waiting for more guidance but there were already many structures and ways of working in place via funding etc such as Better Care Funds.

In terms of involvement in future decision making, and particularly that of primary care clinicians, Mark advised that they were looking to see how they could preserve that going forwards. Mark stated that they want this to continue but need to understand how it would work at an ICS level.

In terms of the makeup of the Partnership Board, Mark stated that whilst they had received some insight into this he considered that they still did not have full clarity. Mark stated that it was important that they received further clarity from guidance and also more information on the flexibilities available to the ICSs so that the NE & NC ICS could put in place the structures it wanted to reflect its size and the fact that it covers thirteen different places.

Sir James advised that there had been a lot of discussions regarding the composition of the two Boards and he stated that the NHS Body would be unitary where representation had to be detached from function. It was proposed that representation on the Partnership Board would be quite large as this was the forum to allow everyone's voice to be heard. Sir James advised that he understood that more detail on this was likely to be received in the next couple of weeks.

Councillor Dixon noted the responses but also noted that there had been no mention of democratic accountability.

Councillor Caffrey stated that this was the responsibility of the Joint Committee and was something that the Joint Committee was very interested in.

Councillor Caffrey stated that the Joint Committee was concerned that the proposals relating to the ICS could be seen as being an NHS plan and that local government had been tacked on. Councillor Caffrey also stated that the fact that the Secretary of State was proposing to take more powers for himself did not sit well and was a cause for concern. Councillor Caffrey stated that it would therefore be important to see the detail going forwards.

Councillor Caffrey noted that more guidance was due in June if not before and she asked Mark if he would provide a further update on the position to the Joint Committee at a meeting in June. Mark confirmed that he would.

Councillor Caffrey stated that if any member had any additional questions which they would like a response to in addition to the twelve written questions shared at the start of the meeting they should send them through and responses to the questions would be circulated to the Joint Committee as soon as they were received.

122 UPDATE ON LEARNING FROM COVID 19 PANDEMIC / ROLE OF ICS IN LOCAL RESPONSE & PLANS FOR SERVICE RECOVERY

Sir James Mackay, Chief Executive Officer, Northumbria Healthcare NHS FT provided the Joint Committee with a presentation on the above.

Sir James noted that it was the anniversary of the first lockdown tomorrow and he stated that throughout the pandemic one of the strengths of the ICS in the NE & North Cumbria had been clinical collaboration which had allowed well established networks to offer mutual aid and react quickly in times of pressure. Overall, the NE & North Cumbria ICS had the strongest performance and the North ICP had the strongest performance of the ICPs.

The ICS has also been a very innovative system enabling new ways of working to deliver services differently and addressed issues such as PPE shortages. The ICS had also had a very strong vaccination programme both in terms of delivering the flu vaccine and the Covid 19 vaccine and a very strong workforce which enabled work across organisational boundaries. This was supported by a strong communications programme educating the public at different stages during the pandemic.

Sir James stated that they are now working through how to deliver a recovery programme both in terms of health and care and also address health inequalities and the impact on the economy.

Sir James advised that during the pandemic regional collaborations were key in helping the ICS to mobilise quickly and deal with many of the challenges posed by the pandemic. Sir James stated that within the ICS the Chief Executives of the respective Trusts agreed to support each other so that each Trust filled up together from a critical care perspective. The Trusts also all supported each other when there were insufficient supplies of PPE and created their own production system.

Sir James outlined the current picture in terms of the rate of Covid 19 infections per 100,000 population and indicated that infection rates were much reduced and were now back to September/ October levels. If there was going to be a bounce back as a result of schools this would become apparent this week but so far there were no signs that this was happening. Sir James stated that they were now down to 200 inpatient beds occupied by Covid 19 patients.

Sir James advised that there was a great deal of learning from the pandemic which they were working their way through to understand.

Sir James stated that during winter 2020-21 referrals to elective and diagnostic services had dropped off but these were now starting to pick up and the ICS was now focused on recovery. Sir James indicated that the NE has less recovery work to do than other areas due to its stronger performance, however, there will be backlogs which need to be addressed. The NE was performing at around 85% against a target of 92% for elective work, which was higher than national performance prior to the pandemic.

Sir James highlighted the excellent collaborative work which had taken place via clinical networks to ensure access to care at times of pressure and to ensure cancer patients were appropriately prioritised for urgent surgery and with Directors of Public

Health and Directors of Adult Social Services which had assisted in interpreting guidance, infection control and testing. Joined up work across primary and secondary care to safely manage / monitor some patients at home during the pandemic was also highlighted.

Sir James advised that there were many examples of innovations during the pandemic and stated that the ICS continue to be at the forefront via involvement in the recovery trials at North Tees and the Integrated Covid Hub North East which is the first of its kind in England. This places the region at the forefront of managing the virus. There has also been digital innovation via " Attend Anywhere" which has tried to reduce the number of unnecessary miles patients have to travel to access services. However, one of the major innovations has been in the area of PPE where the region co-ordinated efforts to manage immediate shortages of supplies and also created sustainable supplies to support organisations now and going forwards. The opening of the Northumbria Manufacturing and Distribution Hub in May 2020 created more jobs for local people and is now ensuring a sustainable supply for the trust, the region and beyond.

Sir James also advised that workforce collaborations had enabled a regional offer of psychological support to health and care staff across the region, in addition to that provided by specific organisations. It is also planned to expand this offer to cover areas such as occupational health. Joint working and establishment of memorandum of understanding has also enabled easier movement of staff between organisations based on service need. The ICS had also deployed 413 "NHS returners" to support capacity pressures through the pandemic and the vaccination programme and plans include a collaborative bank to retain staff to provide additional capacity during the recovery phase. Joined up work had also allowed medical students to support the vaccine programme and the launch of the ICS black and minority ethnic groups Promise and establishment of a staff network would help ensure support and participation from all groups of staff no matter what their background.

Sir James stated that a real success story for the region was in relation to vaccinations. A Regional Vaccination Board had been established with the aim of increasing uptake of the flu vaccine and this had resulted in a higher uptake across most key groups.

In terms of Covid 19, vaccines there had been more than 1 million doses delivered across the ICS, more than any other region thanks to a collective effort across vaccinations centres, primary care, hospital hubs and partners including local authorities, volunteers, transport and many more.

Sir James advised the Joint Committee of the current position in relation to the percentage of the population vaccinated within the key groups and the effectiveness of the vaccines. Sir James noted the issues currently being raised in relation to the Astra Zeneca vaccine and stated that he was not aware of anything which would lead him to have concerns about the vaccine and he would strongly encourage everyone to take up the vaccine when this was offered to them. Sir James stated that across the ICS there had been a strong regional communications approach in relation to the pandemic and the vaccination programme which had focused on key areas where public support was needed and helped provide reassurance and

maintain public confidence.

Sir James stated that across the ICS joint work was continuing to develop and take forward plans for recovery and this would focus on:-

- Ongoing Covid-related demand pressures.
- Service recovery due to postponed elective work.
- Supporting our workforce.
- Sustaining effective new ways of working developed during the pandemic and learning lessons from the past year.
- Planning for the winter ahead has started - winter 2020/21 de-brief on 17 March to look at learning.
- Focus on ensuring we address health inequalities and economic recovery

Councillor Caffrey thanked Sir James for the interesting and helpful presentation and stated that she was particularly pleased to learn of the success in creating a production company for PPE and hoped that this would continue. Councillor Caffrey stated she was also really pleased to hear about the increase in uptake of the flu vaccine in addition to the Covid 19 vaccination programme.

Councillor Taylor agreed that the region had done incredibly well during the pandemic and particularly in relation to the vaccination programme. Councillor Taylor stated she had received nothing but praise from local people in contrast to the national NHS online booking system which she viewed as chaotic.

Councillor Taylor stated that one area of concern for her related to the mental health of staff as a result of the pandemic. She was aware of some staff who were distressed as a result of redeployment and other staff who were exhausted but were not in a position to take annual leave. Councillor Taylor stated that she considered that there needed to be a real emphasis within the ICS on supporting the mental wellbeing of staff as the situation was not going to become any easier as staff tried to deal with backlogs arising from the pandemic.

Sir James advised that a huge effort was ongoing across the ICS to provide support to staff who needed it as well as get the balance right and move back into a normal working rhythm.

Councillor Taylor noted that the figures provided showed differences across the areas within the ICS in terms of hospitalisation and general health and she presumed that good practice was being shared across ICSs and that information on lessons learned would be produced so that the Joint Committee could see these.

Sir James stated that he would pick up this point within the ICS and see how best these lessons could be written up and publicised Sir James confirmed that ICSs across the country have been sharing learning some of which had fed through into trials and this had been a real strength both here and across the country.

Councillor Mendelson stated that she considered that during the pandemic the LA7 had worked really well in terms of public health messaging and within the ICS she

wanted to build on the general public's interest in public health and she did not want the focus to become too impersonal again.

Sir James advised that he agreed and stated that there was a strong appetite to build on the work already done to promote health and wellbeing and lifestyle challenges. Sir James stated that collaborative work was now taking place with Sir Brendan Foster to help people move and exercise more as there was information that over the last few months there had been a loss of impetus to exercise.

Councillor Caffrey noted that the pandemic had led to an increase in health inequalities across the board and she was concerned to understand how the ICS would harness learning to address this going forwards. Councillor Caffrey noted that across the region there were real pockets of deprivation where poverty and inequalities are high and where individuals were not able to afford to stay off work and where they were not getting paid time off to get vaccinated.

Councillor Caffrey stated that Sunderland had carried out an initial analysis and modified its Health and Wellbeing Strategy to reflect this and other local authorities were now analysing data in their localities and were looking to build this into their strategic approaches. Councillor Caffrey considered that this was something which needed to be examined at a regional level by the ICS.

Sir James stated that this would be a key part of the work of the ICS Partnership Board in the future. Sir James stated that pre Covid there had been discussions in relation to the Marmot recommendations and a decline in progress and going forwards there would need to be a focus on Marmot and making this central to the ICS work.

Councillor Caffrey stated that it was really pleasing to see how the system was working together.

123 PROVISIONAL WORK PROGRAMME

Councillor Caffrey noted that Mark Adams had agreed to provide a further update to the Joint Committee on the next steps for the ICS at the meeting to be scheduled in June 2021.

Councillor Caffrey stated that given the uncertainties in relation to the way forward for the ICS no other proposals had been put forward for the work programme at this stage.

As such it was proposed and agreed by the Joint Committee that any other suggestions for the Joint Committee's work programme should be sent to Angela Frisby.

124 DATE AND TIME OF NEXT MEETING

It was proposed and agreed that the next meeting be scheduled in June 2021 - the date and time to be confirmed.

Chair……..

APPENDIX 1

1. Our ICS is the biggest ICS in the country. It is all the more important therefore that there is not a ‘one-size fits all’ approach that is imposed upon all areas within the ICS.

Although the White Paper states that there will be sufficient flexibility to allow the bespoke shaping of arrangements at Place level (consistent with the ‘primacy of place’ principle), how do you see this working in practice across our ICS?

2. The White Paper refers to the establishment of an ‘ICS Health and Care Partnership’ for each ICS (with local government involvement). How can we be sure that this will be a true partnership instead of an NHS controlled partnership? How do we ensure Social care and public health agendas are fully recognised ?

3. The White Paper makes reference to local areas having autonomy and delegated budgets from the ICS. Is that the proposed direction for our ICS and how will it work – will there be an assessment of the ‘maturity’ of Place based partnerships to be entrusted with delegated budgets etc? How does this sit with the proposed increase in powers for the Secretary of State?

4. How do you see Provider Collaboratives working across our ICS?

5. What will be the role of the ICS in the area of prevention and, particularly in tackling the social determinants of health and health inequality?

6. Partnership working is about relationships and good relationships have been developed with CCGs since 2013 across the NE and North Cumbria patch. What measures can be taken across our ICS to ensure that those relationships with professionals and clinicians are not lost as part of the new NHS landscape?

7. CCGs currently have particular statutory responsibilities, for example in safeguarding. How will those responsibilities transfer across to the ICS and how will they be fulfilled at a place level?

8. Given the size of our ICS, we currently have a number of ICPs within our patch (such as the ICP North and ICP Central that fall within the remit of the Joint OSC). What does the future hold for these ICPs as part of the new NHS landscape?

9. As the White Paper makes it clear that CCG's will no longer exist from 1st April 2022, where does that leave system agreements that are in place at that time e.g. the Collaborative Newcastle Agreement and the Alliance Agreement for the Gateshead System ('Gateshead Cares') will the ICS take on the obligations set out within those Agreements from 1st April 2022?

10. How can this joint OSC committee be involved going forward in helping to shape the emerging arrangements for our ICS?

11. What arrangements will there be in place for public engagement within our ICS?

12. The White Paper mentions that further national guidance will provide more detail on various aspects of the proposals. What is the latest timeline for the release of this guidance, the anticipated Bill etc?

Wednesday 16 June 2021

Integrated Care System for the North East and North Cumbria

Answers to questions from the Joint Overview and Scrutiny Committee for the North East and North Cumbria ICS and North and Central Integrated Care Partnerships (ICPs)

1. Our Integrated Care System (ICS) is the biggest in the country. It is all the more important therefore that there is not a 'one-size fits all' approach that is imposed upon all areas within the ICS. Although the White Paper states that there will be sufficient flexibility to allow the bespoke shaping of arrangements at place level (consistent with the 'primacy of place' principle), how do you see this working in practice across our ICS?

As at 7/6/2021 we are still awaiting guidance relating to this however we are acutely aware of the importance to maintain focus at a place level, and we are committed to retaining and building upon existing joint planning arrangements between the NHS and council partners in each of our thirteen local authority areas.

2. The White Paper refers to the establishment of an 'ICS Health and Care Partnership' for each ICS (with local government involvement). How can we be sure that this will be a true partnership instead of an NHS controlled partnership? How do we ensure social care and public health agendas are fully recognised?

The White Paper sets out statutory establishment in each ICS of a health and care partnership - bringing together NHS organisations and local councils in a partnership of equals, alongside the statutory NHS bodies. This will therefore ensure social care and public health agendas are fully recognised. This is not an NHS controlled partnership.

From a legislative point of view, we expect there to be a core mandatory membership requirement for the partnership and the NHS ICS Board. We also expect there to be flexibility to invite any other organisation or representatives to be involved in a way that best suits our region.

3. The White Paper refers to local areas having autonomy and delegated budgets from the ICS. Is that the proposed direction for our ICS and how will it

work? Will there be an assessment of the 'maturity' of place based partnerships to be entrusted with delegated budgets etc? How does this sit with the proposed increase in powers for the Secretary of State?

As at 07/06/2021 we are still awaiting further guidance regarding this.

4. How do you see Provider Collaboratives working across our ICS?

Provider collaboratives will be an essential part of future system working and NHS provider chief executives have formed a collaborative for the North East and North Cumbria Integrated Care System footprint. The collaborative includes ambulance, hospital/community and mental health trusts across the region who have come together to share their expertise and improve access to services.

The focus for provider collaboratives will be to operate at scale to deliver specialist care effectively, reduce variants in clinical practice and outcomes, support workforce planning and provide equal access to care and treatment. NHSE/I has set out minimum standards for collaboratives which include agreeing and implementing changes developed by clinical and operational networks, challenge and hold each other to account and enact mutual aid arrangements. More guidance is expected but we also expect there to be flexibility for us to develop our own collaborative arrangements to best suit the needs of our region.

The North East and North Cumbria Provider Collaborative is jointly chaired by chief executive of Newcastle upon Tyne Hospitals NHS Foundation Trust Dame Jackie Daniel and chief executive of North Cumbria Integrated Care NHS Foundation Trust, Lyn Simpson. You can read the first briefing from the provider collaborative which sets out their key areas of focus going forward here.

Joint working across our provider organisations already exists and work well but the development of the Integrated Care System and the recent White Paper will enable us to build on this on a more formal footing. For example, we already have well established clinical networks which have, and continue to, support mutual aid arrangements when required and work together to ensure a joined up approach to ensuring equal access to specialist care.

The collaborative will not replace 'place-based' collaborations and system working (e.g. those already established such as for example Newcastle Collaborative and Northumberland System Transformation Board). The collaborative will not change the core duties and functions of NHS trusts and foundation trusts in their own right either.

A current focus within the North East and North Cumbria Collaborative is to all address the waiting list backlog as part of our overall pandemic recovery plans. You can read a recent release describing how we are part of a national 'accelerator' programme to address this and work in this area is ongoing. Due to strong relationships and collaborations in our region we maintained significant

amount of activity and care throughout the pandemic.

As the briefing mentioned above describes, the focus of our North East and North Cumbria Provider Collaborative will be to:

- Creating a wider clinical strategy which is sustainable for the future and helps us collectively recover from Covid-19
- Prioritising areas for capital investment ensuring all providers have the right environment and equipment to enable them to continue to provide the best possible care whilst enabling innovation;
- Efficiencies across the provider network driving productivity and maximising efficient practice;
- Developing principles and proposals for close integration of providers

5. What will be the role of the ICS in the area of prevention and, particularly in tackling the social determinants of health and health inequality?

This needs to be the cornerstone of our collective plans and all partners have a responsibility to focus on prevention and tackle the social determinant of health inequalities. Much has been written about the important of anchor institutions and the need for large organisations to play their part in tackling the challenges of health inequalities. See here for an event from The King's Fund. Not one organisation can tackle this alone however and therefore the importance of partnership cannot be underestimated.

6. Partnership working is about relationships and good relationships have been developed with clinical commissioning groups (CCGs) since 2013 across the North East and North Cumbria patch. What measures can be taken across our ICS to ensure that those relationships with professionals and clinicians are not lost as part of the new NHS landscape?

We agree. Relationships are pivotal in ensuring we deliver what is right for our local communities which is why the emphasis must always be on place-based delivery. We are anticipating further guidance regarding this in the coming weeks.

7. CCGs currently have particular statutory responsibilities, for example in safeguarding. How will those responsibilities transfer across to the ICS and how will they be fulfilled at a place level?

National guidance is being developed on the future arrangements to ensure the safeguarding of vulnerable service users. Although the ICS will inherit the statutory responsibilities of our current CCGs, safeguarding, and the monitoring of service quality, will continue to be an important place-level function.

8. Given the size of our ICS, we currently have a number of ICPs within our patch (such as the ICP North and ICP Central that fall within the remit of the

joint OSC). What does the future hold for these ICPs as part of the new NHS landscape?

Taking into account the direction of travel set out in the White Paper, the most recent NHS Planning Guidance and the helpful conversations we have had with local authorities over the last two months, we will retain both the existing joint-working arrangements at place-level between the NHS and local authorities. We will continue to support the existing ICP planning arrangements and partnership meetings across our four ICP footprints.

9. As the White Paper makes it clear that CCGs will no longer exist from 1st April 2022, where does that leave system agreements that are in place at that time e.g. the Collaborative Newcastle Agreement and the Alliance Agreement for the Gateshead System ('Gateshead Cares')? Will the ICS take on the obligations set out within those agreements from 1st April 2022?

These are place based arrangements that will continue in their current form with local partners.

10. How can this joint OSC committee be involved going forward in helping to shape the emerging arrangements for our ICS?

It is for the joint OSC to consider what its scrutiny role is, as arrangements emerge. This will no doubt be influenced by the national guidance we are waiting to be released. Notwithstanding this, local organisations will need to continue to satisfy the requirements for local scrutiny especially given the importance of place-based activity.

11. What arrangements will there be in place for public engagement within our ICS?

It is important to note that the focus for engagement and communications has got to be driven locally at a place-based level. This also supports and builds local relationships. We are awaiting further guidance regarding the requirements at an ICS level however it is important to differentiate between the statutory NHS body requirements from the requirements for the partnership board – engagement requirements for the latter will need to cater for the objectives set out by the partners.

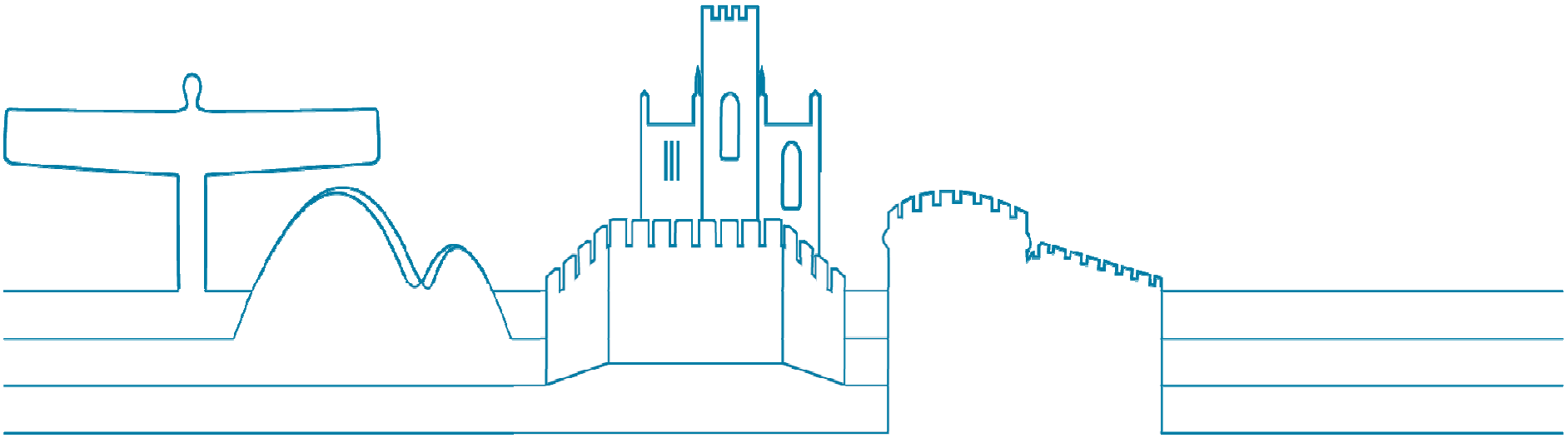
12. The White Paper mentions that further national guidance will provide more detail on various aspects of the proposals. What is the latest timeline for the release of this guidance, the anticipated Bill etc?

The Health and Care Bill was set out in the Queen's Speech on 11 May and we expect this to be set for a second reading in Parliament sometime in July 2021. We then expect a series of rolling guidance for the transition year (2021/22) and then implementation of legislative change from 2022.

White paper - Integration and Innovation: working together to improve health and social care for all

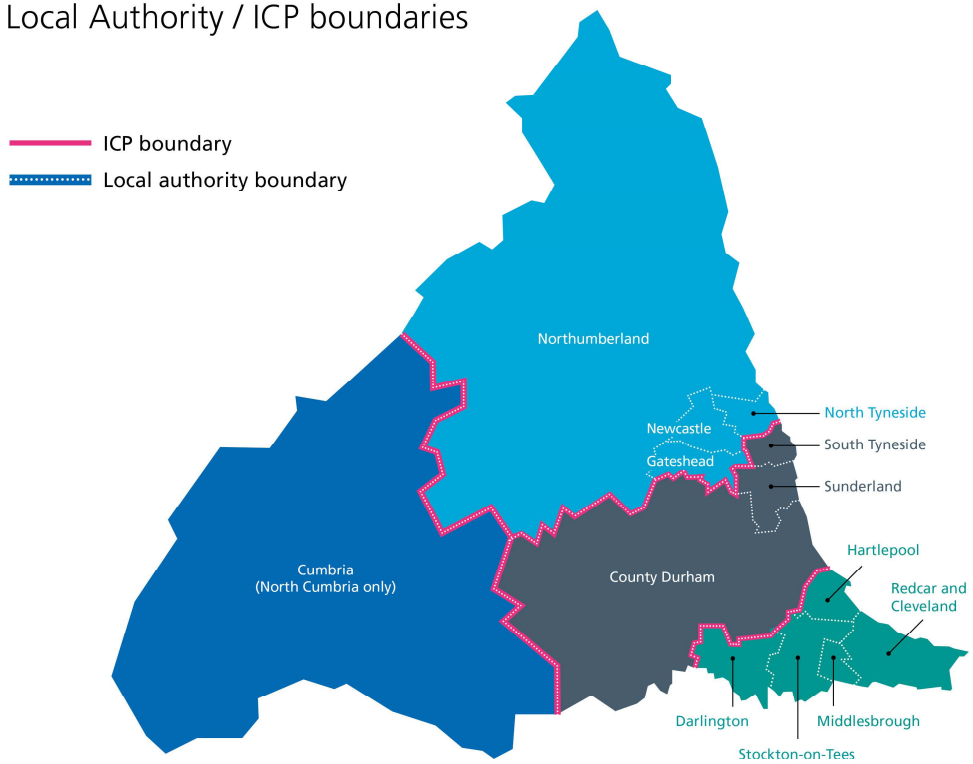
Update for

Joint Overview and Scrutiny Committee for the North East and North Cumbria ICS and North and Central ICPs



Reminder of our wide footprint

North East and North Cumbria
Local Authority / ICP boundaries



North Cumbria ICP

Population: 324,000

1 CCG: North Cumbria

Primary Care Networks: 8

1 FT: North Cumbria Integrated Care NHS Foundation Trust (NCIC)

1 Council Area: Cumbria County Council (with 4 District Councils)

North West Ambulance Service

NENC ICS-wide

North East Ambulance Service FT covers: North of Tyne and Gateshead ICP; Durham, South Tyneside and Sunderland ICP; Tees Valley South ICP

CNTW Mental Health FT covers: North Cumbria ICP; North of Tyne and Gateshead ICP; plus part of South Tyneside and Sunderland ICP

TEWV Mental Health FT covers: Tees Valley ICP; plus part of South Tyneside and Sunderland ICP

Newcastle upon Tyne Hospital FT: provider of highly specialised and specialised national and regional services (including transplant, paediatric specialisms and major trauma)

South Tees Hospitals FT: provider of highly specialised north of England and regional services (including cardiothoracic, spinal, cochlear implant neurosciences, gynaecology, urology and major trauma)

North of Tyne and Gateshead ICP

Population: 1.079M

3 CCGs: Northumberland, North Tyneside, Newcastle Gateshead

Primary Care Networks: 22

3 FTs: Northumbria, Newcastle, Gateshead

4 Council Areas: Northumberland, North Tyneside, Newcastle, Gateshead

Durham, South Tyneside and Sunderland ICP

Population: 997,000

3 CCGs: South Tyneside, Sunderland, County Durham

Primary Care Networks: 22

2 FTs: South Tyneside & Sunderland, County Durham and Darlington

3 Council Areas: South Tyneside, Sunderland, County Durham

Tees Valley ICP

Population: 701,000

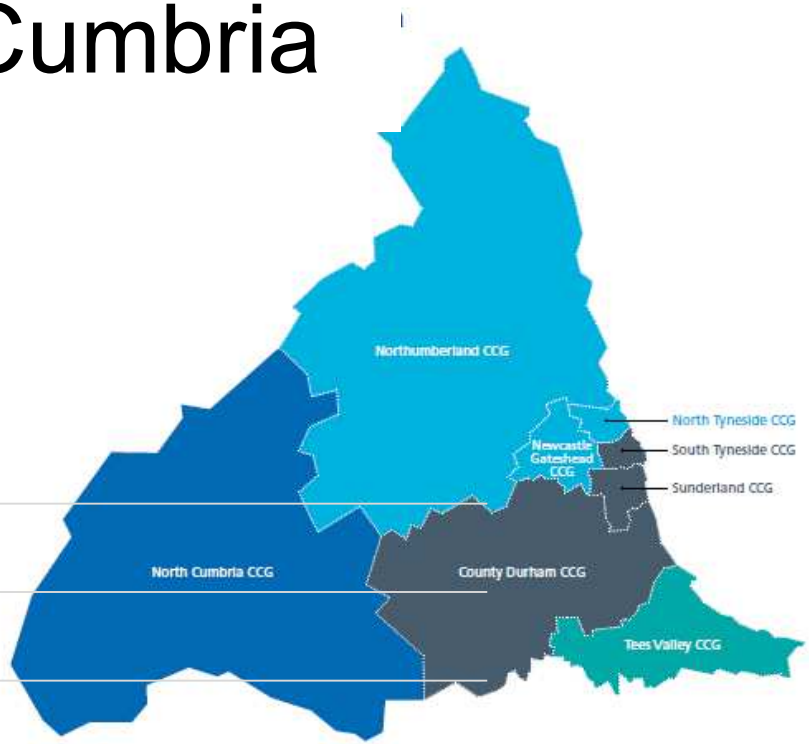
1 CCG: Tees Valley

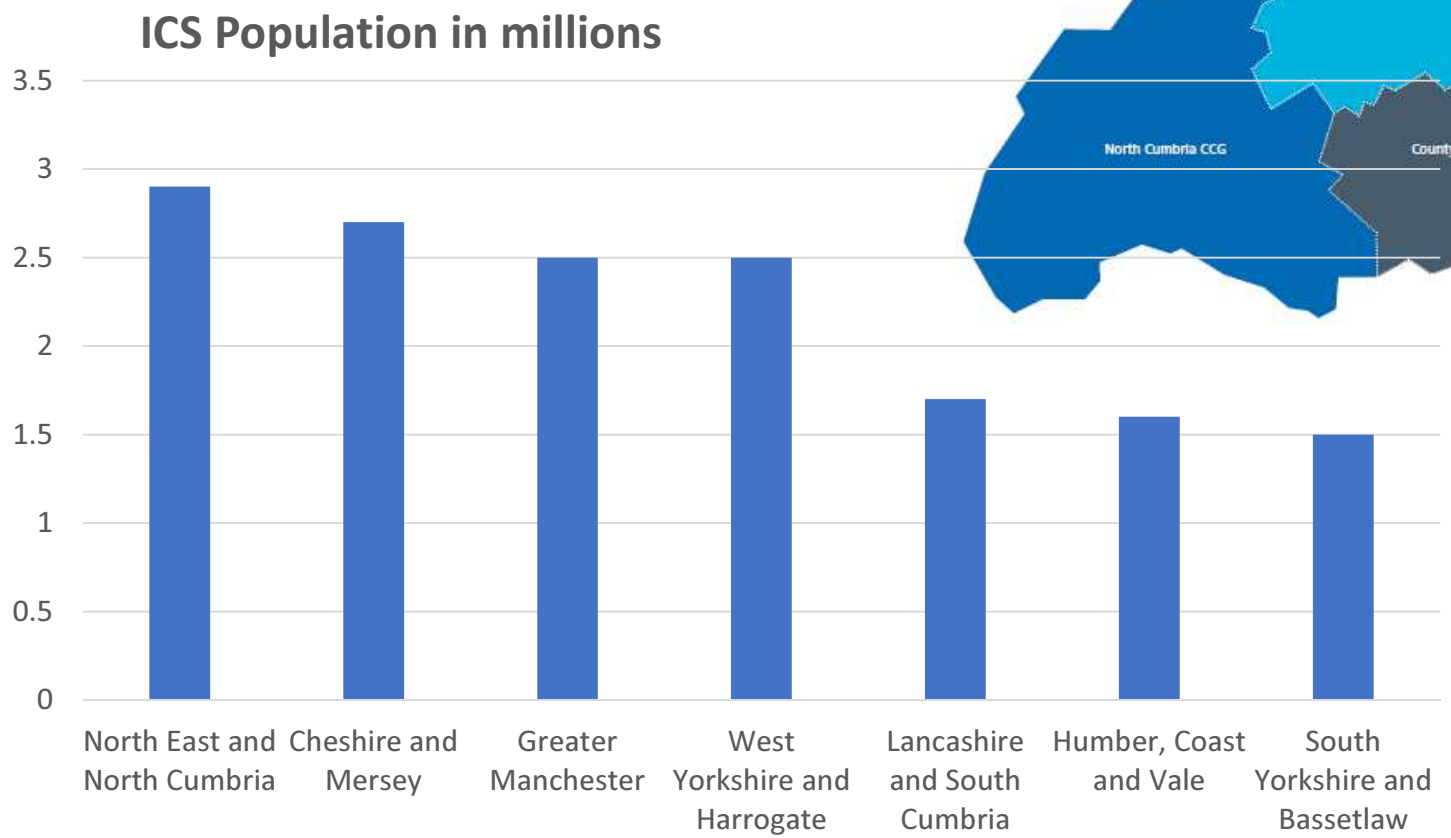
Primary Care Networks: 14

3 FTs: County Durham and Darlington, North Tees & Hartlepool, South Tees

5 Council Areas: Hartlepool, Stockton on Tees, Darlington, Middlesbrough, Redcar & Cleveland

North East and North Cumbria ICS





White paper aims…

- Improving population health and healthcare
- Tackling unequal outcomes and access
- Enhancing productivity and value for money
- Helping the NHS to support broader social and economic development

What does the white paper say about place?

- A key responsibility for these systems will be to support **place-based joint working** between the NHS, local government, community health services, and other partners such as the voluntary and community sector.

- Frequently, place level commissioning within an integrated care system will **align geographically to a local authority boundary**, and the Better Care Fund (BCF) plan will provide a tool for agreeing priorities.

- This will be further supported by other measures including improvements in data sharing and enshrining **a 'triple aim' for NHS organisations** to support better health and wellbeing for everyone, better quality of health services for all, and sustainable use of NHS resources.

What does the white paper say about place?

- Legislation can help to create the right conditions, but it will be the hard work of the workforce and partners in **local places and systems** up and down the country that will make the real difference.

- …there is a real chance to **strengthen and assess patient voice at place and system levels**, not just as a commentary on services but as a source of genuine co-production.

What does the white paper say about place?

- This will allow the NHS to shift away from an adversarial and transactional system centred on contracting and activity payments to one that is far **more collaborative and dedicated to tackling shared problems.**
- While NHS provider organisations will retain their current structures and governance, they will be expected to work in **close partnership with other providers and with commissioners** or budget holders to improve outcomes and value.
- **It's about population health**: using the collective resources of the local system, NHS, local authorities, the voluntary sector and others to improve the health of local areas.
- Even before the pandemic, many local system leaders were seeing **huge benefits** from joining up across health and local authorities.

What does the white paper say about place?

- **It is not expected that there will be any legislative provision about arrangements at place leve**l - although expecting NHSE to work with ICS NHS bodies on different models for place-based arrangements.

- **Place-based arrangements…should be left to local organisations to arrange -** expect local areas to develop models to best meet their local circumstances.

- **Health and Wellbeing Boards will remain in place** and will continue to have an important responsibility at place level to bring local partners together, as well as developing the JSNA and Joint H&WB Strategy…

- **The ICS NHS Body will take on the commissioning functions of the CCGs**…as well as CCGs' responsibilities in relation to Oversight and Scrutiny Committees. **It will not have the power to direct providers…**

Legislative timeline

Legislative steps: Step/Activity/Process	Indicative dates
1. Bill begins parliamentary process (first reading)	4 May 2021
2. Second reading of Bill in first House (usually the House of Commons)	18 May 2021
3. Committee stage in first House	8 June 2021
4. Bill progresses through second House (usually the House of Lords)	Nov 2021
5. Bill received Royal Assent and becomes an Act	Jan 2022
6. NHSE/I approve NHS constitution and ICS body mandate	Feb 2022
7. Relevant provisions of the Act are brought into force: NHS ICS bodies are established	1 April 2022

Establishing ICS during 21/22 – national expectations

Timeline	National expectations
By April 2021	All systems to work as ICSs, including ICS partnership board and partnership model
	Each ICS to develop a plan setting out how it will meet current operating arrangements & further planning requirements for next phase of Covid-19 response
By September 2021	Each ICS to develop ICS implementation plan for its future roles (adaptable to legislative developments)
By April 2022	Provider collaboratives to be established in ICSs – all Trusts to be a member of one or more collaborative
	Place based partnerships to be established in ICSs
	Commissioning functions to be coterminous with ICS boundaries
April 2022	Changes to legislation enacting ICSs as entities (subject to parliamentary decision)

Planning guidelines

By end Q1	Update System Development Plans and confirm proposed boundaries, constituent partnerorganisations and place-based arrangements.
By end Q2	Confirm designate appointments to ICS chair and chief executive positions (following the second reading of the Bill and in line with senior appointments guidance to be issued by NHSEI). Confirm proposed governance arrangements for health and care partnership and NHS ICS body.
By end Q3	Confirm designate appointments to other ICS NHS body executive leadershiproles, including place-level leaders, and non-executive roles.
By end Q4	Confirm designate appointments to any remaining senior ICS roles. Complete due diligence and preparations for staff and property (assets andliabilities) transfers from CCGs to new ICS bodies. Submit ICS NHS body Constitution for approval and agree "MOU" with NHSEngland and NHS Improvement
1 April	Establish new ICS NHS body; with staff and property (assets and liabilities)transferred and boards in place.

National policy/guidance

Quarter	Products
Q4 – 2020/21	Core principles for transition including employment commitment National narrative on senior leadership support People Impact Assessment Approach
Q1 – 2021/22	Model constitution Appointments guidance and process Remuneration guidance HR framework Talent approach and guidance Board level support package (TBC)
Q2 – 2021/22	Model transfer document and consultation Guidance on ESR transition
Q3 – 2021/22	Statutory NHS ICS body operates in shadow form from 1 October
Q4 – 2021/22	ICS Statutory Guidance

Twin boards model

Statutory ICS NHS Board

- Each ICS NHS body will have a unitary board directly accountable for NHS spend and performance within the system.
- The ICS Chief Executive becoming the Accounting Officer for the NHS money allocated to the NHS ICS Body.
- The board will include a chair, the CEO, and representatives from NHS trusts, general practice, and local authorities, and others determined locally.
- ICSs will also need to ensure they have appropriate clinical advice when making decisions.
- There will also be a more clearly defined role for Social Care within the structure of an ICS NHS Board to give ASC a greater voice in NHS planning and allocation.
- As with CCGs now, NHSE/I would approve ICS constitutions in line with national statutory guidance, and NHSE will publish further guidance on how Boards should be constituted, and appointments made.

ICS Health and Care Partnership Board

- NHS England have stated that there should be 'maximum local flexibility as to how ICS partnerships are constituted'.
- Main purpose as a forum for agreeing co-ordinated action and alignment of funding on key issues, as well as providing direction on the early stages of ICS formation.
- ICS Partnerships will be tasked with developing a plan to address the health, social care and public health needs of their system.
- Each ICS NHS Body and local authority would have to have regard to this plan – but the Partnership could not impose arrangements that are binding on either party.
- Membership of ICS Health and Care Partnerships will not be specified nationally but could be drawn from a number of sources including Health and Wellbeing Boards, Healthwatch, VCSE partners, social care, and housing providers.

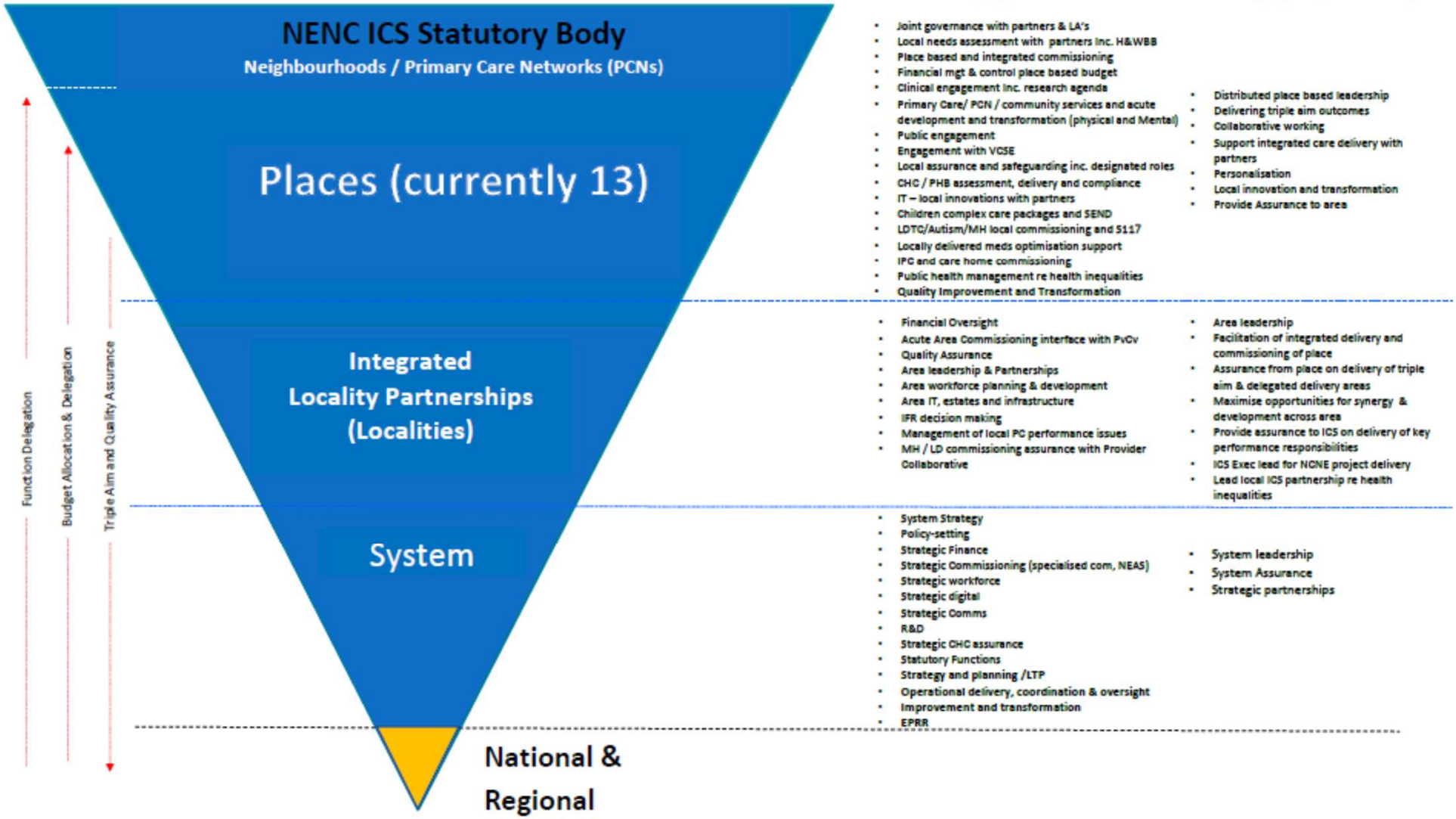
Key areas of focus

- Decisions taken closer to the communities they affect are likely to lead to better outcomes;
- Collaboration between partners in a place across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities, improve outcomes, and deliver joined-up, efficient services for people; and
- Collaboration between providers (ambulance, hospital and mental health) across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity.

Key areas for development

- ICSs also need to be able to ensure collectively that they are addressing the right priorities for their residents and using their collective resources wisely. They will need to work together across partners to determine:
  - distribution of financial resources to places and sectors that is targeted at areas of greatest need and tackling inequalities;
  - improvement and transformation resource that can be used flexibly to address system priorities;
  - operational delivery arrangements that are based on collective accountability between partners;
  - workforce planning, commissioning and development to ensure that our people and teams are supported and able to lead fulfilling and balanced lives;
  - emergency planning and response to join up action at times of greatest need; and
  - the use of digital and data to drive system working and improved outcomes.

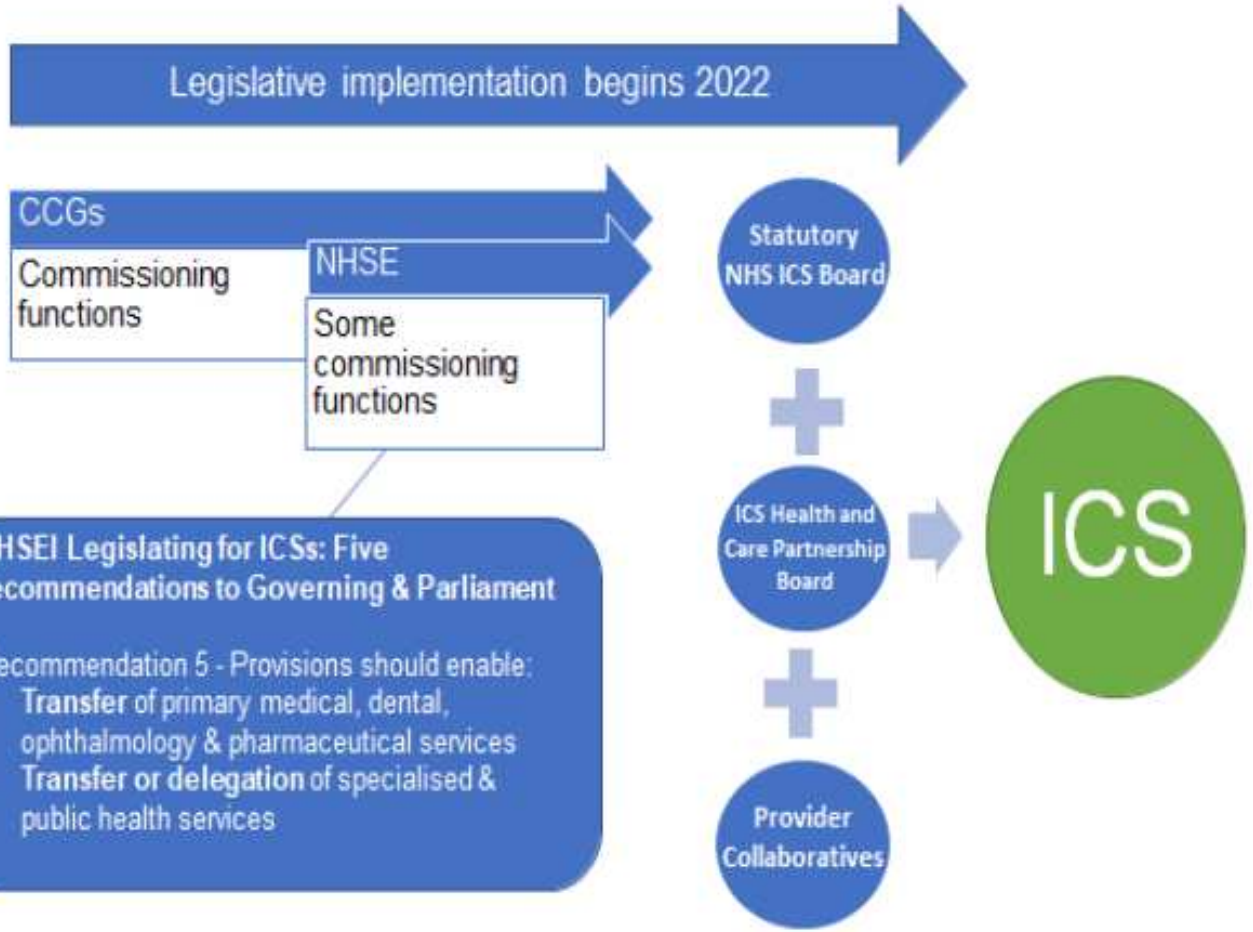
NENC – emerging structure



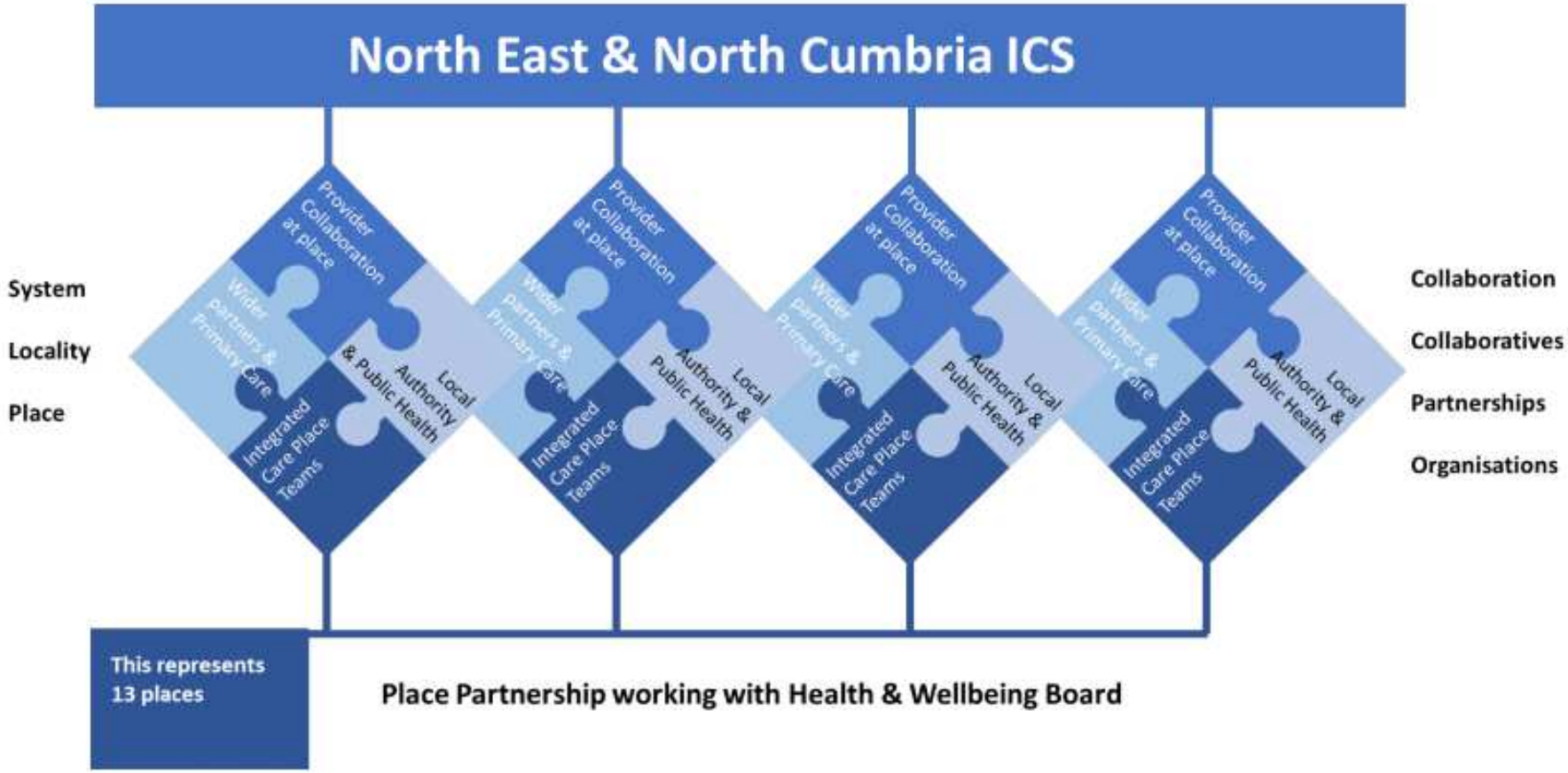
National emerging ICS operating model

Managing Change
(Sources: White Paper & NHSE/I FAQs)

- Care for our people
- Minimise staff uncertainty
- Minimise disruption
- Limit employment changes
- CCG staff employed by ICS NHS Body as legislation comes into effect & ICS become statutory body
- Employment commitment (T&Cs) to all NHS people directly affected below Board level
- Best practice in engaging, consulting & supporting workforce
- National HR principles (April 2021)
- National guidance on appointments to new roles in ICS NHS Bodies
- Implementation programme
- Joint appointment guidance



ICS emerging operating model at ‘place’



ICS and place-based partnerships

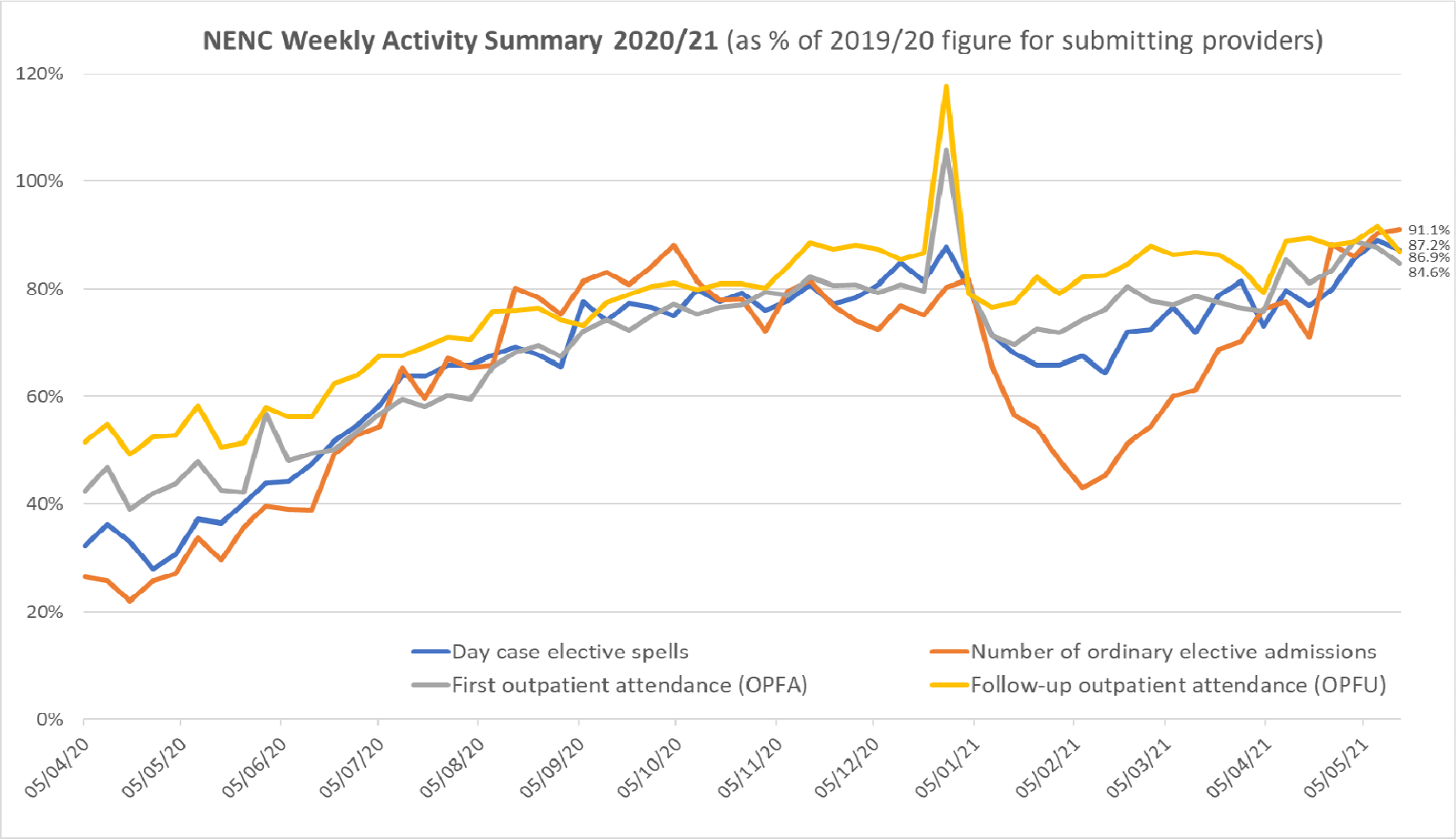
Place based partnerships - 3 core components

- Improved population health
- Improved service quality and patient experience
- Financial sustainability

Examples of work in practice

- Provider Collaborative are already working together on some key areas of work
- Elective recovery is a key priority and we have all seen the headlines
- NENC are in a better position than most

Weekly Activity | Week ending – 16/05/2021



Please note missing Weekly Activity Return for North Tees & Hartlepool WE 09/05/2021

Historic Data Comparison

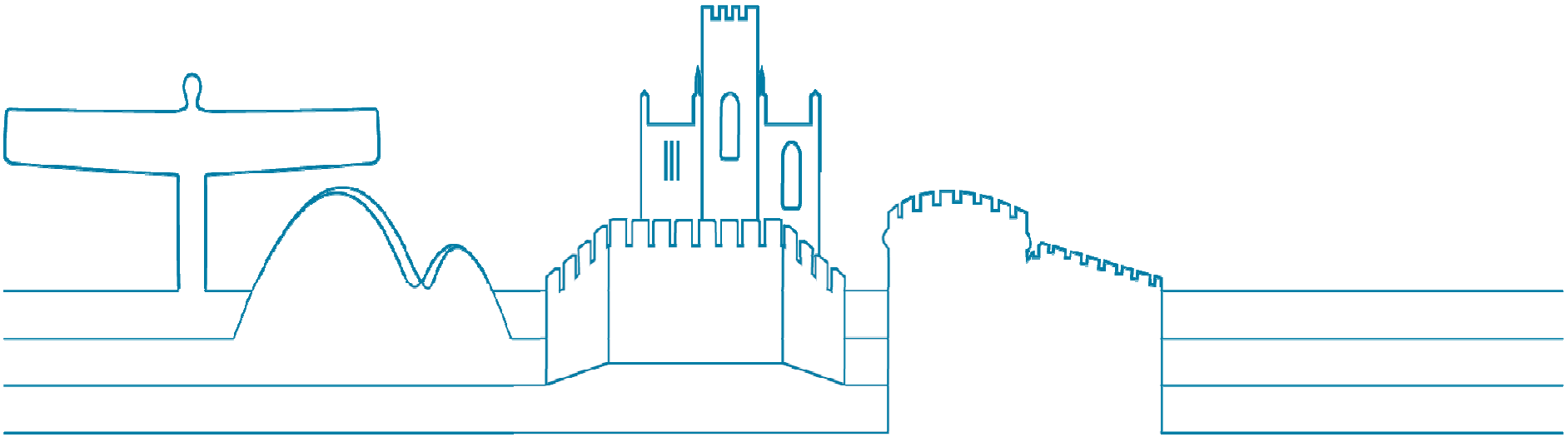
Please note that historic data is taken from SUS whereas the 2020/21 data is taken from the NHS Weekly Activity return. Although the same definitions are used, the application of two different sources may mean that historic data is not always directly comparable to the weekly return - this chart is provided as a guide only. Data is working day adjusted to account for bank holidays.

Summary

- Still lots to be done
- When we collaborate we can focus on making a difference
- Focus is on place and how joint working can improve outcomes for our communities
- Need to build on existing joint arrangements at place between local authorities, the NHS and wider partners
- Models of place-based working are emerging but no decisions on structures have been made
- National guidance on ICS development is imminent and we will need to digest this together with our partners and plan a way forward

iCS
Integrated Care System
North East & North Cumbria

Questions?



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