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Adult Social Care, Health and Wellbeing Sub-Committee

Friday, 28 October 2022

Monday, 7 November 2022 0.02 Chamber - Quadrant, The Silverlink North, Cobalt Business Park, North Tyneside, NE27 0BY **commencing at 6.00 pm**.

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** To Confirm the minutes of the meeting held on 29 September 2022.	**5 - 6**
5.	**Availability and Access to NHS Dentistry Services in North Tyneside** To receive information from NHS England on the availability of dentistry services in North Tyneside.	

Members of the public are entitled to attend this meeting and receive information about it. North Tyneside Council wants to make it easier for you to get hold of the information you need. We are able to provide our documents in alternative formats including Braille, audiotape, large print and alternative languages.

Agenda Item		Page
6.	**Adult Social Care**	**7 - 14**

To receive an update on:

- Northumbria Health Care Trust Care Pilot
- Care Northumbria – a new service from Northumbria NHS Foundation Trust

7.	**Joint OSC for the NE&NC ICS and North and Central ICPs'**	**15 - 78**

To receive an update following the meeting of the Joint Health Scrutiny Committee held on 17 October 2022.

A copy of the agenda and papers from the meeting are attached for information.

Circulation overleaf …

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

Councillor Joe Kirwin (Chair)
Councillor Michelle Fox (Deputy Chair)
Councillor Mrs Linda Arkley OBE
Councillor Tracy Hallway
Councillor Jim Montague
Councillor Josephine Mudzingwa
Councillor Tommy Mulvenna
Councillor Tricia Neira
Councillor Rebecca O'Keefe
Councillor Paul Richardson
Councillor Olly Scargill
Councillor Jane Shaw

Adult Social Care, Health and Wellbeing Sub-Committee

Thursday, 29 September 2022

Present: Councillor J Kirwin (Chair)
Councillors M Fox, T Hallway, J Montague, J Mudzingwa, T Mulvenna, T Neira, R O'Keefe, P Richardson, O Scargill and J Shaw

Apologies: None

ASCH15/21 Appointment of Substitute Members

There were no substitute members.

ASCH16/21 Declarations of Interest

There were no declarations of interest.

ASCH17/21 Minutes

Resolved: That the minutes of the meeting held on 14 July 2022 be confirmed and signed by the Chair.

ASCH18/21 Commissioning of Dentistry Services in North Tyneside

It was noted that a representative of NHS England had been due to attend the meeting to provide information on the commissioning of dentistry services in North Tyneside. Unfortunately, the representative had been unable to attend at short notice and this item was therefore postponed to the next meeting in November.

ASCH19/21 Better Care Fund Update

Sue Graham, Health and Social Care Integration Manager, attended the meeting to provide an update on the activity of the Better Care Fund (BCF) in 2022/23.

It was noted that the BCF is a component of government policy to improve integration between health and social care. It creates a pooled fund, operated jointly by Local Authorities and the new established Integrated Care Boards (ICBs) with this duty transferred during 2022/23 from the former NHS Clinical Commissioning Groups. The use of the pooled fund is agreed locally with joint development of the individual schemes and services that are part of the fund. The BCF arrangements commenced in 2015/16.

It was noted that the BCF objectives for 2022/23 are:

- Enable people to stay well, safe and independent at home for longer;
- Provide the right care in the right place at the right time.

It was noted that the arrangements for the BCF and its component parts are set out annually by the NHS in its BCF Planning Guidance. There have been minimal changes to the BCF from 2021/22. The policy objectives are:

i. A jointly agreed plan between local health and social care commissioners, signed off by the Health and Wellbeing Board (HWB)
ii. NHS contribution to adult social care at HWB level to be maintained in line with the uplift to NHS minimum contribution
iii. Invest in NHS commissioned out-of-hospital services
iv. Implementing the BCF policy objectives.

It was noted that there had been an overall increase in the BCF in 2022/23 of 4.47%. This is in line with national framework and planning guidance. The table at Appendix 1 to the report set the BCF services and expenditure for 2022/23.

Members raised some concern about the carryover of funds in relation to the Disabled Facilities Grant which for 2022/23 was £1,157,668. It was noted that this money was ring-fenced to be spent on specific capital schemes and had quite narrow eligibility criteria. The underspend had resulted from a national increase in the allocation, but spend was demand-led and means-tested and could be used for capital spending only. There was some discussion about whether this Grant needs to be more widely publicised to encourage eligible people to come forward. It was suggested by offers that they return to a future meeting to provide more detailed information on this grant and the eligibility criteria and restrictions of the grant.

There was some discussion about the reporting mechanism. It was noted that the ICB and Local Authority had submitted the plan to the Health and Wellbeing Board before being submitted to NHS England. The BCF Board meets every other month to monitor the plan and targets.

There was some discussion about support available for unpaid carers. It was noted that some support for carers is funded via the BCF, but this is part of wider support available via the Council. There was also some discussion about work on prevention of falls and it was noted that the BCF does partially cover some of this work but that the falls prevention service is delivered by health.

There was some discussion about the list of projects that has changed over time. For example, the intermediate care set up has changed with a move away from in-house bed provision and a move towards supporting people in their own homes through the reablement service.

At the end of this item an issue was raised by a member about the recording of the meeting by other members. The Chair highlighted the Council's protocol for members of the public wishing to report on meetings of the Council which confirmed that those attending meetings as members of the public are entitled to report on meetings, including by filming, photographing or making an audio recording of the proceeds of the meeting. This protocol is available on the Council's website.

NHS England

Provision of NHS General Dental Services in North Tyneside

North Tyneside
Adult Social Care health and Wellbeing Sub-Committee

7 November 2022

Background/context

NHS

access care.

Dental contracts and provision is activity and demand led with the expectation practices deliver and manage their available commissioned activity to best meet the needs of patients presenting to the practice.

The contract regulations set out the contract currency which is measured in units of dental

regulations.

NHS England do not commission private dental services but the NHS dental regulations do not prohibit the provision of private dentistry by NHS Dental Practices. Where this is the case practices have separate appointment books and clinical capacity assigned.

In 2019-20 (pre-Covid) circa 91% of the total commissioned capacity in North Tyneside was utilised demonstrating that at that time practices were meeting the expressed demand of the local population.

COVID- 19 pandemic and requirement to follow strict infection prevention control guidance

care remains high across all NHS dental practices.

NHS

General Dental Services
Units of Dental Activity (UDAs) only

NHS Dental Contracts (general dental services)	UDA Capacity Commissioned	
22	378,167	10,443,243

Note: The above table includes the small NHS contract in Wallsend that is due to end on 30 November 2022 (3941 UDAs) following the retirement of the provider.

Pressures & Challenges

1. COVID-19 Impact
2. NHS dental contract / Dental System Reform
3. Workforce recruitment and retention

1. COVID Constraints/Impact

NHS

COVID 19 and the need for dental practices to follow national IPC guidance has had a significant impact on the number of patients that practices were able to see.

During the first wave of the pandemic in the interest of patient and dental staff safety, routine dental services were paused in March 2020 and urgent dental care centres (UDCs) were established to provide access to urgent care.

In July 2020 all practices re-opened for face to face care and have steadily increased activity.

All practices were required to prioritise patients based on clinical need and urgency into their available capacity with inevitable delays for patients seeking non-clinically urgent and more routine dental care

National contractual arrangements put in place to reflect the reduced capacity that could be delivered - minimum thresholds against contracted levels for income protection as follows:

- 20% between July - December 2020
- 45% between January - March 2021
- 60% between April - September 2021
- 65% between September - December 2021
- 85% between January - March 2022

100% from July 2022

recovering system

2. NHS dental contract & Dental System Reform

Legacy 2006 NHS dental regulatory UDA system.

March 2021 Department of Health asked NHS England to lead on dental system reform.

In July 2022, NHS England published a package of initial reforms to the NHS dental contract. These included but were not limited to:

Prioritising care for patients with high needs by increasing the remuneration practices receive for more complex treatments.

this).

Greater flexibility in how dental funding can be used by enable practices who can deliver more to do so and to release funding locked into practices who are unable to deliver the commissioned activity so that it can be moved to those who can deliver.

Personalisation of recall intervals - move away from the default position of patients attending every 6 months to intervals that are clinically appropriate based on the oral

Making it easier for practices to introduce skill mix - utilising the skills of the wider dental care professionals (dental therapists and hygienists) to work within their full scope of practise thereby freeing up dentist time to focus on more complex treatments.

Improving information for patients - requirement for dentists to update the NHS website

Start of the process

Engagement has commenced to inform the next stages of the reform programme

3. Dental workforce recruitment and retention

Provider and dental professional workforce choosing to retire early/move to private dentistry/away from the dentistry all together.

FD Training constraints and Overseas recruitment difficulties.

Recruitment and retention pressures - challenges in recruiting and retaining dentists to work on NHS contracts.

Impact on ability to deliver commissioned levels of service or offer additional access for patients.

Local measures/actions

Offered incentives for ALL NHS dental practices to prioritise patients not seen in the practice within the previous (24 months) adults and 12 months (children) who require urgent dental care;

Invested in additional clinical triage capacity within the out of hours integrated NHS111 North East and North Cumbria Dental Clinical Assessment Service;

Increased investment into the new Dental Out of Hours Service contract (from 01 Oct

investment/capacity in process of being commissioned to provide additional resilience over the winter period until end of March 2021).

Additional funding made available to practices in 2021-22 who were able to offer additional clinical capacity above their contracted levels with a focus on prioritising patients with urgent dental care needs and access for nationally identified high risk groups, ie children.

New offer recently issued to practices with enhanced rates where they are able to deliver additional clinical capacity on a sessional basis until end of March 2023.

NHS

Working with practices to maximise their clinical treatment capacity, ie encouraging them to maintain short notice cancellation lists to minimise as far as possible any clinical downtime.

Engaging with dental providers within the areas where contracts have been handed back to see if they are able to take on additional NHS capacity on either short-term or long term basis.

Working with local dental networks/committees and local Health Education England colleagues to explore opportunities to improve workforce recruitment and retention and to identify further measures to improve access for patients, includes

Continue engagement to influence the work taking place at a national level to identify solutions to the recruitment and retention pressures in NHS dental services and to understand and address the constraints of the current national dental contract mechanisms.

Summary - Key Points

All NHS dental practices are able to safely provide a full range of treatments however demand for care remains extremely high with dental practices having to balance addressing the backlog of care with managing new patient demand.

Practices are being incentivised to prioritise patients with the greatest clinical need, ie those requiring urgent dental care and delayed treatments including patients not known to the practice as well as vulnerable/high risk groups such as children.

High treatment needs of patients and workforce recruitment and retention issues means a delay in practices being able to meet the demand for more routine and non-urgent care.

All opportunities are being explored to increase the clinical capacity available and improve access for patients.

NHS
Northumbria Healthcare
NHS Foundation Trust

Care Northumbria

Marion Dickson, Executive Director of Nursing, Midwifery & AHPs, Surgery and Community Services

Gillian Finn, Operational Services Manager Home Care / Care Homes

What is Care Northumbria?

A new domiciliary care service

Offers support with personal care to people in their own homes

Is commissioned to provide services in both Northumberland and North Tyneside, allocated work through usual local authority pathways

Supports people to return home with care as needed when they are ready to leave hospital

Supports patients, families and carers to receive high quality packages of care at home that meet their needs

Supports local authority and care provider market gaps within

need Care Northumbria?

Across both local authority areas there are substantial gaps in availability of care provision

People are often in hospital awaiting care packages or placed in a step down facility while they await care at home, which can increase the risk of dependence upon services and reduce the opportunity to return home. It is critical that we support people home at speed and with good quality care to prevent this

The sector has had a hard time and is under pressure

We want to enter the market to deliver high quality NHS care and give value back to the caring role in which morale has been severely damaged

The opportunity feels right for the Trust to move into this area and deliver personal care and elevate the standards across the system for those who need it

Where have we got to so far in this development?

- Quality Commission (CQC) registration
- Registered manager in post
- Structure for Care Northumbria service agreed
- Phased recruitment in progress
- Induction and training programme in place
- Communication strategy in place

CareNorthumbria
You're in the right hands

Hurdles

- New area of work for the Trust
- Providing support in this area in a way that does not de-stabilise or threaten existing provision:
  - Although we recognise that there is likely to be some disruption
- Financial modelling and financial viability:
  - Our staff will be employed on NHS terms and conditions
  - They will be part of our broader organisation
  - We will be receiving payment at prevailing market rates
- Sequencing and mobilisation speed
- Organisational understanding of personal care

Northumbria Healthcare
NHS Foundation Trust

This is an exciting new area of work for us

For us, it is an innovative, new way of delivering care and provision at home

The ability to increase capacity for domiciliary care provision in the Trust area will be welcomed

NHS
Northumbria Healthcare
NHS Foundation Trust

Any questions?

Northumbria Healthcare
NHS Foundation Trust

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

Gateshead Council

Meeting on Monday, 17 October 2022 at 1.30 pm in the Bridges Room, Civic Centre Gateshead

Agenda

1 Appointment of Chair

In line with the terms of reference of the Joint Committee, the Joint Committee is asked to appoint a replacement Chair for the 2022-2023 municipal year as the current Chair is no longer able to continue in the role.

2 Apologies

3 Declarations of Interest

4 Minutes (Pages 3 - 14)

The minutes of the meeting of the Joint Committee held on 4 July 2022 are attached for approval.

5 Next Steps for ICS

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

6 Workforce Progress Update

Annie Laverty, Chief People Officer, North East and North Cumbria Integrated Care Board, will provide the Joint OSC with an update on this matter.

7 Update on ICS Mental Health Collaborative

Scott Vigurs, Mental Health ICS Programme Director, will provide the Joint OSC with an update on this matter.

8 Work Programme 2022 -23

The Joint Committee has agreed that the below issues should be included in the 2022-23 work programme:-

Meeting Date	Issue
21 November 2022	• Next Steps for ICS • Inequalities Update

23 January 2023	• Next Steps for ICS • Oncology Services – Proposed Service Changes and briefing on Gynae Oncology services • Emergency Planning
20 March 2023	• Next Steps for ICS • Progress of the Digital Strategy

Issues to slot in

- Children's Mental Health Provision – Update on Current Performance and Future Provision
- Winter Planning – Update

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

9 Dates and Times of Future Meetings

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

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

Contact: Angela Frisby Tel 0191 4332138 **Date: 7 October 2022**

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

Monday, 4 July 2022

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

151 APPOINTMENT OF CHAIR

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

152 APPOINTMENT OF VICE CHAIR

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

153 PROTOCOL / TERMS OF REFERENCE

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

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

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

154 APOLOGIES

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

Tyneside Council)

155 DECLARATIONS OF INTEREST

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

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

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

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

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

156 MINUTES

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

157 UPDATE ON NEXT STEPS FOR THE ICS

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

Mark advised that a huge amount of work had gone into the position we are now at with the new statutory ICS coming into being last Friday. The ICB Operating Model now takes over from the CCG's that local authorities previously worked with and this sets out how the ICB delivers its objectives within the integrated care system, how decisions are made and who makes them and how the ICB assure itself that its objectives are being met.
Principles of ICB development have been progressed to establish joint working and governance structures which have had involvement not just from the NHS but also local authorities and other partners ie the voluntary and community sector so that the ICB can have a clear focus going forwards on its four strategic aims of improving outcomes in population health and healthcare, tackling inequalities in outcomes, experience and access, enhancing productivity and value for money and helping the NHS support broader social and economic development.

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

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

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

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

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

Mark highlighted that there would be one whole system ICP built up from four smaller locally sensitive ICPs and the Chair of the ICB Sir Liam Donaldson had agreed the approach of how the ICPs would work in practice over a series of meetings with partners. The whole system ICP would therefore meet on a bi-annual basis and the four smaller ICPs would meet more frequently and would involve representatives from Local Authorities, FTs and Primary Care Networks. The ICP would sign off the Integrated Care Strategy and how this is translated into the four areas.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mark stated that at present officers in the CCGs and ICB were working with the funding that they have at the minute. Going forwards they will be consulting in different ways with each place as to funding and how it can be used. Mark acknowledged that there is a role for the ICS in tackling the wider determinants of health eg job creation etc and he advised that these are the conversations that officers within the ICB want to have with each place.

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

Mark advised that there is a process in place for the ICB to deal with GP closures although this is not something the ICB wishes to see. In terms of links between place based working and the ICB where feedback can be provided, Mark advised that Directors of Place based working were in place and there would be staff within the ICB who would work in each place and build links.
Councillor Kirwin indicated that he was really pleased to see continuity of care highlighted. However, Councillor Kirwin noted that previous presentations had referred to new powers to help place based working but he had not seen anything further as to what this would entail and he queried when this was likely to be known.

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

Councillor Mulvenna expressed concern that currently it is planned that the ICB will only have four members who are councillors. Councillor Mulvenna considered this was insufficient given the huge geography covered. Councillor Mulvenna considered that unless there was increased representation from grass roots councillors the ICB would face difficulties in progressing its objectives. Mulvenna advised that

councillors in each respective place needed to be engaged and involved although he acknowledged that there may be a need for a couple of councils to come together but he considered that greater representation was needed.

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

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

The Chair thanked Mark for the very informative presentation.

158 ONCOLOGY SERVICES BRIEFING

The Joint Committee was provided with a briefing paper and a presentation on this matter from representatives from NHS England, who are responsible for commissioning oncology services, Newcastle Hospitals as the provider of the services and the Northern Cancer Alliance and the newly formed Provider Collaborative, which represents all the FT's in the region.

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

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

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

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

The Joint Committee was advised that there would be no changes to how patients

would access their systemic treatment. The only impact would be for patients having their first face to face outpatient appointment with the consultant oncologist and for any necessary face to face follow up appointments with the consultant oncologist during their chemotherapy treatment. Clinic co-ordinator roles would be employed by Newcastle Hospitals to ensure efficient and effective use of all available appointments and virtual appointments would continue to be offered and maximised where this was appropriate.

The Joint Committee was informed that recruitment was ongoing and other appropriate staff groups who could provide support were being involved but given scale of challenge it was not clear how quickly the current workforce position would be resolved. The Joint Committee was informed that nationally there is a predicated consultant oncologist shortage of 28% by 2025 and regionally a predicated shortage of 43% over next 5 years.

The Joint Committee was advised that the proposed changes would begin to take effect in July and would be monitored for twelve months and during this time work would take place to look at a more sustainable model for the longer term.

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

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

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

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

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

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

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

Ian advised that work had been taking place to ensure that the hubs would be robust and responsive. This had involved examining whether long term follow ups could be

carried out potentially via primary care and looking at ensuring there would be slots for emergencies. Ian also advised that specialist nurses would also work in the hubs.

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

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

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

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

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

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

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

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

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

159 COVID RECOVERY PLAN

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

Page 10

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

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

Matt advised that in relation to the waiting list for patients waiting 104 weeks, again pre-Covid it was rare for anyone in the region to have waited this long. Post - Covid this waiting list had been reduced to approximately 50 patients who require very specialist services due to their complex needs. Numbers of patients waiting 78 weeks had now reduced from 4000 to 1000 and were continuing to reduce.

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

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

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

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

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

Councillor Kirwin acknowledged the excellent work taking place but asked Matt what

good looked like in terms of recovery given that the waiting list was at an all - time high at pre Covid levels.

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

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

Matt advised that the funding for the new Centre in Newcastle was from a national pot and so other Trusts in the region had to support funding being allocated to Newcastle for the Centre. Matt stated that it was then his job to ensure the best use of resources across the patch. This was achieved by ensuring that all Chief Officers at specific Trusts learn about the work of other Trusts and where they are doing well / share good practice etc. Matt stated that all the Trusts are clear that they need to recover together.

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

Matt clarified that 1 in 10 of the population would be waiting for something on the pathway – which could include things like a first diabetes check and various out-patient procedures not just surgery – which is why the waiting time figures can be misleading.
Councillor Wallace queried if a person needed say a new hip and then also needed a new knee whether they would show in the figures one or twice.

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

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

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

160 WORK PROGRAMME 2022-23

The Joint Committee agreed that the below issues should be rolled forward from the previous work programme to the Joint Committee's 2022-23 work programme:-

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

In addition to the above, the Joint Committee agreed that the below issue should be included in the work programme:-

- Update on ICS Mental Health Collaborative

The Chair reminded the Joint Committee that if councillors had any other issues which they would like included in the work programme they should forward these to the scrutiny officer for Gateshead.

161 DATES AND TIMES OF FUTURE MEETINGS

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

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

Chair………………………..

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Workforce : current challenges for health and social care

JOINT ICS OSC -17 October 2022

National context

Workforce challenges

As of September 2021, nationally the NHS was advertising 99,460 vacant posts: for social care, it was 105,000

NHS in England short right now of 12,000 hospital doctors and over 50,000 nurses and midwives

Impact on the health and care workforce

Multiple factors impacting the workforce including;

- Pension rules influencing early retirement decisions, especially within the NHS
- In August 2021, the NHS lost two million full-time equivalent days to sickness with more than 560,000 days lost due to anxiety, stress, and depression
- Overall pressures and demands across health and social care
- Pay and conditions in social care
- Competitive recruitment market for lower paid jobs

Regional Context

Summary

NHS

Performing better than most but still much to do

But we still have challenges

Social Care

Public perception of social care, and lack of awareness of different roles, career pathways

High turnover and the challenge of retaining skilled staff with competition from other sectors

Difficult to recruit high quality people and expectations do not match the reality of the work

Relatively low pay and poor terms and conditions of employment in parts of the sector

Regional comparison: North East and North Cumbria ICS

Recruitment: Healthcare Support Workers

Please note: as this data is collected more regularly, this is information from the HSCW recruitment reporting of 19 July, pertaining to the June position.

Trust-level trajectories HCSW recruitment programme

Additional context:

Leavers

An increase of leaver rates and turnover rates has been seen

has the lowest leaver rates across all regions, the whole NHS

compared to the strong downward trend we had in early 2020,

April 22 saw the highest leaver and turnover rates in the past 12 months, and an increase of both leaver and turnover rates across all workforce groups in April 22 compared to previous months.

Top five reasons for leaving for all staff (in order) are: 1. End of fixed term; 2. Retirement; 3. Unknown; 4. Pay/Reward; 5. Relocation

Recruitment: Reduced Vacancy Rate

Geography	Mar-22	Apr-22	May-22	Change from March baseline
North East and Yorkshire				+1.4%
North East and North Cumbria				-0.4%
Humber and North Yorkshire				+1.5%
South Yorkshire				-0.7%
West Yorkshire				+5.1%

Data source: PWR

Retention: Reduced Leaver Rate (rolling 12 months)

National Staff Survey, National Quarterly Pulse Survey and Engagement

Slide contents	This slide summarises the Annual Staff Survey and National Quarterly Pulse Survey (NQPS) data incorporating the People Promise elements.
National Staff Survey Data	The response rate for the 2021 NE&Y region was 98,305 which is **48.3%** of the workforce an increase from 44.4% in 2020. The national staff survey response rate was 48% up by 1% from 2020.
NQPS Data	The latest NQPS survey ran from 01 April 2022 to 02 May 2022, with an **11%** response rate which was up 3% on the January 2022. This is on par with the national response rate. Out of 33 trusts in the region 29 submitted responses which is average when compared to other region. This compares to 31 responses in January 2022 in the region. The reason for the four non returns was a result of staffing changes with the engagement teams.

Data source: National Staff Survey 2021

Engagement Scores

*

Data source: NQPS January 2022 and April 2022

Top and Bottom Scoring Trust NQPS Staff Engagement element for April 2022

*

People Promise Themes

shows colleagues feel there could be more recognition for the work they do and want to feel the organisation values their work, with the level of pay being the biggest contributing factor. Being able to access the right learning and development opportunities, feel supported to develop potential and having opportunities for career development are other areas for improvement.

Note: Northumbria HealthCare NHS Foundation Trust use a different sampling methodology other NHS trusts. Data Source: NQPS April 2022

recommended place to work.

Social care

which is so essential to those who receive social care.

In December 2021, Care England reported that 95% of care providers were struggling to recruit staff, and 75% were struggling to retain their existing staff.

Care workers often find themselves in under-paid roles which do not reflect the value to society of the service they provide.

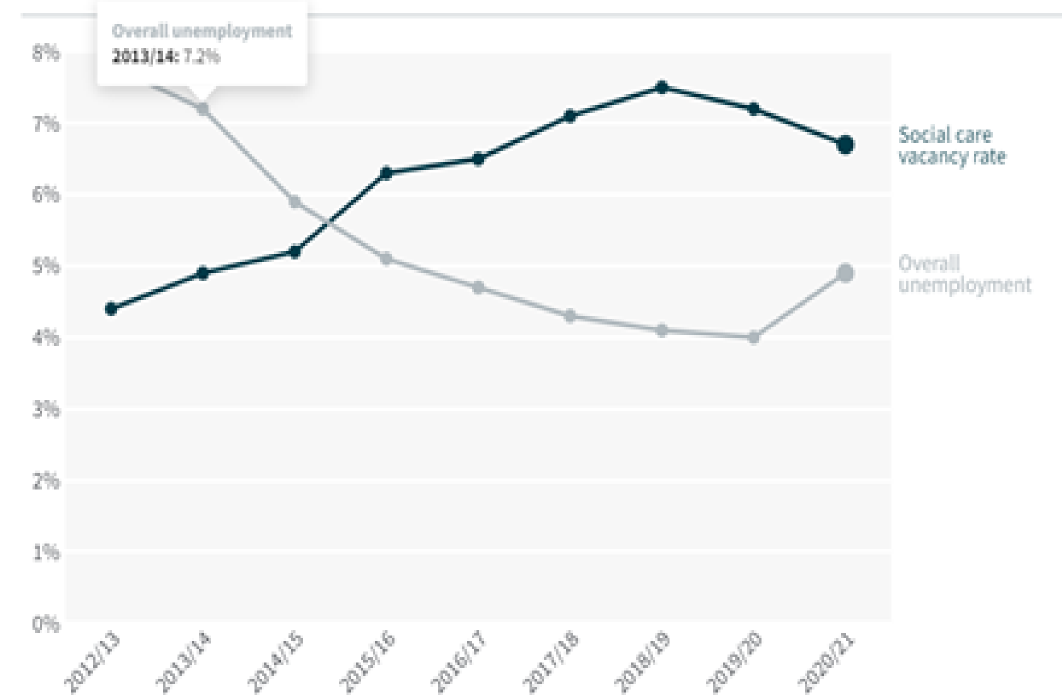
Without the creation of meaningful professional development structures, and better contracts with improved pay and training, social care will remain a career of limited attraction even when it is desperately needed.

Social care vacancies

The vacancy rate remains much higher than the overall unemployment rate and it appears that as unemployment falls, social care vacancies rise.

Vacancy rates in adult social care similar to the NHS

Much higher than in other areas of the economy such as retail (1.6 per cent), education (1.5 per cent) and manufacturing (2.2 per cent).



Recruitment and retention in social care

Pay is a crucial factor in recruitment and retention in social care. Social care providers are consistently being outbid by the retail and hospitality sectors

A long-term, sustainable strategy is needed with the prospect of pay progression, professional development, and career pathways

New regulations should be introduced in which care workers initially employed on zero-hours contracts are offered a choice of contract after three-months of employment

An externally validated care certificate which is transferable between social care providers and between social care and the NHS

Clear progression paths for those who want to continue professional development who enter social care and provide standardisation between training received in the sector to allow such progress and recognition

Action

NHS People Plan Priorities

To address its workforce challenges now, and for the future, the NHS needs more people, working differently, in a compassionate and inclusive culture:

- more people in training and education, and recruited to ensure that our services are appropriately staffed
- working differently by embracing new ways of working in teams, across organisations and sectors, and supported by technology in a compassionate and inclusive culture by building on the motivation
- at the heart of our NHS to look after and value our people, create a sense of belonging and promote a more inclusive service and workplace so that our people will want to stay.

The NHS People Plan sets out the actions that employers and systems should take, focussing on:

- Looking after our people particularly the actions we must all take to keep our people safe,
- Belonging in the NHS highlighting the support and action needed to create an organisational culture where everyone feels they belong.
- New ways of working and delivering care emphasising that we need to make effective use of
- Growing for the future particularly by building on the renewed interest in NHS careers to expand and develop our workforce, as well as retaining colleagues for longer.

Positive and inclusive working cultures

21% of the social care workforce and 22.1% of the NHS workforce is black, Asian, or minority ethnic, compared to 15.7% of the population of England.

According to the NHS Workforce Racial Equality Standard (WRES), racism impacts many parts of working life in the NHS: from pay, to career development, to the likelihood of being subject to disciplinary action

The NHS must commit to the creation of positive working cultures and inclusive work environments.

Creating and enforcing zero tolerance policies for harassment, discrimination, and bullying towards all staff, with targeted policies for staff who may be particularly vulnerable to these behaviours, and online behaviours.

International recruitment

The NHS is dependent on the service of highly qualified and dedicated overseas staff. One in seven current NHS staff reports a non-British nationality.

47% of new GP trainees are international medical graduates.

Just over 50% of new registrants to the GMC register are international graduates.

Level of international recruitment unsustainable in the context of a global shortage of health professionals

However, more also needs to be done to make the NHS an attractive, welcoming, and supportive place for international healthcare staff.

Recruitment and retention

Workforce Action in Social Care

Increasing coordination via the Association of Directors of Adult Social Services (ADASS) network

Understanding the workforce given gaps in the data from self-funders and the PA workforce

Joint work with the NENC ICS workforce team

Promoting opportunities for flexible apprenticeships across health and social care settings.

health and social care placements)

Local FE colleges are involving health and social care employers to develop the curriculum, to

future careers

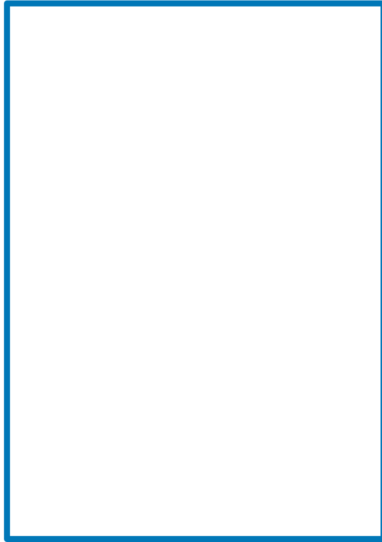
Skills for Care's 'Finders Keepers Valuable People' programme, supporting social care organisations to retain the right people

Thanks for listening

Any questions or feedback ?

Joint Overview and Scrutiny Committee

17/10/22



Updates to the interim guidance published in August 2021 on the functions and
there will be an expectation
that there will be options for an ICB to delegate its commissioning functions to collaboratives. ICBs will continue to be held to account for the way in which the function has been discharged OR for the ICB to arrange for its commissioning functions to be delegated to a joint committee of itself and another/other NHS trust(s) and/or

Key Benefits of a Mental Heath Learning Disabilities and Autism Collaborative include, but are not limited to:

1. Supporting the reduction in health inequalities and improving population health outcomes
2. Supporting the establishment of Statutory ICSs
3. Sharing our commissioning expertise to support the delegation and contracting to an MHLDA Collaborative which bring greater engagement of professionals into the planning and delivery of care
4. Supporting Place Partnership Development with greater and faster decision making closer to the front line
5. Reducing Fragmentation , joining up pathways and growing models of care that meet the health and care needs of our population
6. Delivering our duty to collaborate and integrate across Health and Care
7. Reducing bureaucracy and duplication and ensuring good value for money by applying our experiences and sharing capacity and capability
8. Supporting system recovery
9. Sharing a significant level of clinical/professional expertise , supporting service development
10. Working together to support our people planning together

The aim is to further develop and build on our approach over the coming year as part of ICS Development across three stages, the first as we continue to develop our plans ready for the 1st July when the ICS becomes a formal statutory body for the NENC and legislative change comes in to effect and we work within a new legislative framework; and then move into a transitional arrangement with our system partners preparing for a go live date of April 23. We are committed to the delivery of the triple aims, and feel together we can progress at pace over the coming months to develop our model for the benefit of our population.

Our Task

North East and North Cumbria
Mental Health, Learning Disability and Autism Partnership

Development of a Mental Health, Learning Disabilities and Autism (MHLDA)Collaborative will support the ICS with the commissioning and delivery of Mental Health, Learning Disabilities and Autism Services. This will include both working with local Places to support commissioning and delivery to our local communities and system commissioning and provision.

We have been tasked:

- To build on our experiences to date across the NENC to further develop our approach in to a MHLDA Collaborative
- To work throughout 2022/23 and beyond, to design the structures and requirements of the ICS Operating Model to grow our commissioning function and continue to deliver high quality services to the 3.1m population
- To work with our Partners to grow the Collaborative , creating a partnership model that spans all sectors, particularly working with Local Authorities, the Voluntary and Community Sector , and ensuring that we involve service users, carers, and their families in developing and governing our work
- To ensure we meet our duties around the triple aims, duty to collaborate and integrate we will engage and involve a broad range of partners in our approach including; Places, Local Authority colleagues and Provider partners. Designing a model that supports place and system with patients and service user outcomes as the centre of our approach

Place based focus

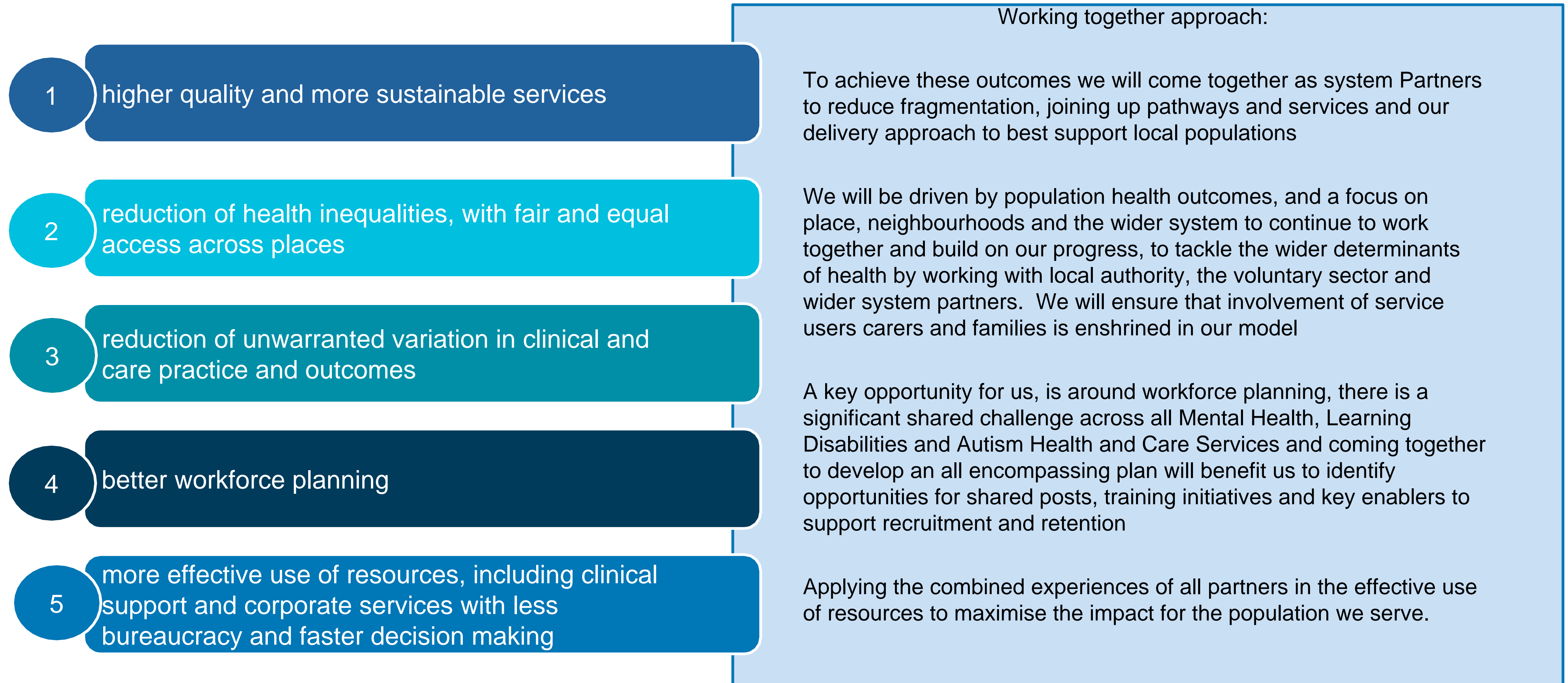
integrated into place based governance arrangements

understanding of the strategic level plan and vice versa.

We will reduce bureaucracy enabling faster decision making

Deliverables of a MHLDA Collaborative

As part of developing any proposal, we will need to consider the key deliverables from developing a MHLDA Collaborative, as set out in national policy, and developing an approach to delivering these outcomes, together across neighbourhoods, places and the system with our system partners.



Foundations of the MHLDA Collaborative

North East and North Cumbria
Mental Health, Learning Disability and Autism Partnership

We already have a strong track record of coming together as Partners under the North East and North Cumbria Mental Health, Learning Disabilities and Autism Programmes and the Specialist Services Partnership which has demonstrated the benefits of partnership and system working

The MHLDA Collaborative will be a vehicle for:

- Delivering Integrated planning and service provision on behalf of the ICS
- Integrating the planning and commissioning of specialised and local mental health services to reduce fragmentation across pathways
- Delivering mental health transformation at scale on behalf of the ICS and importantly through place based partnerships
- Delivering the Long Term Plan for Mental health
- Driving up quality

The MHLDA Collaborative should:

- Have a firm relationship with partnerships at places, who will determine the needs of the local population
- Strengthen the role of the local authority and VCSE in at scale and place based transformation
- Ensure deep involvement at all levels by service users carers and their families
- Drive collaboration of MHLDA expertise to enable workforce development

The MHLDA Collaborative will engage and form part of both place and system development by:

- Working with our Partners at Place across health and care, commissioning and provision
- Being active members of the ICS, where we work with our wider system partners to achieve our vision
- Focussing on delivering improved outcomes, reduction in health inequalities and the provision of sustainable service
- Reducing bureaucracy and ensuring enabling faster decision making

and care colleagues to deliver holistic services to best support our 3.1m population

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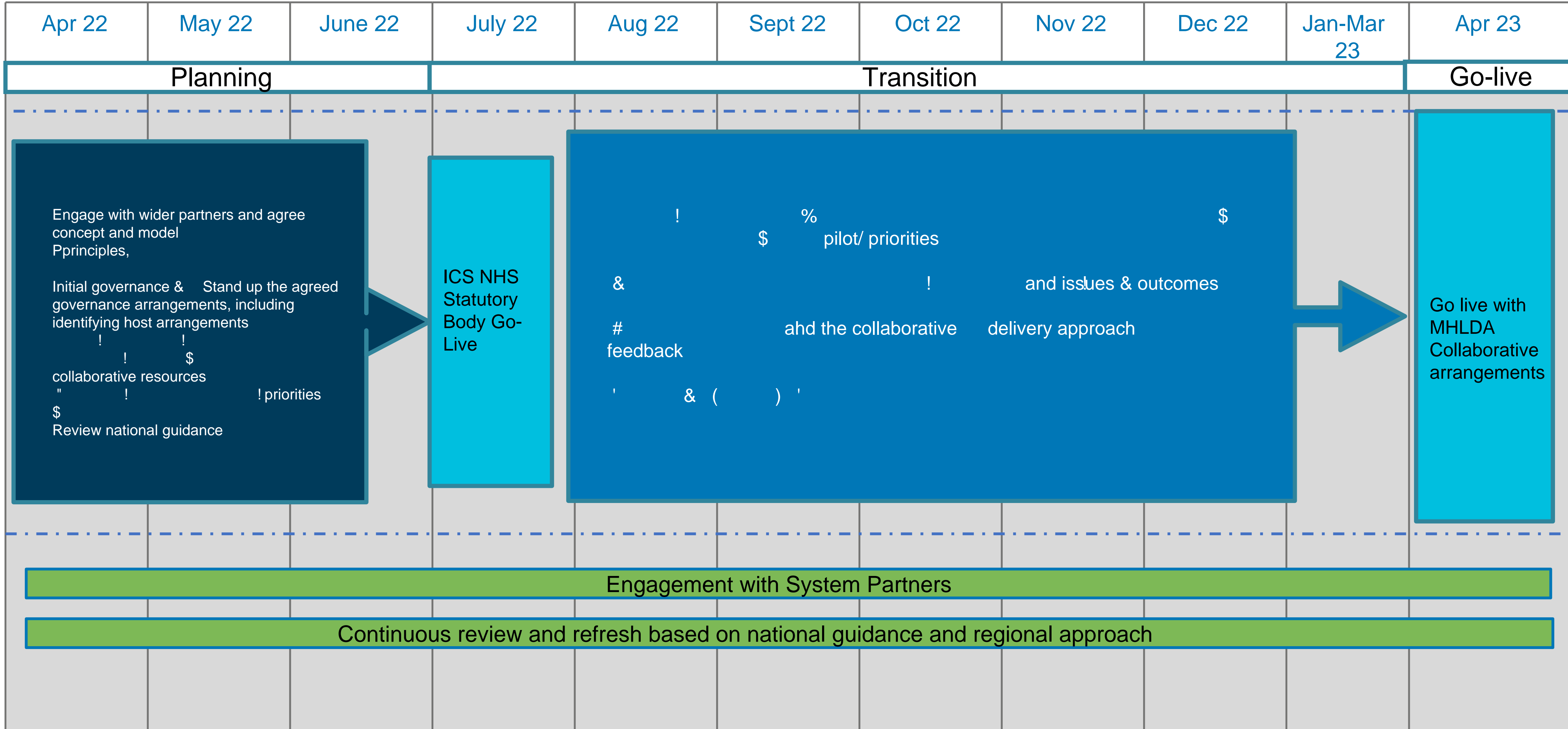
The timeline below sets out some of the key next steps and associated timeline, related to the Planning Guidance Timeline as to how we might further develop our approach. The suggested focus in the first instance, will be engagement with system partners around membership.



Work in progress to build upon

Regional group looking at future options for MHLDA commissioning

Understanding of existing place-based partnerships

Engagement across commissioners and system partners

Explored potential collaborative arrangements using the following principles:

*
*
Increases clinical input into commissioning
+
,
Ensure we have oversight of the whole pathway
Improved VFM

Developed a proposed future governance model (see next slide)

North East and North Cumbria Integrated Care System Mental Health Programme

Work continues through the NE&NC MHLDA programme which started in 2018 with the purpose that we:

* - .
- . / 0 # 1 2 3 3 4 5

Support the transformation process through communication, information sharing, best practice, reducing duplication and progressing system wide engagement;

Inform locality arrangements to progress Integrated Care Systems (ICS) aligned to an informed needs profile;

Understand variation and promote innovation and evidence based practice to address gaps.

The year 4 report for the NE&NC MHLDA programme is now ready for publication

We would see these approaches coming together as part of the establishment of the Collaborative

Proposed governance model

Place: Linking with existing place-based partnerships

* Tees Valley may need broken down further into individual LA areas

Working in partnership with our Councils

With our Council partners we have to date:

- Held joint sessions with NE ADDAS / NHS providers and ICB Colleagues to agree priority pathways for the collaborative to focus on:
  - Children and Young People
  - Workforce
  - All age Autism/ ADHD Diagnostic services
  - Access and early support
  - Inpatient pathways
  - High cost care packages
- Established a working party to set up a North partnership with representatives from Local Authorities which will replicate a existing partnership in the South of the ICS
- Invited Local Authority representatives to join the Provider Collaborative Board
- Agreed Local Authority representation on the Learning Disability and Autism Funding Pathway Panel

Further Actions

December 2022

Agreed delegated decision making and regional governance arrangements

Develop effective implementation plans for priority areas

Continue to meet with ADASS and ADCSS colleagues as systems and at place

Consider financial and contracting models and arrangements as a system particularly where there are mutual concerns around quality and value more money

Evaluate initial arrangements in March 2023

For Discussion

Can you foresee any barriers to implementation / if so how to overcome?

How do we ensure strong Local Authority & Social Care Partnership?

How should we further align and strengthen place based arrangements?

What does our new joint governance structure look like, is it fit for purpose?

Integrated Care Board Update
Briefing for Elected Members

Key Priorities for ICS development

The formation and membership of our strategic Integrated Care Partnership (ICP), and its relationships with our four Area ICPs

The joint development of our Integrated Care Strategy through the ICP, which the ICB and all of the local authorities in our ICS area must have regard to in making decisions.

The development of formal place-based governance arrangements between the ICB and local authorities

Taking forward the 8 actions from the vision work that PWC shared with us

Continuity and change

What will stay the same?

The continued statutory role of local authorities in improving the health and wellbeing of their local population, and providing local public health and social care services.

A 'duty to collaborate' between NHS organisations and local authorities to promote joint working across healthcare, public health, and social care

The continued statutory role of Health and Wellbeing Boards, in preparing Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

Former CCG teams are now part of the ICB and will

as now, ensuring operational continuity and stability

Continued NHS representation at Health and Wellbeing Boards through our new ICB teams.

Joint working between ICB teams and local authorities on issues such as health and social care integration, continuing healthcare and local safeguarding

What will change?

One Integrated Care Board has replaced eight CCGs, inheriting their budgets and responsibilities (but

Streamlined decision-making via the ICB on key strategic issues (such as the commissioning of hospital services, investment decision, or workforce planning)

The creation of a statutory Integrated Care Partnership of the ICB and our 13 local authorities setting joint system priorities in an Integrated Care Strategy

The ICB and each local authority must have regard to the Integrated Care Strategy when making decisions. The strategy will inform and be informed by the joint health and wellbeing strategies at a local level.

A new procurement commitment from the ICB to help the NHS support broader social and economic development in our region

Potential for greater alignment & pooling of budgets to promote the key determinants of good health

Confirmed ICB leadership team

Sir Liam Donaldson
Samantha Allen

Partner Members

Local Authorities: Cllr Shane Moore (Hartlepool), Tom Hall (South Tyneside), Ann Workman (Stockton-on-Tees), Cath McEvoy-Carr (Newcastle),
Primary Care: Dr Saira Malik (Sunderland), Dr Mike Smith (County Durham)
NHS Foundation Trusts: Ken Bremner MBE (NHS South Tyneside and Sunderland Foundation Trust), Dr Rajesh Nadkarni (NHS Cumbria, Northumberland and Tyne & Wear Foundation Trust)

Non Executive Directors

Dr Hannah Bows
Prof Eileen Kaner
Jon Rush
David Stout OBE

Participants

ICS HealthWatch Network: David Thompson (Northumberland HealthWatch)
ICS Voluntary Sector Partnership: Jane Hartley

Executive Directors

Dr Neil O'Brien
Jon Connolly
David Purdue
Annie Laverty
Professor Graham Evans
! " Claire Riley
Aejaz Zahid
$ # $ Jacqueline Myers
% & Dave Gallagher ($)
% & Mark Adams *)

Our Integrated Care Partnerships

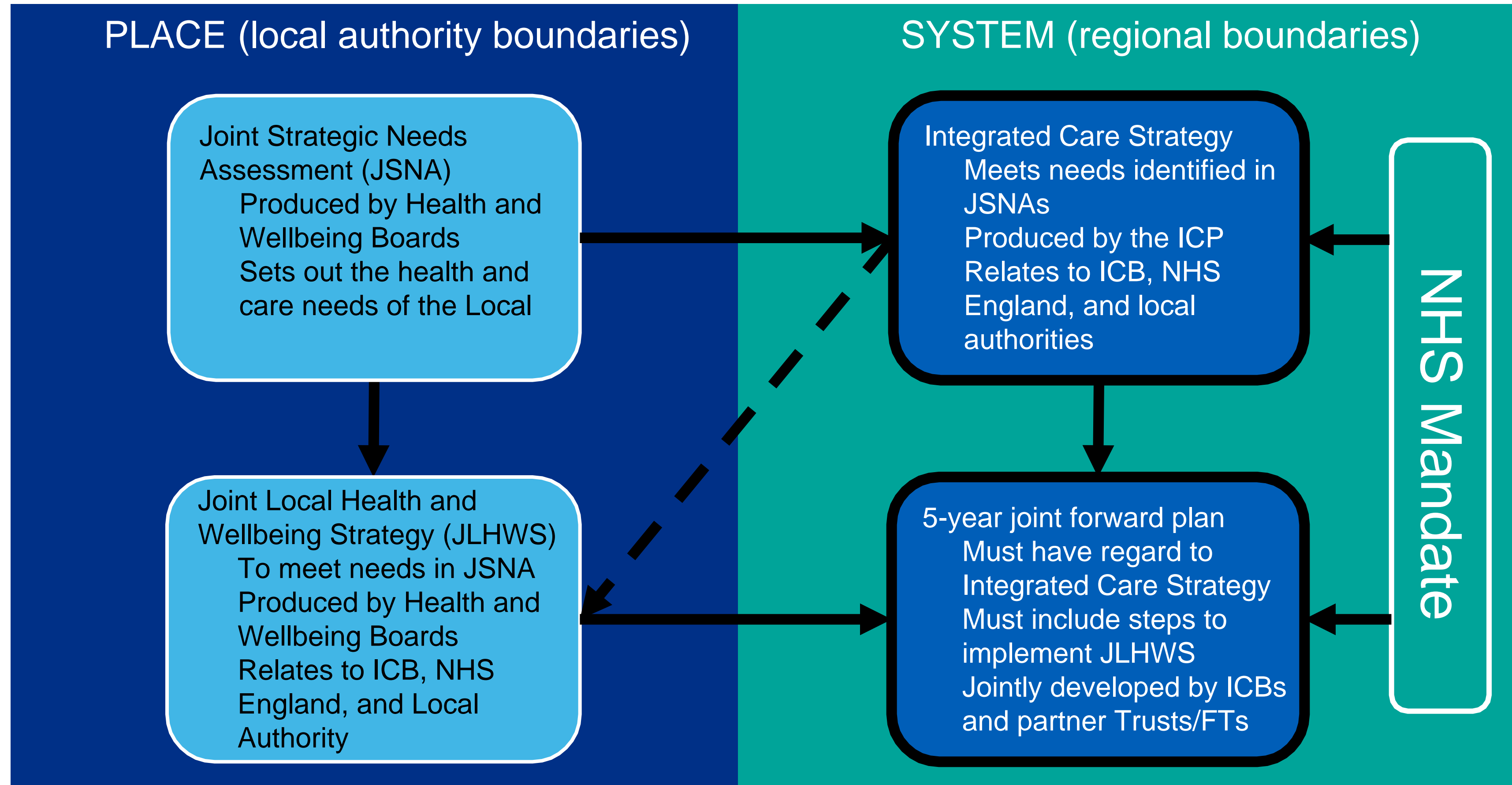
ICP boundaries

Following feedback from our local authority partners, our

Role of our Integrated Care Partnerships

1 region-wide ICP	4 Area ICPs
Would meet as an annual or biannual strategic forum Membership comprising the ICB and all thirteen local authorities (plus other partners to be determined)	Based on existing geographical groupings Would meet more frequently Membership from ICB place teams, local authorities, foundation trusts, primary care networks
Main role to sign off the ICS-wide Integrated Care Strategy This strategy will build on the analysis of need from the four ! Directors of Public Health Network Will promote a multi agency approach to improving population health & wellbeing and tackling the wider social and economic determinants of health for the 3 million people in our ICS Will also consider health inequalities, experiences and access to health services at this same population level " # $ % large scale social and economic development	Key role in analysing & responding to need from each of its constituent places (using the HWBB-led JSNA process) Sharing intelligence & removing duplication to ensure the evolving needs of the local population are widely understood A forum to agree shared objectives and joint challenges Developing relationships between professional, clinical, political and community leaders Evaluating the effectiveness and accessibility of local care pathways Translating local health and wellbeing strategies and the Integrated Care Strategy into activity at the ICS Area level

How the ICS strategies and plans link together



Proposed Membership of the ICS-wide ICP

Core Statutory members

Sector	Proposed member	members
ICB	Chair Chief Executive (plus other ICB executives or non-executives as required/or in attendance)	2
Local Authorities	Health and Wellbeing Board Chair (or appropriate Lead Member) Plus one lead officer	26
	Total	28 (min)

Chairing and membership of the ICP will be determined by its statutory members at its first meeting on 20 September

Optional members to consider

Sector	Example membership
Foundation Trusts	& ' ( ) * Plus other leads from our clinical networks.
Primary Care	E.g. our Primary Care Partner members on the ICB
Local Authorities	One or more local authority chief executives
Local Authority networks	Directors of Public Health Directors of Adult Social Services (ADASS) + % , + %
HealthWatch	Representative from ICS HealthWatch Network
VCSE Sector	Representative from ICS VCSE Partnership or other
Economic Regeneration	Local Authority Economic Regeneration Directors network
Combined Authorities	Managing Directors from Tees Valley and North of Tyne
Housing Sector	E.g. the North East Housing Consortium
Police	One or more reps from our four Police forces
Fire & Rescue	One or more reps from our five Fire and Rescue Services
Education sector	Representatives from the schools, FE and university sector

Proposed Membership of the Area ICPs (example
!

Sector	Proposed member	Total number of members
ICB	ICB Executive Director of Place-Based Delivery 3 x Place-Based Clinical Leads	4
Foundation Trusts	4 x Foundation Trust Chairs (3 acute, 1 mental health) 2 x Acute Trust chief executive 1 x Mental Health Trust chief executive	6
Local Authorities	3 x Leaders/Lead Members from each LA (option to include Health and Wellbeing Board chairs too) 1 Lead local authority chief executive	4/7
Voluntary Sector	Representatives from each local authority area (e.g. the local voluntary sector infrastructure organisation)	3
Total		17

Chairing and membership of the Area ICPs will be determined by the ICB and partner local authorities.

ICP Development

We will continue to work with local authorities to shape how the ICPs will operate

A multi-agency working group is meeting to develop recommendations

+ # $ "

engaging with Health and Wellbeing Boards

The statutory members of the ICP will meet for the first time on 20 September to agree its chair, membership, governance and vision.

This will include setting priorities for the next 6-9 months

- Focus on health inequalities and population health
- Restoration and recovery of health and care services
- Development of an Integrated Care Strategy (a statutory requirement), engagement and sign off.
- The value added by the ICP to social and economic development

The ICB and local authorities will also need to agree the membership and functions of the locally-focused ICPs

Continuity of place-based working

Each of our places already has:

A Health and Wellbeing Board
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local authority, responsible for assessing local health and care needs (JSNA) and developing a local strategy (JHWBS)

A non-statutory local partnership forum of NHS and
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operationalising the JHWBS, developing local integration initiatives, and overseeing pooled budgets and joint financial decisions (S75, BCF).

Each Place-Based Partnership/Board/Committee could become accountable for the delivery of objectives set out by the ICB. We will jointly develop a route map to support each of our places to develop the governance that works best for that locality.

Previous CCG area	Local Authority	Partnership Forums
Cumbria	Cumbria County Council	North Cumbria ICP Leaders Board
		North Cumbria ICP Executive
		(Whole of) Cumbria Joint Commissioning Board
		(Whole of) Cumbria Health and Wellbeing Board
Newcastle Gateshead	Newcastle City Council	Collaborative Newcastle Executive Group
		City Futures Board (formerly Health & Wellbeing)
	Gateshead Council	Gateshead Care (System Board and Delivery Group)
		Gateshead Health and Wellbeing Board
Northumberland	Northumberland County Council	Northumberland System Transformation Board
		BCF Partnership
		Northumberland Health and Wellbeing Board
North Tyneside	North Tyneside Council	North Tyneside Future Care Executive
		North Tyneside Future Care Programme Board
		North Tyneside Health and Wellbeing Board
Sunderland	Sunderland City Council	All Together Better Executive Group
		Sunderland Health and Wellbeing Board
South Tyneside	South Tyneside Council	S Tyneside Alliance Commissioning Board & Exec
		South Tyneside Health and Wellbeing Board
Durham	Durham County Council	County Durham Care Partnership
		County Durham Health and Wellbeing Board
Tees Valley	Middlesbrough Council	South Tees Health and Wellbeing Board
	Redcar & Cleveland Council	Adults Joint Commissioning Board
	Hartlepool Council	Hartlepool BCF Pooled Budget Partnership Board
		Hartlepool Health and Wellbeing Board
	Stockton-on-Tees Council	Stockton BCF Pooled Budget Partnership Board
		Stockton-on-Tees Health and Wellbeing Board
	Darlington Council	Darlington Pooled Budget Partnership Board
		Darlington Health and Wellbeing Board

Key place-based Functions

These functions are set out in the 'Functions and Decisions Map' which forms part of the ICB's Constitution and set out how our ICB place-based teams will:

- Develop and agree a plan to meet the health and healthcare needs of the local population
- Plan and commission services, in line with the ICB's scheme of delegation
- Commission local primary care services (excluding nationally negotiated GP contracts)
- Develop local clinical leadership, including clinical pathway redesign and helping to shape the commissioning of acute services.
- Build strong relationships with communities, the wider local system including Healthwatch, the Voluntary Sector, and other local public services.
- Service development and delivery with a focus on neighbourhoods and communities, ensuring local engagement and consultations are undertaken as necessary.
- Monitor local service quality and the place-based delivery of key enabling strategies as agreed by the ICB Board or Executive Committee.
- Monitor and deliver outcomes and outputs set by the Secretary of State, NHS England, CQC and other authorised bodies and providing assurance to the ICB

In addition, ICB place-based teams will play a key role in the formal place-based joint working arrangements between the NHS and Local Authorities, and they will continue to:

- Coordinate NHS input into local partnership initiatives to improve public health, prevent disease and reduce inequalities.
- Fulfill the NHS's statutory health advisory role in adults' and children's safeguarding.
- Jointly commission local integrated community-based services for children and adults (including care homes and domiciliary care), including:
  - Continuing health care
  - Personal health budgets
  - Community mental health, learning disability and autism
  - Children and young people's services (including transitions, Special Educational Needs and Disabilities, Looked After children)
  - Service integration initiatives and jointly funded work through, e.g. the Better Care Fund and Section 75 agreements.

Place based governance within the ICS

The ICB has delegated responsibility for the delivery of its place-based functions, including relevant budgets, through two Executive Directors of Place Based Delivery who will delegate authority to place-based ICB staff
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Business continuity will be vital we are working closely with local authorities to avoid disruption.

The government's Integration White Paper 'Joining Up Care for People, Places and Populations' has set
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between ICBs and local authorities, with places able to select from a range of governance models, including:

A place-based Consultative Forum , with a broad membership, which would act in an advisory capacity to the Executive Directors of Place-Based Delivery but could not make binding decisions.

A formal Place Committee of the ICB , coterminous with a single local authority (or group of neighbouring local authorities), with formal delegation of NHS resources and a direct line of reporting and assurance to
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would be accountable to the ICB. Such a committee could not make decisions on behalf of other bodies

A Joint Committee , coterminous with a single local authority (or group of neighbouring local authorities), allowing collective decisions to be made within its scope of authority on behalf of a number of organisations
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reporting and assurance to both the ICB and the other constituent statutory bodies, requiring agreement by all parties to the level of delegated authority or statutory decisions set out in a formally approved MOU. Such a Joint Committee would allow for Multi-agency decision-making and delegation of resources, which could more effectively address the wider determinants of health and wellbeing.

Next steps and timeline

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- Confirm their place-based senior leadership teams and key delivery roles
- Continue to work with local authorities in their area on local priorities and build on what works
- Explore the governance options for place-based working set out in national guidance and develop a mutually agreed governance roadmap for place-based committees with delegated authority from the ICB
- Develop early proposals for consideration by the ICB and local authorities the autumn
- Shadow-running proposed arrangements from January onwards
- Review in March ahead of formal adoption of local governance arrangements by April 2023

Ongoing engagement

Our ICS will continue to evolve during this transition year and we would welcome your views on how we can improve our ways of working

Elected members can feed in their views as now via Health and Wellbeing Boards, local and sub-regional scrutiny committees and by contacting our teams directly or through their officers engaged with the development of these new arrangements; they will also play a key role on both on our

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meet in public

We will be communicating these changes to the public and how they will benefit our region throughout this year, and we will also continue to gather their views on local priorities for health and care.

Thank you