Stockton-on-Tees BOROUGH COUNCIL
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# Tees Valley Joint Health Scrutiny Committee

Agenda

**Date:** Friday 15 December 2023 at 10.00 am

**Venue:** Jim Cooke Conference Suite, Stockton Central Library, Stockton On Tees TS18 1TU

**Cllr Marc Besford (SBC) (Chair)**
**Cllr Rachel Creevy (HBC) (Vice-Chair)**

Cllr Jonathan Brash (HBC)
Cllr Christine Cooper (MC)
Cllr Lynn Hall (SBC)
Cllr Mary Layton (DBC)
Cllr Vera Rider (R&CBC)
Cllr Heather Scott (DBC)
Cllr Jeanette Walker (MC)
Cllr Ceri Cawley (R&CBC)
Cllr Brian Cowie (HBC)
Cllr Neil Johnson (DBC)
Cllr Paul McInnes (R&CBC)
Cllr Jan Ryles (MC)
Cllr Susan Scott (SBC)

## AGENDA

To consider a presentation on proposals for changes to non-surgical oncology services from representatives of NHS England and the Northern Cancer Alliance. (Pages 59 - 104)

**9 North East and North Cumbria Integrated Care Board - Tees Valley Winter Planning Update**

To consider the annual winter planning update from representatives of the North East and North Cumbria Integrated Care Board (NENC ICB). (Pages 105 - 118)

**10 Work Programme 2023-2024** (Pages 119 - 120)

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# Tees Valley Joint Health Scrutiny Committee

Agenda

**Members of the Public - Rights to Attend Meeting**

With the exception of any item identified above as containing exempt or confidential information under the Local Government Act 1972 Section 100A(4), members of the public are entitled to attend this meeting and/or have access to the agenda papers.

Persons wishing to obtain any further information on this meeting, including the opportunities available for any member of the public to speak at the meeting; or for details of access to the meeting for disabled people, please

Contact: Scrutiny Support Officer Rachel Harrison on email rachel.harrison@stockton.gov.uk

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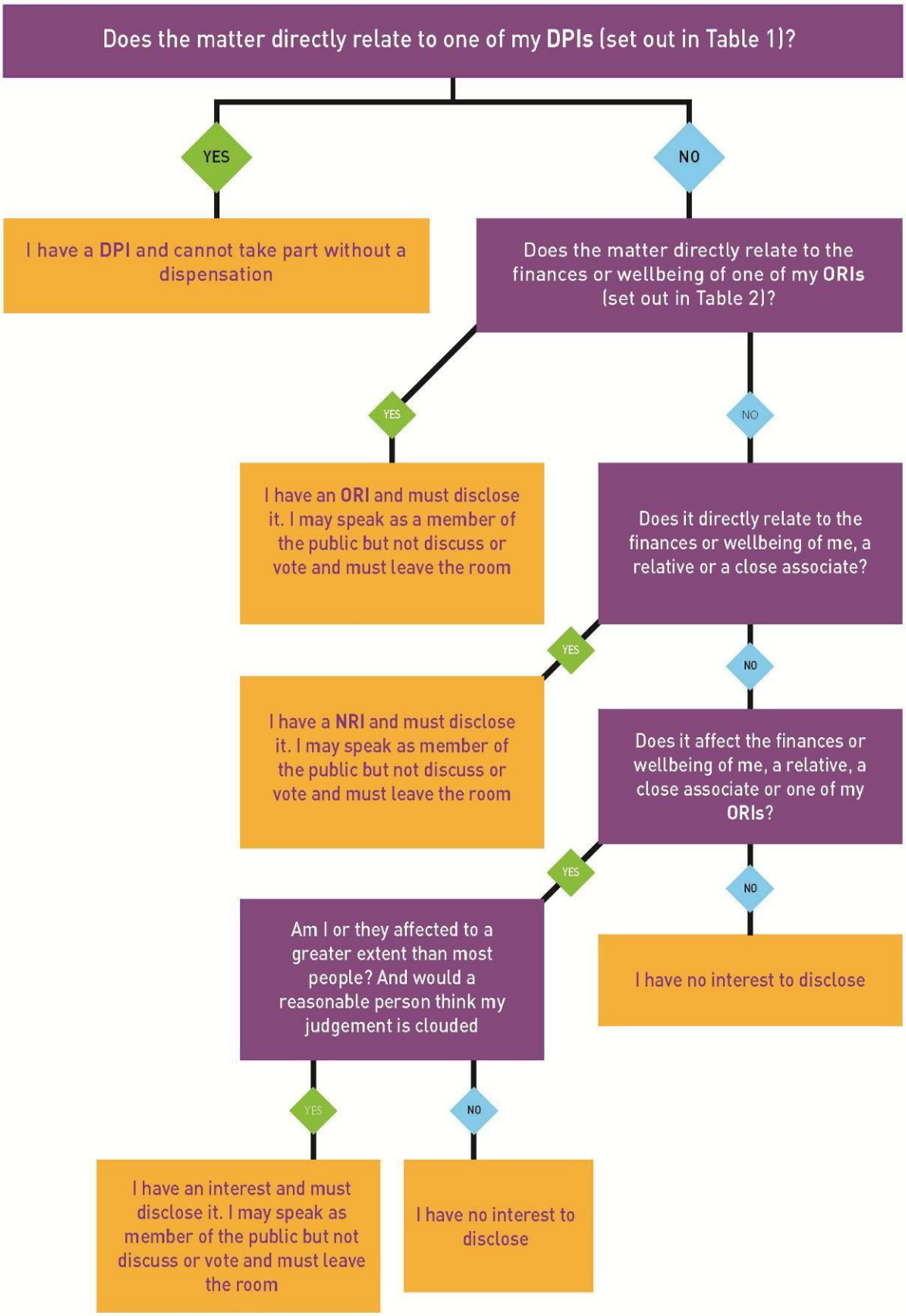
**KEY - Declarable interests are:-**

- Disclosable Pecuniary Interests (DPI's)
- Other Registerable Interests (ORI's)
- Non Registerable Interests (NRI's)

## Members – Declaration of Interest Guidance



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# Table 1 - Disclosable Pecuniary Interests

| Subject | Description |
|---|---|
| **Employment, office, trade, profession or vocation** | Any employment, office, trade, profession or vocation carried on for profit or gain |
| **Sponsorship** | Any payment or provision of any other financial benefit (other than from the council) made to the councillor during the previous 12-month period for expenses incurred by him/her in carrying out his/her duties as a councillor, or towards his/her election expenses.<br>This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992. |
| **Contracts** | Any contract made between the councillor or his/her spouse or civil partner or the person with whom the councillor is living as if they were spouses/civil partners (or a firm in which such person is a partner, or an incorporated body of which such person is a director* or<br><br>a body that such person has a beneficial interest in the securities of*) and the council —<br>(a) under which goods or services are to be provided or works are to be executed; and<br>(b) which has not been fully discharged. |
| **Land and property** | Any beneficial interest in land which is within the area of the council.<br>'Land' excludes an easement, servitude, interest or right in or over land which does not give the councillor or his/her spouse or civil partner or the person with whom the councillor is living as if they were spouses/ civil partners (alone or jointly with another) a right to occupy or to receive income. |
| **Licences** | Any licence (alone or jointly with others) to occupy land in the area of the council for a month or longer. |
| **Corporate tenancies** | Any tenancy where (to the councillor's knowledge)—<br>(a) the landlord is the council; and<br>(b) the tenant is a body that the councillor, or his/her spouse or civil partner or the person with whom the councillor is living as if they were spouses/ civil partners is a partner of or a director* of or has a beneficial interest in the securities* of. |
| **Securities** | Any beneficial interest in securities* of a body where—<br>(a) that body (to the councillor's knowledge) has a place of business or land in the area of the council; and<br>(b) either—<br>(i) the total nominal value of the securities* exceeds £25,000 or one hundredth of the total issued share capital of that body; or<br>(ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the councillor, or his/ her spouse or civil partner or the person with whom the councillor is living as if they were spouses/civil partners have a beneficial interest exceeds one hundredth of the total issued share capital of that class. |

* 'director' includes a member of the committee of management of an industrial and provident society.

* 'securities' means shares, debentures, debenture stock, loan stock, bonds, units of a collective investment scheme within the meaning of the Financial Services and Markets Act 2000 and other securities of any description, other than money deposited with a building society.

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## Table 2 – Other Registerable Interest

You must register as an Other Registrable Interest:

a) any unpaid directorships

b) any body of which you are a member or are in a position of general control or management and to which you are nominated or appointed by your authority

c) any body

(i) exercising functions of a public nature

(ii) directed to charitable purposes or

(iii) one of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union) of which you are a member or in a position of general control or management

**Jim Cooke Conference Suite, Stockton Central Library**
**Evacuation Procedure & Housekeeping**

If the fire or bomb alarm should sound please exit by the nearest emergency exit. The Fire alarm is a continuous ring and the Bomb alarm is the same as the fire alarm however it is an intermittent ring.

If the Fire Alarm rings exit through the nearest available emergency exit and form up in Municipal Buildings Car Park.

The assembly point for everyone if the Bomb alarm is sounded is the car park at the rear of Splash on Church Road.

The emergency exits are located via the doors between the 2 projector screens. The key coded emergency exit door will automatically disengage when the alarm sounds.

The Toilets are located on the Ground floor corridor of Municipal Buildings next to the emergency exit. Both the ladies and gents toilets are located on the right hand side.

**Microphones**

During the meeting, members of the Committee, and officers in attendance, will have access to a microphone. Please use the microphones, when directed to speak by the Chair, to ensure you are heard by the Committee.

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# Tees Valley Joint Health Scrutiny Committee

A meeting of the Tees Valley Joint Health Scrutiny Committee was held on Friday 28 July 2023.

**Present:** Cllr Marc Besford (SBC), Cllr Ceri Cawley (R&CBC), Cllr Christine Cooper (MC), Cllr Brian Cowie (HBC), Cllr Rachel Creevy (HBC), Cllr Mary Layton (DBC), Cllr Paul McInnes (R&CBC), Cllr Lynn Hall (SBC), Cllr Vera Rider (R&CBC), Cllr Jan Ryles (MC), Cllr Susan Scott (SBC)

**Officers:** Hannah Miller (DBC); Joan Stevens (HBC); Georgina Moore (MC); Sarah Connolly (R&CBC); Judy Trainer, Gary Woods (SBC)

**Also in attendance:** Richard Morris (County Durham and Darlington NHS Foundation Trust); Mark Cotton, Helen Ray (North East Ambulance Service NHS Foundation Trust); Craig Blair, Charlotte Bourke, Anna Williams (North East and North Cumbria Integrated Care Board); Ruth Dalton, Rowena Dean, Kevin Etherson, Phil Woolfall (North Tees and Hartlepool NHS Foundation Trust); Leigh Trimble (Red Balloons); Mike Carr, Stuart Finn, Simon Milburn (South Tees Hospitals NHS Foundation Trust); Catherine Wakeling (Starfish Health and Wellbeing); Mike Brierley, Belinda Brooks, Dominic Gardner, Chris Morton (Tees, Esk and Wear Valleys NHS Foundation Trust)

**Apologies:** Cllr Jonathan Brash (HBC), Cllr Neil Johnson (DBC), Cllr Heather Scott (DBC), Cllr Jeanette Walker (MC)

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| **1** | **Appointment of Chair for 2023-2024**<br><br>Nominations for the position of Committee Chair were put forward for Councillor Lynn Hall and for Councillor Marc Besford. Following a vote, Councillor Besford was appointed as Chair for the 2023-2024 municipal year.<br><br>AGREED that Councillor Marc Besford be appointed as Chair of the Tees Valley Joint Health Scrutiny Committee for 2023-2024. |
| **2** | **Appointment of Vice-Chair for 2023-2024**<br><br>A nomination for the position of Committee Vice-Chair was put forward for Councillor Rachel Creevy who was appointed for the 2023-2024 municipal year.<br><br>AGREED that Councillor Rachel Creevy be appointed as Vice-Chair of the Tees Valley Joint Health Scrutiny Committee for 2023-2024. |

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| **3** | **Evacuation Procedure**<br><br>The evacuation procedure was noted. |
| **4** | **Declarations of Interest**<br><br>There were no interests declared. |
| **5** | **Minutes of the meeting held on 16 December 2022**<br><br>Consideration was given to the minutes from the Committee meeting held on 16 December 2022.<br><br>AGREED that the minutes of the Committee meeting on 16 December 2022 be approved as a correct record. |
| **6** | **Notes of the meeting held on 17 March 2023**<br><br>Consideration was given to the notes from the Committee meeting (not quorate) held on 17 March 2023.<br><br>With reference to the *Update on NHS Dental Services – Tees Valley* item, Members highlighted the benefits associated with the school supervised toothbrushing programme and noted the discussion around the impact of water supply fluoridation.<br><br>AGREED that the record of the Committee meeting (not quorate) on 17 March 2023 be noted for information. |
| **7** | **Tees Valley Joint Health Scrutiny Committee – Protocol and Terms of Reference**<br><br>The Committee's existing protocol (including Terms of Reference) was considered. No changes were proposed.<br><br>AGREED that the existing protocol for the Tees Valley Joint Health Scrutiny Committee continues unchanged and is circulated for information to those organisations listed in paragraphs 2-6. |
| **8** | **Tees Valley Breast Care Services**<br><br>Consideration was given to an update on the continuing developments in relation to Tees Valley Breast Care Services. Following a brief introduction by the North East and North Cumbria Integrated Care Board (NENC ICB) Director of Place-Based Delivery, the North Tees and Hartlepool NHS Foundation Trust (NTHFT) Acting Chief Operating Officer, supported by managerial and clinical colleagues from both NTHFT and South Tees Hospitals NHS Foundation Trust (STHFT), gave a presentation (circulated in advance) which focused on the following:<br><br>➢ Breast Services Clinical Services Strategy<br>➢ Current screening population |

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| | ➢ Current breast screening provision<br>➢ Current breast symptomatic service provision<br>➢ Recap on work undertaken pre-pandemic<br>➢ Post-COVID recovery<br>➢ The challenges to delivery<br>➢ Current progress<br><br>During the presentation, officers emphasised the importance of understanding the difference between 'screening' and 'symptomatic' services. In terms of the Tees Valley, the screening service had a catchment population of 55,000 per annum and was provided by NTHFT via mobile vans or static sites. 50- to 70-year-olds were invited to a screening every three years and were asked to attend specific sites based upon their GP registration.<br><br>For symptomatic patients, treatment diagnostic and treatment was provided in Darlington (Memorial Hospital), Hartlepool (University Hospital) and Stockton (University Hospital of North Tees), with the latter two involving longstanding close clinical collaboration with STHFT. Required surgery following diagnosis was mostly provided at the patients' local hospital Trust sites.<br><br>Whilst breast screening was suspended nationally from June 2020 due to the emergence of COVID-19, the Tees Valley offer was the first in the North East to recommence its services (in July 2021), and the second to fully recover the backlog. Current waiting lists were now at pre-COVID levels.<br><br>As with many areas of health and care, workforce challenges within breast services remained prominent, and there had been a reliance on retire-and-return Consultant Radiologists. Consultant Radiographer practitioners were in place and there were a number of trainee practitioners continuing their qualification journey, but this ultimately takes time (five years training) before it can assist in relieving pressure on services. The current radiology workforce gap was outlined, as were the estate / equipment needs to provide one-stop provision at some spoke sites.<br><br>Several strands demonstrating progress in the development of services were outlined, including the introduction of a breast pain pathway which reduced reliance on the radiology workforce and could be delivered at pace without additional specialist equipment (anticipated 15% of future referrals could follow this pathway). The direction of travel through training is for future Consultant Breast Surgeons to no longer take part in emergency surgery on-call rota and thereby increase capacity for breast surgery. The commencement of planning for the procurement of a mammography machine for the James Cook University Hospital to support the re-introduction of surveillance mammograms on this site, as well as improved access for patients who can be offered immediate breast reconstruction free-flap surgery (specialist procedures undertaken at a tertiary site), was also noted.<br><br>The Committee queried how many men were invited to the screening service as breast cancer was known to affect males as well as females. Clinical representatives present stated that breast cancer was around 100 times less common in men than women, and that a screening programme for males could |

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| | not be justified due to these very low rates. However, assurance was given that men could be referred into the symptomatic service and would be treated in the same way as women were.<br><br>Referencing delays in diagnosis as a result of the COVID-19 pandemic, the Committee asked if this had had an impact on the severity of cases being seen within breast services. Officers felt that more time would be required to understand the effect of the pandemic as evidence would be determined to a large extent by survival times across a longer period (e.g. 5 years, 10 years, etc.). It was, however, acknowledged that services did have to prioritise during this period and that some individuals were put on medication to slow disease.<br><br>In relation to the stated workforce gaps, Members questioned if there was anything more that could be done / considered to help with staffing resources, and were informed that a business case had recently been approved to boost recruitment (including from overseas).<br><br>AGREED that the Tees Valley Breast Care Services update be noted. |
| **9** | **Tees Valley Community Diagnostic Centres**<br><br>The Committee received an update on the continuing developments in relation to Community Diagnostic Centres (CDCs) across the Tees Valley footprint. Introduced by the Tees Valley Community Diagnostics Programme Director and supported by senior clinical and operational leads / directors from County Durham and Darlington NHS Foundation Trust (CDDFT), NTHFT and STHFT, a presentation (circulated in advance) was given which focused on the following:<br><br>➢ Background<br>➢ What are they (CDCs)?<br>➢ Diagnostic centre locations<br>➢ Key facts and figures<br>➢ Engagement and involvement<br><br>A key driver behind the development of CDCs was the independent review of NHS diagnostics capacity undertaken by Professor Sir Mike Richards CBE. The final report included 24 recommendations which included a focus on capacity (equipment, staff) and the splitting of acute and diagnostic services (which can assist with improving the patient experience).<br><br>Whilst not solely about radiology, diagnostics enabled increased identification of cancers and other serious health conditions at an earlier stage. Pressure on most diagnostic services was already growing prior to the COVID-19 pandemic (e.g. demand for CT scanning was currently growing at around 7% per annum) – waiting times had therefore inevitably risen.<br><br>The Tees Valley CDC sites were outlined, with the intended CDC ‘hub’ within Stockton-on-Tees currently being developed on the former Castlegate shopping centre (a temporary mini-hub was operating from Lawson Street in Stockton). South Tees ‘spoke’ sites existed (and were continuing to be developed) in Redcar and at the Friarage Hospital, Northallerton, with the North Tees ‘spoke’ offer |

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| | nearing full capacity within Hartlepool. In terms of the CDDFT footprint, the ongoing service at Bishop Auckland had operated well (made easier due to the adaptation of an existing building) and was working alongside other Tees Valley sites in what was a real step-change to partnership-working across the region – a five-year plan was in place which differentiated between acute and diagnostic activity, with the Trust working to ensure an educational programme around access and utilisation of these services.<br><br>Officers spoke of the opportunity to put diagnostics on the footing it should have been on years ago, with ongoing developments seeking to deliver an additional 150,000 diagnostic tests annually across the Tees Valley from 2024-2025 (with further growth planned based on demand). However, it was emphasised that CDCs would operate on a 'referral only' basis (from primary and secondary care services), and that the public would need to be clear what the new Stockton 'hub' was and how it worked – it was not a drop-in centre, nor a hospital, but should instead be viewed as an additional imaging facility. In that regard, referral processes would continue into each service as they did now, therefore the service would manage where these referrals were seen based on capacity at the time of booking patients in.<br><br>Further detail around the construction and resourcing of the Tees Valley CDC sites was provided, and it was stated that the aim was for the new 'hub' in Stockton to be open by mid-2024 (earlier than the original estimate of April 2025). CDDFT had replaced all of its diagnostic equipment as a result of the funding for the CDC programme and COVID-related financing.<br><br>In terms of public engagement around the CDCs, officers welcomed the input of the Committee as to the best way to communicate the Tees Valley offer. Some engagement had already taken place with GPs (though it was acknowledged that this needed to go further as GPs had a critical role in educating patients on available options), and the ICB would also be an important partner in raising awareness of diagnostic capacity. Crucially, there was a need to ensure services were accessible, with considerations around transport routes / options and parking capabilities central to this. It was also hoped that the enhanced facilities would help attract new professionals to the area.<br><br>Reflecting on the content of the presentation, the Committee welcomed the significant developments around diagnostics across the Tees Valley (particularly the focus on health in the community), and commended NHS Trusts for working collaboratively to ensure the best possible offer. Clarity was then sought around the exact services which would be available within the Stockton 'hub' site – Members were informed that there would be a small number of consulting rooms in addition to the diagnostic capacity, but that the exact disciplines were yet to be determined (clinical colleagues would be approached for a view on how best to use these spaces).<br><br>Regarding diagnostic equipment, the Committee asked whether maintenance was outsourced or conducted in-house. Members heard that this was mainly done by the companies who supplied the equipment, though, outside this, medical departments also had a role to ensure these operated effectively. CDDFT had a contract with Philips which automatically replaced equipment every 7-9 years, and |

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| | had access to an external technician.<br><br>Discussion ensued around the key issue of accessibility, including the importance of Local Authorities working with NHS Trusts to facilitate adequate parking options, and the challenges associated with reduced bus provision. Members were assured that liaison with Councils over parking capacity had already been undertaken in order to maximise opportunities for patients to attend sites, and that the expansion of Patient Transport Services (PTS) was also being considered.<br><br>Continuing this theme, the Committee noted that there were some communities in Redcar and Cleveland which were not covered by PTS. Officers emphasised that it was pointless spending money on buildings / diagnostic equipment and then not enabling people to access them, and stated that any Member support in terms of linking-in with transport providers (e.g. Arriva) would be welcome.<br><br>Returning to the key issue of communications, the Committee asked if there was any specific funding earmarked for this critical element and heard that, whilst there was no formal budget, the collaborative nature of the CDC project meant that organisations were looking to pool their resources anyway. There was a big national agenda around diagnostics (and health inequalities) at present, and work had already been undertaken with regional media partners to make it clear what CDCs were and dispel any myths. Members cautioned against the use of the word 'hub' which, to some, may imply a drop-in feature – officers responded that this would be considered as part of future public engagement around the CDC offer (it was noted that the term 'hub' was used in order to allocate funding) and that a further update on CDC developments could be provided to the Committee at a future meeting if desired.<br><br>AGREED that the Tees Valley Community Diagnostic Centres update be noted. |
| **10** | **North East Ambulance Service NHS Foundation Trust – CQC Inspections / Independent Review**<br><br>Senior representatives of the North East Ambulance Service NHS Foundation Trust (NEAS) were invited to provide the Committee with a response to recent Care Quality Commission (CQC) inspections of its services, as well as the findings of an independent review of the Trust. Led by the NEAS Chief Executive Officer and supported by the NEAS Assistant Director – Communications and Engagement, a presentation (circulated in advance) was given which drew attention to the following:<br><br>➢ Latest CQC Position<br>➢ Improvement Plan Overview<br>➢ Workstream Actions Progress<br>➢ Progress on Medicines Management<br>➢ Progress on Incident Reporting<br>➢ Progress on Governance<br>➢ Progress on Culture<br>➢ Response Time Benchmark Performance (June 2023)<br>➢ Draft June 2023 Position<br>➢ Independent Review – NEAS Assurance Statement |

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| | It was stressed from the outset that NEAS had worked hard with the CQC to fully understand the concerns raised following the regulator's inspection of the Trust in July and September 2022 (published in February 2023). The CQC had subsequently re-visited the Trust and the individual grading for its Emergency and Urgent Care (EUC) services had since improved from 'inadequate' to 'requires improvement' (with the Section 29A warning notice lifted).<br><br>As part of the Trust's ongoing improvement plan, it was stated that two full cycles of audit over a timeframe of a year would be needed before there was sufficient confidence that actions undertaken as a result of the CQCs findings had become embedded into practice, and that independent auditing would be used to determine this. It was acknowledged that organisational culture can take time to change and even longer to embed.<br><br>Progress against the four identified workstream actions was detailed. Specific reference was made to developments around 'medicines management' and the ability for paramedics to collect required drugs from a location other than their base station, as well as the strengthening of 'incident reporting' which included the intended introduction of a new patient safety incident review framework by the end of 2023-2024 (NEAS being the first ambulance Trust to roll this out). In terms of 'culture', progress around this would be monitored through staff surveys.<br><br>Despite the challenges identified by the CQC, comparative data indicated that, for June 2023, NEAS was the best performing ambulance Trust in the country in relation to category 1 (an immediate response to a life-threatening condition, such as cardiac or respiratory arrest) response times, an achievement which led to positive clinical outcomes for patients. NEAS was working towards being the best for category 2 (a serious condition, such as stroke or chest pain, which may require rapid assessment and / or urgent transport) response times too, though this continued to be a struggle, with all Trusts above the national target (some others significantly so).<br><br>A brief background to events which culminated in a NHS England-commissioned independent review into patient safety concerns and governance processes related to NEAS was given. Following issues raised by a whistle-blower back in 2018 regarding coronial processes, the Trust commissioned a review which culminated in significant change – however, despite the regulators being satisfied with these developments, the Trust was unable to agree with the whistle-blower that enough had been done. NEAS acknowledged that it did not do the right thing by the families in question and had since publicly apologised.<br><br>Most of the recommendations emerging from the independent review were already being addressed (or had been completed) by NEAS prior to the publication of the report in July 2023. There were some additional areas of focus identified, though, including the medical examiners model, the constitution of a committee (to be independently chaired) to allow families to see changes made (the Trust welcomed this and would be in contact with families in the future), and enhanced Board processes to ensure learning had been achieved.<br><br>The Committee drew attention to cases where independent services were being |

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| | brought in to enhance the existing NEAS offer and queried whether Trust leaders had sufficient oversight of this. In response, Members were informed that the only external / consultancy support being used was in relation to the 'governance' workstream and that this was on a short-term basis.<br><br>Continuing with the theme of governance, the Committee sought further details on the NEAS executive management team buddying programme with directors from Northumbria Healthcare NHS Foundation Trust. Officers confirmed that support was being received for the benefit of the whole Trust, and that Northumbria had an excellent internal management programme which NEAS had been offered places on. Critically, this arrangement provided challenge to the executive.<br><br>With reference to the independent review outcomes, the Committee asked if progress on implementation of the recommendations would go back to the report author, Dame Marianne Griffiths DBE. Officers stated that ultimate responsibility sat with NHS England who commissioned the review, though a monthly quality improvement group that was co-chaired by NHS England and the North East and North Cumbria Integrated Care Board (NENC ICB) provided scrutiny of the Trust's response to the recommendations.<br><br>AGREED that the North East Ambulance Service NHS Foundation Trust update regarding recent CQC inspection / independent review outcomes be noted. |
| **11** | **Tees, Esk and Wear Valleys NHS Foundation Trust – Lived Experience Directors**<br><br>The Committee received a Lived Experience and Co-creation presentation (circulated in advance) from representatives of Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), which included an update on the work and impact of the Trust's Lived Experience Directors. Introduced by the TEWV Assistant Chief Executive, and supported by colleagues including the TEWV Lived Experience Director for Durham, Tees Valley and Forensics, content highlighted:<br><br>➢ TEWV Journey to Change – Progress<br>➢ The role of our Lived Experience Directors<br>➢ Durham, Tees Valley and Forensic Co-creation Board – Terms of Reference<br>➢ Co-creation Board – Overview / Early Action Areas<br>➢ Lived Experience Forums – Aims / Journey So Far / Future Plans<br><br>From the beginning, it was emphasised that a lived experience and co-creation focus was at the heart of everything which TEWV was doing, and that this approach was a crucial feature of the strategic and cultural shift within the Trust which began a couple of years ago (indeed, co-creation was one of the five key pillars identified).<br><br>Reflecting on a poor personal experience of past care and a subsequent desire to help others have more positive involvement with health services, the TEWV Lived Experience Director for Durham, Tees Valley and Forensics gave a brief outline of the role, a vital element of which was to check and challenge ongoing provision to ensure the patient voice was heard. Driving forward what patients / carers wanted to see was fundamental, though it was important to acknowledge that |

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| | TEWV were just one member of the overarching mental health offer, and that partnerships with other relevant organisations (e.g. Rollercoaster, Pioneering Care, etc.) were also significant.<br><br>A critical aspect of the Co-creation Board was around the concept of how people can challenge and speak to 'power' – to this end, membership included service-users, patients and carers, as well as TEWV staff. A host of aims and objectives were outlined, central to which was the creation of safe, informal creative spaces where people were equal, could speak openly and honestly, and could challenge the status quo.<br><br>Aided by representatives of two voluntary, community and social enterprise (VCSE) organisations, Red Balloons and Starfish Health and Wellbeing, an overview was given of Lived Experience Forums – collaborative platforms for using people's experience and knowledge to help services be the best they could be. With the intention of being independent from such services, seeking and enabling input from a wider cohort of voices also fed into the community transformation agenda.<br><br>Already established in Stockton and Hartlepool, work to ensure Forums were operational across the whole Tees Valley footprint continued. In addition, the recent Lived Experience Conference which took place in June 2023 was highlighted – a collaborative event which celebrated numerous Tees Valley organisations and used lived experience to inform future service delivery. From a TEWV perspective, listening and acting upon the work of the Forums represented an approach which went beyond the usual meaning of 'engagement' and was being adopted across all levels of the Trust.<br><br>The Committee was highly encouraged to hear of the work of the Lived Experience Forums and asked a number of questions around their composition and meetings. In response, Members were informed that anyone 16+ can attend and that for those who cannot physically be present, other mechanisms (emails, surveys, etc.) were used to connect individuals. There was also a dedicated lead for the younger Forum cohort as it was recognised that the usual adult model of connecting may not always be appropriate.<br><br>The value and importance of the Forums being independent from services was emphasised by the Committee who also queried where people were being referred from. Members heard that Red Balloons and Starfish Health and Wellbeing were linked-in with Catalyst (as the conduit for the wider VCSE sector), Stockton-on-Tees Borough Council (via an employee with lived experience) and TEWV (utilising a mailing list of around 200 individuals which information was relayed to) – a video had also been produced to highlight the Forums and invite input / attendance. TEWV officers noted that its Lived Experience Director was trying to be an enabler for the charities' endeavours and that the Trust wanted them to be involved in some programmed TEWV work too. The importance of connecting voices to wider mental health provision (not just TEWV) was emphasised, possibly via the new Tees Valley Integrated Care Partnership (ICP) 'place-based' group.<br><br>Involvement from Healthwatch into each of the Forums was noted, and it was |

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| | stated that should any individuals wish to lodge an official complaint to a service, Healthwatch was there to support / signpost. TEWV officers added that the Trust had partnered with Healthwatch for its community transformation work as it attempted to seek views from those who did not already access its offer.<br><br>Highlighting a case of a retired older person struggling to get mental health support, the Committee probed whether older adults were getting appropriate access to services and were having their voices heard. In response, it was confirmed that there was no upper age limit for involvement in the Forums and that older adult support was certainly available depending on an individual's circumstances. Members were encouraged to relay relevant details of any specific cases which could be followed-up outside of this meeting.<br><br>Finally, the Committee commended the Lived Experience Conference initiative and welcomed any feedback which could be provided on this annual event. It was stated that Members were very much welcome to future conferences, particularly those with lived experience themselves.<br><br>AGREED that the Tees, Esk and Wear Valleys NHS Foundation Trust update on Lived Experience and Co-creation be noted. |
| **12** | **Work Programme 2023-2024**<br><br>Consideration was given to the Committee's work programme for 2023-2024.<br><br>An accompanying report drew attention to both standing items and other topics which had been on the Committee's radar for some time under the 'to be scheduled' section. Meeting dates for the remainder of the municipal year had been identified and included for agreement, and a suggested outline of potential items for these meetings was proposed.<br><br>Highlighting the dentistry update that the Committee received at the last meeting in March 2023, and given the ongoing high-profile attention surrounding these services, Members felt this should again feature on the work programme at some point during the municipal year.<br><br>Discussion ensued around the possibility of holding hybrid Committee meetings which facilitated simultaneous in-person and remote attendance. It was noted that guidance on the hosting of meetings following the relaxation of COVID-19 social distancing measures in 2021 had been interpreted in differing ways by Councils, but that this Committee had returned to in-person formal meetings for some time now. Members subsequently expressed their preference for scrutinising organisations via a face-to-face approach, and felt that officers should be requested to physically attend as Members themselves are required to do.<br><br>AGREED that the Committee's work programme for 2023-2024 be noted and the proposed meeting dates for the remainder of the municipal year be approved. |

# Tees Valley Joint Health Scrutiny Committee

A meeting of the Tees Valley Joint Health Scrutiny Committee was held on Friday 6 October 2023.

**Present:** Cllr Marc Besford (SBC) (Chair), Cllr Rachel Creevy (HBC) (Vice-Chair), Cllr Ceri Cawley (R&CBC), Cllr Lynn Hall (SBC), Cllr Susan Scott (SBC)

**Officers:** Michael Conway (DBC); Gemma Jones (HBC); Georgina Moore (MC); Sarah Connolly (R&CBC); Gary Woods (SBC)

**Also in attendance:** Craig Blair, Peter Rooney (North East and North Cumbria Integrated Care Board); James Graham, Patrick Scott, Jamie Todd (Tees, Esk and Wear Valleys NHS Foundation Trust)

**Apologies:** Cllr Jonathan Brash (HBC), Cllr Neil Johnson (DBC), Cllr Mary Layton (DBC), Cllr Paul McInnes (R&CBC), Cllr Vera Rider (R&CBC), Cllr Jan Ryles (MC), Cllr Heather Scott (DBC)

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| **1** | **Evacuation Procedure**<br><br>The evacuation procedure was noted. |
| **2** | **Declarations of Interest**<br><br>There were no interests declared. |
| **3** | **Minutes**<br><br>Consideration was due to be given to the minutes from the Committee meeting held on 28 July 2023. However, approval of these minutes would need to be deferred to the next Committee meeting in December 2023 as attendance at this meeting was inquorate.<br><br>AGREED that consideration of the minutes of the Committee meeting on 28 July 2023 be deferred until the next Committee meeting in December 2023. |
| **4** | **North East and North Cumbria Integrated Care Strategy / Joint Forward Plan**<br><br>The Committee received a presentation on the implementation of the North East and North Cumbria Integrated Care Strategy and associated Joint Forward Plan |

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| | (included within the papers). Led by the North East and North Cumbria Integrated Care Board (NENC ICB) Director of Strategy and Planning, and supported by the NENC ICB Director of Place Based Delivery (In-Hospital Care), key aspects included:<br><br>➢ Process: Developing the Joint Forward Plan<br>o National Guidance<br>o NHS Plan aligned to our Partnerships<br>o How the Plans fit together<br>o Process and Timeline<br>o Feedback<br>➢ Content: Sections of the Joint Forward Plan<br>o North East and North Cumbria Plan<br>o Service Action Plans<br>o Enabler Action Plans<br>o Place Action Plans<br>➢ Tees Valley Priorities and Strategic Context<br>➢ March 2024 Refresh<br><br>As per national guidance, the overarching purpose of the Joint Forward Plan (JFP) was to demonstrate how the ICB and its associated NHS Trusts would arrange and / or provide NHS services across the totality of healthcare. Allied to this, it would need to show how legal requirements for the ICB would be met, as well as support the delivery of the NHS Mandate and NHS Long-Term Plan across its footprint (the latter of which would end during the five-year period covered by the JFP (2023/24-2028/29) and would require a refresh).<br><br>The medium-term JFP sits between the 10-year partnership-based Integrated Care Strategy (focusing on population health), and the annual NHS Operating Plan (focusing on NHS activity, finance, performance, and workforce). It comprises a host of detailed Action Plans and acts as a summary document. The timeline for its construction was outlined, including opportunities for stakeholder feedback (which was widely encouraged, properly considered, and sometimes acted upon within the context of varying and occasionally directly opposing views). The final version was approved at last week's ICB meeting, and there were plans for an easy-read document given its existing detail and length. An annual update would take place each March (though maintaining the five-year horizon), and the ICB would seek input from the public, service-users, families / carers, Elected Members, partners, etc., at any point in time.<br><br>Feedback received on the proposed content of the JFP revealed several themes. Ensuring the appropriate use of language (to aid readability and avoid stigmatisation) was a key element, as was the need for clarity around the plan's objectives (including measurable indicators). Balancing local focus within a North East and North Cumbria footprint was always likely to be a challenge given the large geographic area the plan covers, though health and care issues were often replicated across numerous different locations.<br><br>Reflecting the system-wide priorities established through the NENC Integrated Care Partnership (ICP) *Better health and wellbeing for all* strategy, the JFP comprised fifteen service Action Plans which now included trauma-informed |

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| | services (not originally within the draft version) as well as women's health (acknowledging that provision was not always right for all women and recognising the national women's health strategy). Underpinning progress on these fifteen topics were several 'enabler' Action Plans concerning aspects such as workforce, finance, data and digital, estates, and environmental sustainability.<br><br>From a sub-regional perspective, Tees Valley priorities were outlined, though it was noted that even this smaller part of the overall North East and North Cumbria coverage was made up of a collection of five Local Authority areas each with its own characteristics (common themes did, however, exist, some of which could be viewed as unique to Tees Valley). Recognising the need for strong alignment with Health and Wellbeing Boards, five Tees Valley pillars that supported delivery of organisational, place and system plans had been identified – prevention; admission avoidance and hospital discharge (keeping hospitals / urgent care settings available for those who really need them); mental health, learning disabilities and autism (across all age bands); reducing health inequalities; and sustainability. Ultimately, health promotion and prevention should be at the root of everything services do.<br><br>Mindful of the JFPs annual March refresh, the NENC ICB had already identified required improvements in relation to clearer implementation of its content, as well as greater acknowledgement of the voluntary, community and social enterprise (VCSE) sector which plays such an important role in supporting health and care provision. Specific focus on general practice (GPs seeing more people than ever yet still the public continue to raise concerns about access), long-term conditions, and dementia (better clarity over future plans) would also feature. Recognition of anticipated changes to ICB resourcing (not to actual healthcare spend, though) would also be factored in.<br><br>Committee comments / questions centred predominantly on the JFPs service Action Plans. In response to a Member query around women's health, it was confirmed that there was already a specific piece on maternity matters within the 'best start in life' section of the plan (part of which was an attempt to drive improvements around pre-birth mental health for both mothers and fathers). For the autism strand, Members expressed a wish to see more autistic-friendly organisations and greater awareness of this condition – officers acknowledged the need for services that can serve all people by making any reasonable adjustments to its existing offer in the context of ongoing resource / demand challenges. With reference to the trauma-informed element of the plan, the Committee felt that numerous organisations needed to be involved in developing this aspect, not just Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), with officers adding that it was the ICBs desire for all healthcare services and their staff to have a basic awareness of trauma so individuals were less likely to experience further negative responses to a previous event.<br><br>Ensuring relevance for local areas within an overarching plan, and the inclusion of measurable targets, was debated, with the Committee also emphasising that aspects of good practice within a certain location should be shared on a wider North East and North Cumbria level. Officers described the national context which impacted upon regional planning, with NHS England publishing its operating framework each year setting out key requirements for the whole sector |

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| | which ICBs then needed to adjust to (including any financial repercussions) – the NHS Long-Term Plan also needed to be taken into consideration. Regarding targets, there were measurables within individual Action Plans that were not reflected within the JFP – the ICB was considering how it could best represent these as part of future versions. As for the dissemination of good practice, the ICB Learning Board enables the sharing of ideas and experiences, with a recent example being the standardisation of specifications for the urgent care offer (a key reason why North Tees and Hartlepool NHS Foundation Trust performs well compared to other NHS Trusts).<br><br>Welcoming the emphasis on partnerships and the inclusion of Tees Valley-specific priorities, Members noted the additional pressures that could be created as a result of good performance as services are asked to support similar functions outside their organisation. Officers stated that there were situations where this would occur, and that the ICB was trying to meet demand in the best way possible within the context of a restrictive workforce. In response, the Committee highlighted the value of the voluntary sector in providing additional support to statutory services, with numerous newly retired people willing to give their time – further developing VCSE relationships to assist with the overarching health and care offer should therefore be a key part of future planning.<br><br>Commenting on the expected focus on general practice as part of the JFP 2024 refresh, the Committee noted the ability for female patients to request to see a female GP and highlighted instances where a male patient had experienced difficulties requesting an appointment with a male GP. Officers were happy to follow-up specific cases outside this meeting, though confirmed that gender preference should be offered to patients.<br><br>AGREED that the North East and North Cumbria Integrated Care Strategy / Joint Forward Plan update be noted. |
| **5** | **Tees, Esk and Wear Valleys NHS Foundation Trust - CAMHS Update**<br><br>Consideration was given to an update on the current situation regarding the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) Child and Adolescent Mental Health Services (CAMHS). Presented by the TEWV CAMHS Head of Service, and supported by the TEWV Managing Director – Durham, Tees Valley and Forensic Care Group and Deputy Chief Executive, content in relation to children and young people services was as follows:<br><br>• Within the context of TEWVs previous Care Quality Commission (CQC) inspection outcomes and the issues this had raised (waiting lists, processes to manage risk, etc.), the five key areas of focus were outlined:<br><br>o Waits: including what to do whilst waiting.<br>o Staffing: vital issue, with a significant pressure area around Consultant Psychiatrists; realigning budgets; looking at skills mix and working with medical leadership to address gaps.<br>o Caseload / caseload management: constantly reviewing; size of caseloads was previously flagged by the CQC – this had since been addressed.<br>o Training: do this in partnership with acute Trusts and the voluntary sector |

(e.g. Oliver McGowan training).
- Community Transformation: strong partnership arrangements within Tees Valley – helps to deliver services in different ways.

Work to develop the service and address concerns raised by the CQC had continued, and it was hoped that improvements made would be reflected when the CQC next inspects.

- The iThrive framework was explained, with the broad expectation that around 80% of those approaching CAMHS will only require advice to continue 'thriving'. Of the remaining 20%, around two-thirds to three-quarters would require focused goals-based input (e.g. low-intensity cognitive behavioural therapy (CBT)), with the rest being split between either those who need more extensive and specialised goals-based help, and those who have not benefitted from or are unable to use help, but are of such a risk that they are still in contact with services.

- Despite ongoing challenges, TEWVs 'Getting Help' and 'Getting More Help' teams compared favourably with national benchmarks, the Specialist Eating Disorders team was consistently compliant with national access standards, and Crisis and Intensive Home Therapy teams performed consistently well with high call handling rates and compliance with the four-hour response requirement for urgent referrals (both typically 90-96%). The Committee was reminded that TEWVs in-patient CAMHS provision within the Tees Valley region had ceased and was instead being provided by another Trust at the old West Lane Hospital, Middlesbrough site. However, TEWV was still jointly responsible for overseeing / managing the crisis pathway.

- There was a key pressure around neurodevelopmental assessments (autism and ADHD), demand for which had significantly increased since the emergence and impact of COVID. Assessment completed today had waited 18 months to two years, and the waiting list continued to grow. This was a national issue and was an area of focus for the Trust as part of whole-system planning and ICB commissioning.

- Several elements in the ongoing management and delivery of services were highlighted, including the Trust's 'Keeping in Touch (KIT)' process (which helps mitigate any risks associated with those waiting to access the existing offer), the impact of a young person's Engagement Lead to drive the co-production of care delivery and service development (linking-in with all teams to embed good practice and ensure appropriate engagement with / input of young people), and positive examples of joint-working with Local Authorities (e.g. involvement with family / multi-agency hubs, including an area of focus on perinatal mental health). The roll-out of Primary Care Network (PCN) practitioners to support general practices with the mental health and wellbeing of young people was also noted, as were schools-based Mental Health Support Teams (MHSTs) which were delivered by voluntary, community and social enterprise (VCSE) organisations (unique to Tees Valley) who already had contacts / relationships with schools.

- Transformation plans were relayed, with the intended expansion of MHSTs

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| | and whole-system offer across Teesside, support with family hubs, recovery plans in relation to the neurodevelopmental pathway, and development of the 'Getting More Help' element to better manage expectations and meet demand. The Trust was also looking at smarter ways of working to help with recruitment (e.g. virtual clinic model).<br><br>Reference was also made to an additional 'benchmarks and performance data' paper which included response times for the Crisis service from September 2022 to August 2023 (demonstrating significant improvement in the percentage of patients seen face-to-face within four hours by a suitably trained practitioner), and single point of contact (SPOC – the team receiving the initial call for help) demand with regards referrals and caseloads (April 2022 to July 2023), and access and waiting times (May 2022 to October 2023). It was emphasised that some areas in the UK only accepted referrals to CAMHS from professionals – for TEWV, an open referral process was in operation (which therefore impacts upon volume).<br><br>The supplementary performance document highlighted the number of young people awaiting assessment per individual CAMHS team across the Tees Valley, though it was acknowledged that there were some data quality issues which needed to be addressed – assurance was provided that each team had a patient tracker list (as part of the KIT process) which was continually checked and followed up on. Information was also given on CAMHS Eating Disorders which showed the percentage of children and young people (routine cases) waiting four weeks or less (as per National Institute for Health and Care Excellence (NICE) guidelines) from referral to the start of treatment from April 2021 to August 2023. For urgent cases, issues with the data prohibited inclusion and were being addressed internally to get an accurate picture of compliance with NICE advice (within one week from first contact to start of treatment).<br><br>In response to TEWVs update, the Committee began by welcoming progress on the support provided via the SPOC, though raised the continuing need to break down barriers for those struggling to access services. Members acknowledged pre-COVID pressures which had been exacerbated by the pandemic, and heard that referrals for core services had broadly plateaued, whilst demand for specialist autism / ADHD element had surged.<br><br>Whilst praising TEWVs engagement with partners, the Committee encouraged connectivity with children's charities in terms of service development to ensure the voice of young people was at the forefront of future planning. Subsequent confirmation that TEWV already included HeadStart within its partnership groups was welcomed.<br><br>A question was raised around out-of-hours access and how this was currently being managed / delivered. TEWV confirmed that a bespoke approach to this aspect of the service was in place at present, and that additional slots were made available during peak times. The MHST also supported the alleviation of potential issues (though was not in every school – TEWV subsequently agreed to provide further details on the existing MHST offer), and it was the ambition to get full MHST coverage across the whole of the Tees Valley, though this would likely take time due to resource limitations. |

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| | The Committee noted the statistics around eating disorders and also drew attention to the need for services to be mindful of increases in self-harm incidents which could often be hidden (though, in some cases, was becoming more obvious). TEWV officers commented that it was not possible to funnel all young people into specialist services, and that partners across the health and care system needed to keep working together to lessen the likelihood of individuals getting to a point where they harm themselves.<br><br>AGREED that:<br><br>1) the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) CAMHS update be noted.<br><br>2) further information be provided by TEWV as requested by the Committee. |
| **6** | **Tees, Esk and Wear Valleys NHS Foundation Trust - Adult Learning Disability Respite Services Update**<br><br>Consideration was given to an update on the current situation regarding the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) adult learning disability respite provision. Led by TEWVs Durham, Tees Valley and Forensic Care Group Director of Operations & Transformation (CAMHS & LD), and supported by the TEWV Managing Director – Durham, Tees Valley and Forensic Care Group and Deputy Chief Executive, past and current context was noted as follows:<br><br>• TEWV is commissioned to provide adult learning disability (ALD) respite services for the population of Teesside from two sites – Asgarth (Durham Road, Stockton – 6 beds) and Bankfields Court (Middlesbrough – 5 beds).<br><br>• As previously noted during the last update to the Committee (December 2021), in 2019, the Care Quality Commission (CQC) identified that these facilities did not meet Mixed Sex Accommodation (MSA) guidance – action was undertaken to comply with requirements, a by-product of which was a reduction in the number of days families were able to access services.<br><br>• In 2020, a project steering group completed a comprehensive review of delivery models and building options. This work was paused due to the pandemic but restarted recently upon the appointment of a new director and general manager in ALD services – this included engagement with families, around 70 of which access this offer.<br><br>• The estate is a significant challenge, with both buildings remaining in poor condition due to age.<br><br>The Committee was then informed of TEWVs vision for these services, the longer-term aim being to provide creative health and social care options that are responsive, with fair and equitable access, reflective of the evolving needs of the population, and go beyond a solely bed-based service. Recent developments towards this goal included the re-opening of conversations with stakeholders systemwide (including Local Authorities across Teesside and the NENC ICB) to explore new models of sustainable respite provision across ALD in Teesside, |

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| | engaging with regulators to inform registration requirements linked to 'Right Care, Right Support, Right Culture', and the September 2023 appointment of a Programme Lead for transforming TEWVs ALD bed model. Officers provided assurance that TEWV remained in regular contact with families regarding the existing situation and fully recognised the profound disabilities of those accessing its services.<br><br>Members responded by requesting clarification around whether the number of beds available at the two sites had reduced – officers agreed to confirm any recent changes following this meeting.<br><br>Reflecting on the existing offer, the Committee noted that some may misguidedly view the service as a hospital, and questioned if TEWV was proposing that respite provision should be delivered by social care partners. Drawing attention to the regulatory requirement on TEWV to provide a certain level of service based on the licence it holds, officers confirmed that nothing was being ruled out in terms of future delivery options, though providing the best support for families would remain the priority. Potential alternatives to the existing offer would need to be worked through with partners as part of a broader conversation on ALD services, and assurance was given that TEWV was not attempting to offload this element despite previous regulatory challenges.<br><br>Referencing the systemwide-focus, the Committee welcomed the broader engagement with, and by, partners. However, there remained an issue with those leaving education who were, along with their families, at risk of feeling alone without the appropriate support in place as they moved into adult services. Officers stated that challenges around transition were very much recognised and an area which required improvement – TEWV would be working on this with the NENC ICB and other partners. Developing other models of support away from the bed-based-only offer may help with making the service more accessible to those transitioning into adult provision.<br><br>Emphasising the value of the respite offer for families and thanking those who cared for their loved ones (in turn, saving health and care organisations significant money), the Committee asked if services were flexible enough to meet the needs of those accessing them. TEWV reiterated its continuing close engagement with families who were not giving any indication of a lack of flexibility regarding access, highlighting the positive feedback it had received via the Friends and Family Test, as well as the soon-to-be-restarted service-user group. In addition, a Lived-Experience Lead had been brought into the ALD service to aid developments. Opportunities for families to submit their views were also promoted via a regular newsletter – the Committee subsequently requested a recently issued example of this communication.<br><br>AGREED that:<br><br>1) the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) adult learning disability respite provision update be noted.<br><br>2) further information be provided by TEWV as requested by the Committee. |

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| **7** | **Work Programme 2023-2024**<br><br>Consideration was given to the Committee's work programme for 2023-2024.<br><br>Discussion ensued around the potential agenda for the next Committee meeting on 15 December 2023. It was agreed to retain the intended items on winter planning, strategic options for non-surgical oncology, and community water fluoridation, as well as add an update on NHS dentistry (to complement the latter). The North East Ambulance Service NHS Foundation Trust (NEAS) and Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) performance updates would instead be requested as part of the two Trusts Quality Account submissions at the Committee meeting scheduled for March 2024.<br><br>Reference was also made to the list of 'To be scheduled' items included within the work programme document. Members discussed potential options for covering these issues either as part of a formal Committee meeting or outside these quarterly dates via informal sessions / email updates.<br><br>AGREED that the Committee's work programme for 2023-2024 be noted. |

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# Agenda Item 6

**Agenda Item**

**Tees Valley Joint Health Scrutiny Committee**

**15 December 2023**

## OFFICE FOR HEALTH IMPROVEMENT & DISPARITIES: COMMUNITY WATER FLUORIDATION

### Summary

The Committee will receive an update on plans for community water fluoridation for the North East of England.

### Detail

1. Following a meeting of Tees Valley Directors of Public Health, an approach was made in August 2023 requesting that a briefing on community water fluoridation be given to the Committee.

2. The Office for Health Improvement & Disparities (OHID) Regional Director and NHS Regional Director of Public Health (North East & Yorkshire) is scheduled to be in attendance to provide this update, and will be supported by the Consultant in Dental Public Health, NHS England (North East & Yorkshire). A presentation has been prepared and can be found at **Appendix 1**.

3. For further background reading, a policy paper was published by the Department of Health and Social Care (updated 10 March 2022) in relation to water fluoridation within the context of the new Health and Care Bill. This paper covers evidence of benefit, evidence of potential harm, the impact of the Bill on this scheme, and how these provisions will help to improve public health. Please see the following link:

    - https://www.gov.uk/government/publications/health-and-care-bill-factsheets/health-and-care-bill-water-fluoridation

4. There is also a dedicated 'Fluoride' page on the NHS website which includes commentary on community water fluoridation as well as research on such schemes. Further details can be accessed at the following link:

    - https://www.nhs.uk/conditions/fluoride/

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Office for Health Improvement & Disparities

APPENDIX 1

# Update on plans for community water fluoridation for the North East of England

**Tees Valley Health Scrutiny Committee 15th December 2023**

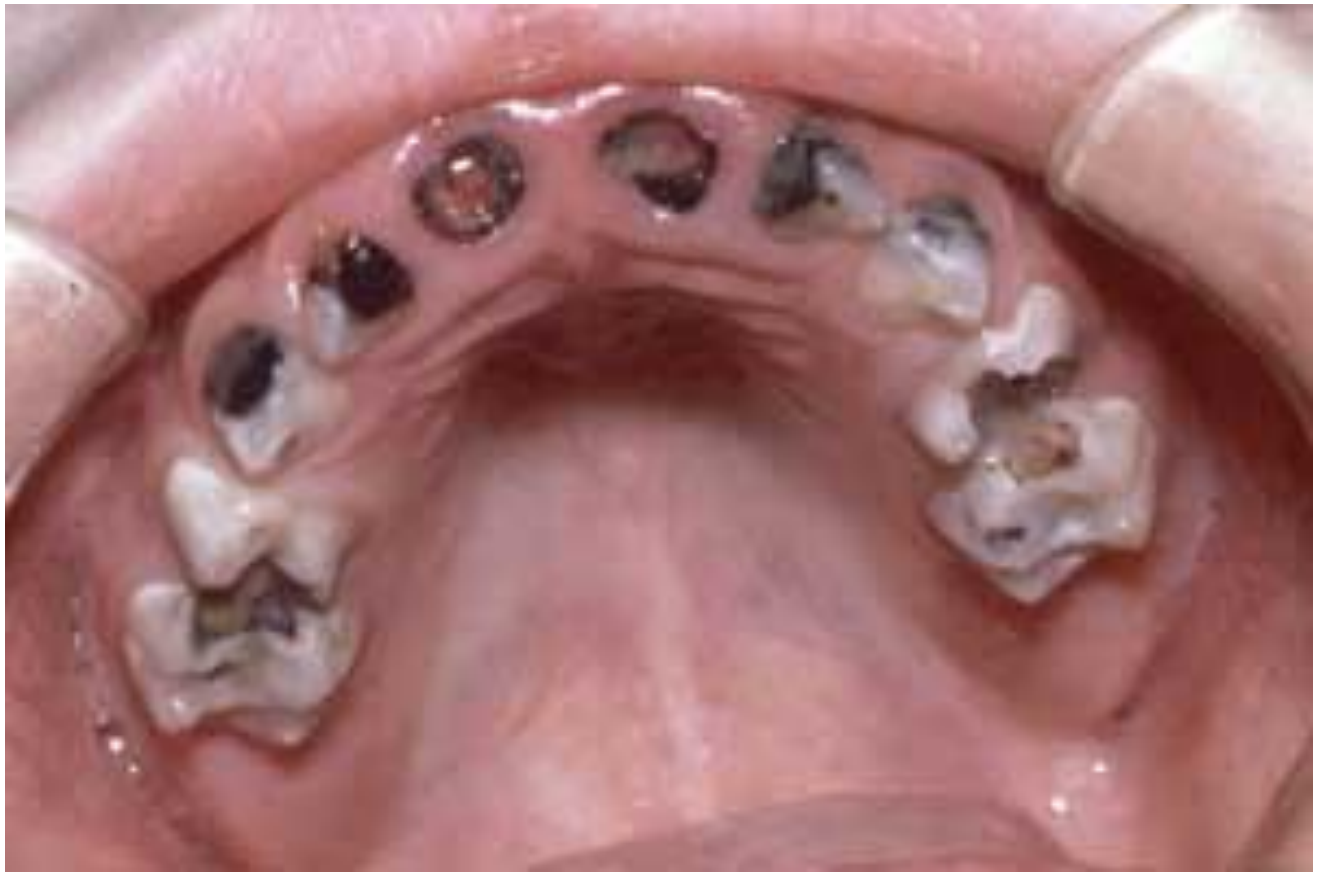
Professor Peter Kelly CBE
OHID Regional Director and NHS Regional Director of Public Health NE&Yorks

Dr Kamini Shah
Dental Public Health Consultant, NHSE, NE&Yorks

# • Outline of current status

- **The government supports the expansion of community water fluoridation across the North East**
- **The North East will be the first to use the new arrangements brought in by the Health & Care Act 2022, which transferred powers to the Secretary of State**
- **Statutory 12 week consultation is currently being developed. Subsequent decision-making will continue through 2024 before any consequential implementation.**
- **DHSC must write to all affected local authorities to notify them of the proposal**
- **Final decision making by the Secretary of State**

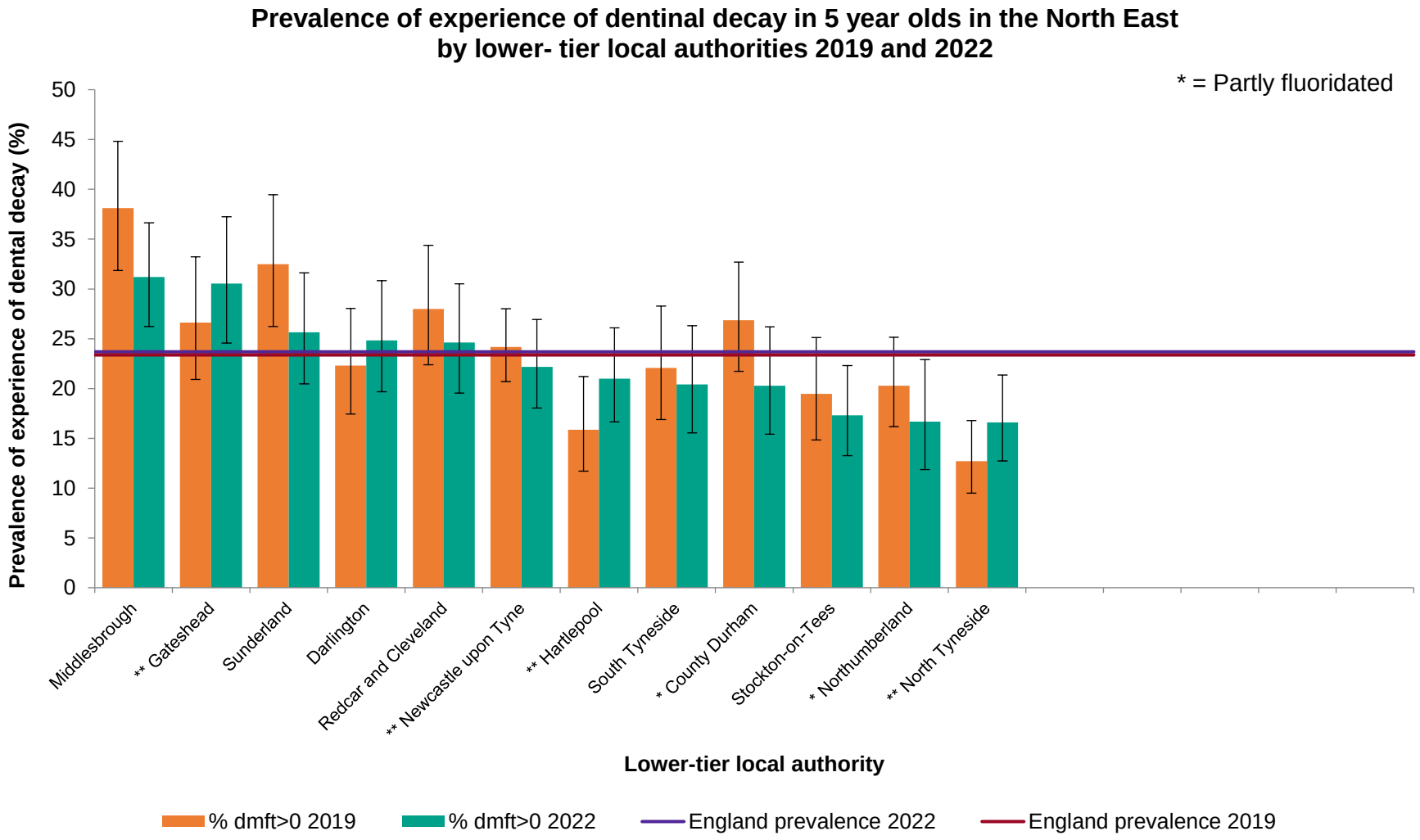
- **Capital and revenue costs will be the responsibility of DHSC**

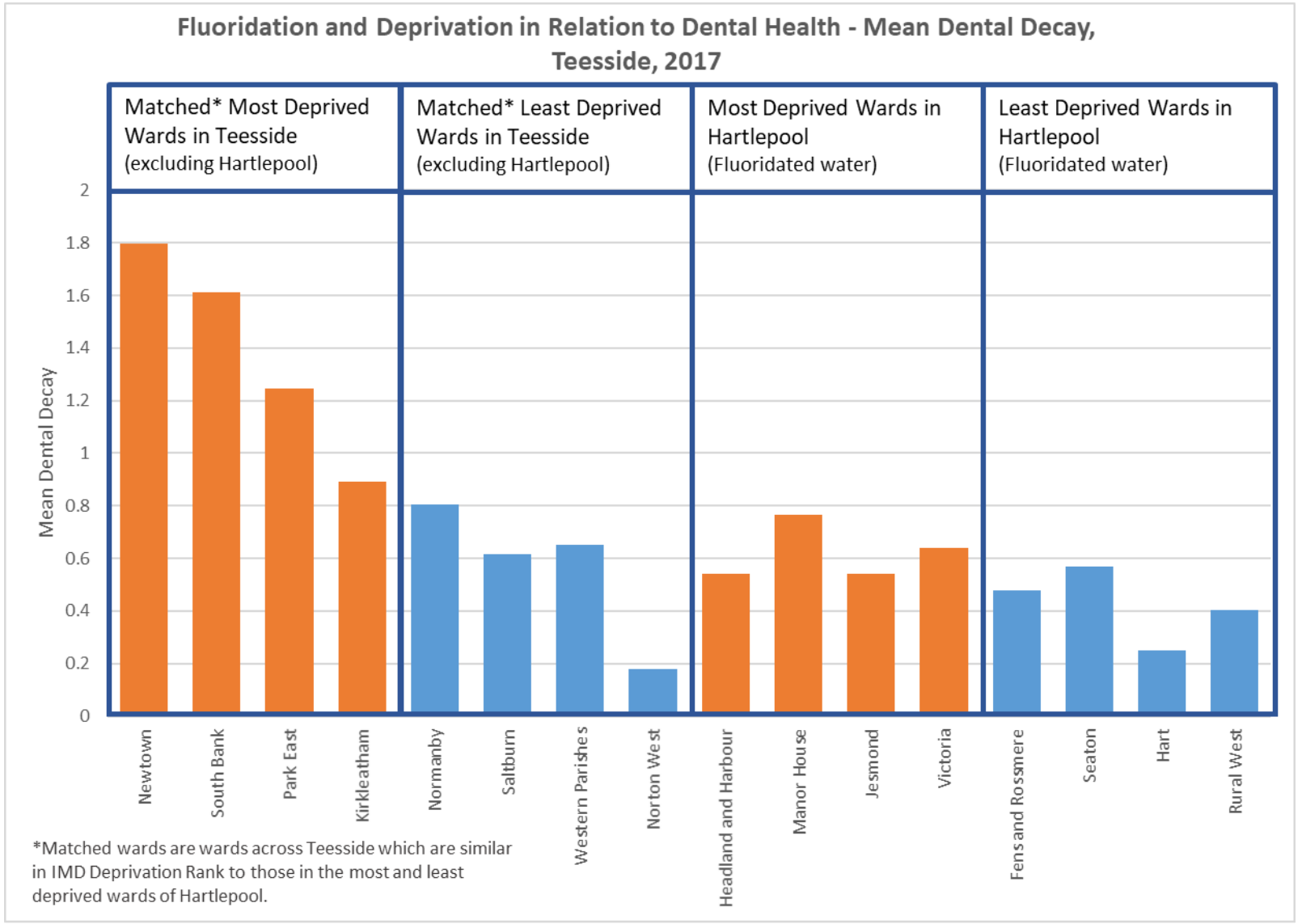


Acknowledgements: healthy teeth.org

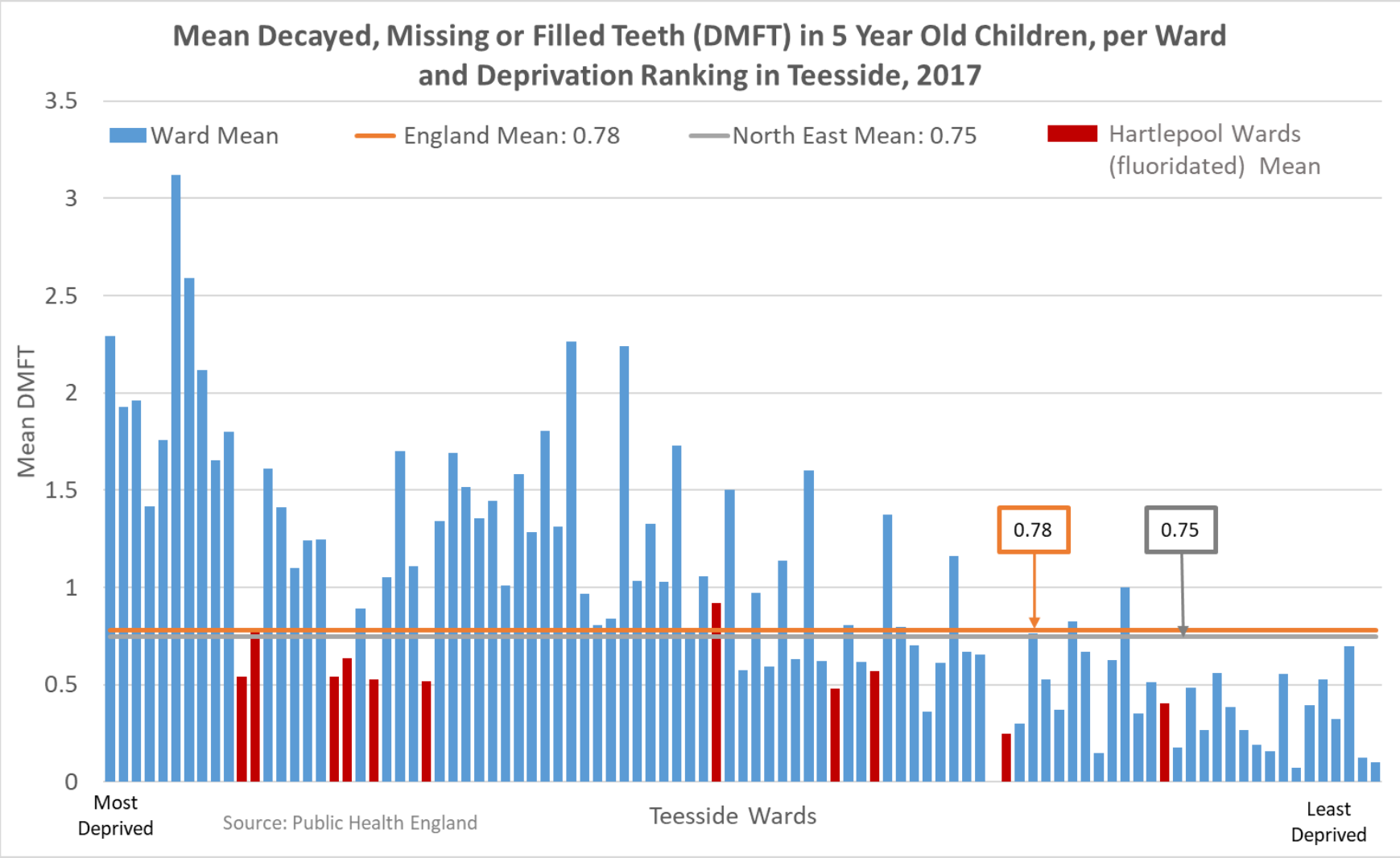
Acknowledgements: nytimes.com

# Oral Health across Tees Valley 2019-2022




Fluoridation and Deprivation in Relation to Dental Health - Mean Dental Decay, Teesside, 2017
Matched* Most Deprived Wards in Teesside (excluding Hartlepool)
Matched* Least Deprived Wards in Teesside (excluding Hartlepool)
Most Deprived Wards in Hartlepool (Fluoridated water)
Least Deprived Wards in Hartlepool (Fluoridated water)
Mean Dental Decay
2
1.8
1.6
1.4
1.2
1
0.8
0.6
0.4
0.2
0
Newtown
South Bank
Park East
Kirkleatham
Normanby
Saltburn
Western Parishes
Norton West
Headland and Harbour
Manor House
Jesmond
Victoria
Fens and Rossmere
Seaton
Hart
Rural West
*Matched wards are wards across Teesside which are similar in IMD Deprivation Rank to those in the most and least deprived wards of Hartlepool.

# Significant Inequalities across LAs



# General Anaesthetic (GA): Numbers and Rates (22/23)

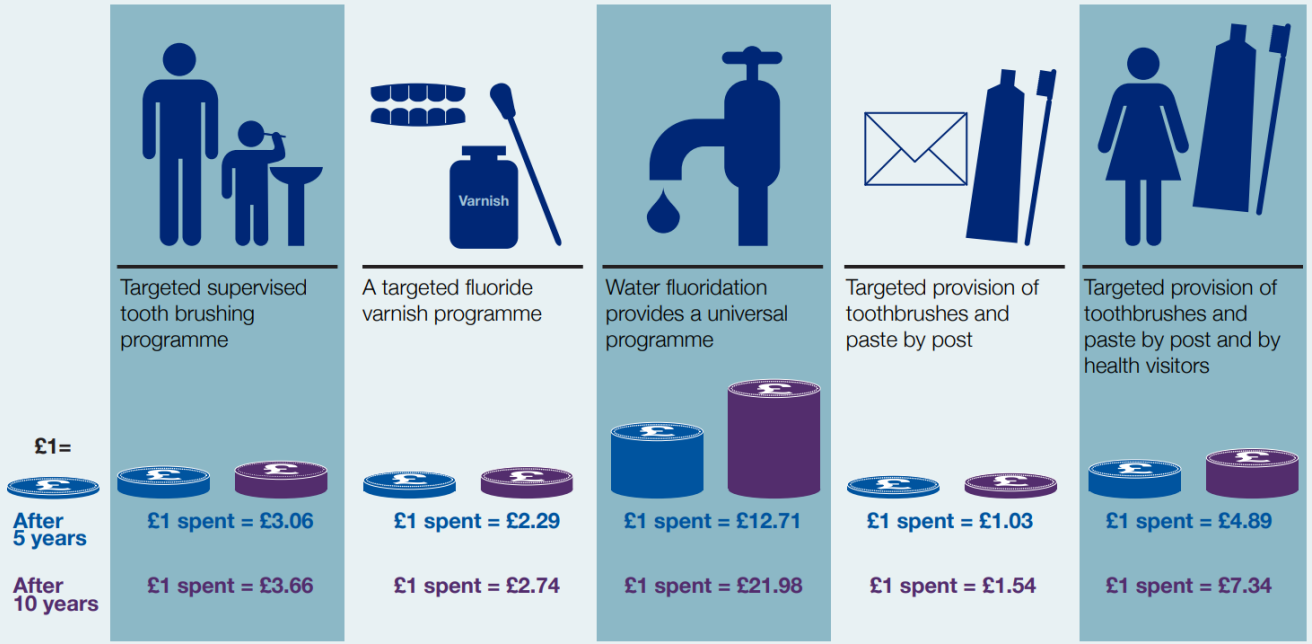
| Local Authority | GA Numbers (22/23) Children | GA rates per 1,000 children |
|---|---|---|
| Hartlepool | 25 | 1.15 |
| Stockton-on-Tees | 92 | 1.97 |
| Middlesbrough | 137 | 3.72 |
| Redcar and Cleveland | 46 | 1.5 |
| Darlington | 128 | 5.46 |

# Evidence-based interventions to improve oral health

Public Health England

## Return on investment of oral health improvement programmes for 0-5 year olds*

Reviews of clinical effectiveness by NICE (PH55) and PHE (Commissioning Better Oral Health for Children and Young People, 2014) have found that the following programmes effectively reduced tooth decay in 5 year olds:




*All targeted programmes modelled on population decayed, missing or filled teeth (dmft) index of 2, and universal programme on dmft for England of 0.8. The modelling has used the PHE Return on Investment Tool for oral health interventions (PHE, 2016). The best available evidence has been used in this tool and where assumptions are made these have been clearly stated

PHE Publications gateway number: 2016321

# Consultation narrative



**What are we doing?**

- The Government wants to expand water fluoridation across the north east of England to reach an additional 1.6 million people.
- This is subject to public consultation and due to start by the end of 2023.
- We are working with Northumbrian Water Ltd on a possible scheme that is feasible and affordable.
- Some areas in the north east are already covered by water fluoridation scheme since.  This scheme would cover Northumberland, County Durham, Sunderland, South Tyneside and Teesside, including Redcar and Cleveland, Stockton-on-Tees, Middlesbrough and Darlington

**Why are we doing it?**

- Tooth decay is largely preventable. However, it remains a serious health problem
- In the region [details of oral health need / health improvement focus].
- Water fluoridation is an effective and safe public health measure.
- Fluoride in water can reduce the likelihood of experiencing dental decay and minimise its severity.
- The effect of fluoridation on hospital admissions to have teeth extracted is substantial
- The impact is greatest for those areas with higher health needs and can reduce this inequality, especially with regard to children living in the most disadvantaged circumstances

**What are our aims and next steps?**

- The government has the power to introduce water fluoridation schemes subject to consultation.
- This process is not a referendum.
- It is a chance to provide more detail on the proposal, the areas affected and give people the opportunity to respond to it.
- The consultation will run for at least 12 weeks.
- After this, ministers will take final decisions on whether to proceed.
- We are seeking views on whether or not to ask the water company to increase levels of fluoride in water to improve dental health.
- Depending on the outcome, we will work with the water company over the next few years to implement the scheme.

# Achieving consensus across the NE

- Local Dental Committees, individual dentist support, paediatric dentists, Dental School and academic dental support
- All NE Directors of Public Health
- HWBs, scrutiny committees, individual members/MP, seeking support from every local authority
- Regional NHSE, NENC ICB, NHS FTs, GPs and medical directors
- Parents and communities

# Where are we now?

- Consultation on track to commence before the end of 2023
- All political stakeholders mapped out
- Seeking HWB board support from every NE local authority
- Teesside joint scrutiny committee in December
- Communication plan in final stages of preparation
- Seeking final ministerial approval

# Recommendations:

- Tees Valley Joint Health Scrutiny Committee are asked to support the community water fluoridation proposals for the NE
- Delegate the responsibility for LA consultation response to the Director of Public Health
- Engage local communities to highlight the process and encourage response

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# Agenda Item 7

**Agenda Item**

**Tees Valley Joint Health Scrutiny Committee**

**15 December 2023**

## NORTH EAST AND NORTH CUMBRIA INTEGRATED CARE BOARD: NHS DENTISTRY UPDATE

### Summary

The Committee will receive an update on NHS primary care dental services and dental access recovery developments.

### Detail

1. An update on NHS dentistry was last provided to the Committee in March 2023 by the Senior Primary Care Manager (Primary Care Dental Commissioning Lead – North East and North Cumbria), NHS England (North East & Yorkshire). Key information and subsequent discussion points can be found within the published minutes of that meeting – please see https://democracy.darlington.gov.uk/mgAi.aspx?ID=9372.

2. Since the previous update, NHS England delegated responsibility to the North East and North Cumbria Integrated Care Board (NENC ICB) for commissioning dental services – this commenced on 1 April 2023.

3. The NENC ICB Director of Place Based Delivery is scheduled to be in attendance to provide this latest update. A presentation has been prepared and can be found at **Appendix 1**.

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APPENDIX 1

North East and North Cumbria

# NHS Primary Care Dental Services & Dental Access Recovery

# Tees Valley Joint Overview and Scrutiny Committee update

December 2023

# Summary Overview of NHS Dentistry

- NHS England has delegated responsibility to North East and North Cumbria (NENC) ICB for commissioning dental services from 1 April 2023
- NHS Dentistry services MUST operate in accordance with Nationally set Government Regulation (2006)
- Under NHS Dentistry national regulation there is no ‘formal registration’ of patients with dental practices as part of their NHS Dentistry offer, patients can therefore approach any dental practice offering NHS care for access.
- Dental contracts and provision is activity and demand led with the expectation practices deliver courses of treatment with recall intervals appropriate to clinical need and manage their available commissioned capacity to best meet local demand and clinical needs of patients presenting to their practice.
- The contract regulations set out the contract currency which is measured in units of dental activity (UDAs) that are attributable to a ‘banded’ course of treatment prescribed under the regulations.
- North East and North Cumbria ICB do not commission private dental services, however, NHS dental regulations do not prohibit the provision of private dentistry by NHS Dental Practices.
- The prolonged COVID- 19 pandemic period required NHS Dental Practices to follow strict Infection Prevention and Control (IPC) guidance which significantly restricted levels of access to dental care. As a result, backlog demand for dental care remains high with the urgency and increased complexity of patient clinical presentations further impacting the ability for the NHS Dental Care system to return back to pre-COVID operational norms.

# Context

- Patients are not registered with a dentist in the same way as GP practices – you can therefore contact any NHS dental practice to access care.

- As independent contractors, dental practice are responsible for managing their appointment books and are best placed to advise on the capacity they have available to take on new patients.

- Practices providing NHS treatment are listed on www.nhs.uk. Practices are responsible for keeping the website updated and whilst it may currently indicate they are not taking on new patients, we would advise that patients do contact them to check the latest position on availability of routine appointments.

- Dental practices are being **encouraged to prioritise patients for treatment based on clinical need and urgency,** therefore appointments for some **routine treatments**, such as dental check-ups, may therefore still be delayed. Some practices are operating waiting lists to manage those patients requesting routine NHS dental care).

- If your teeth and gums are healthy – a **check-up, or scale and polish may not be needed every 6 months.**

# Commissioned Capacity

| Locality | NHS Dental Contracts (General Dental Services)* | UDA Capacity Commissioned 2023-24 |
|---|---|---|
| Middlesbrough | 9 | 301,316 |
| Hartlepool | 8 | 191,367 |
| Redcar & Cleveland | 17 | 273,097 |
| Stockton on Tees | 22 | 370,694 |
| Darlington | 12 | 176,473 |

*** As at 5th December 2023**

# Other Primary and Community Dental Services

In addition to routine General Dental Practice NENC ICB also commissions the following primary care and community dental services.

- Urgent dental care services - in-hours and out of hours appointments via NHS111 (see following slide for detail)
- Community dental services (CDS) – Service for vulnerable patients (adults and children) with additional needs that cannot be met within high street practices.
- Additional Services: Advanced mandatory (minor oral surgery services), Domiciliary care, sedation and orthodontic services (activity commissioned and rates paid vary across the NENC).

# Urgent Dental Care Services

| Service Type | Geographical Coverage |
|---|---|
| NHS 111 Dedicated ‘In Hours’ Direct Booking Hubs | • North Cumbria<br>• Northumberland<br>• Newcastle and North Tyneside<br>• Gateshead<br>• South Tyneside<br>• Sunderland<br>• Durham<br>• Tees Valley |
| NHS 111 Integrated Dental Clinical Assessment Service (DCAS) | • NENC Wide |
| NHS 111 Dedicated ‘Out of Hours’ Direct Booking Treatment Centres | • North Cumbria<br>• North of Tyne<br>• South of Tyne<br>• Durham<br>• Tees Valley |

# Challenges to access

- Dental services have struggled to recover from the impact of covid
- There are significant challenges with recruitment and retention of dentists
- As a result, some providers unable to deliver full commissioned capacity
- There is widespread recognition that the national dental contract requires reform *(see link to House of Commons Health and Social Care Committee report published July 2023 for further details - https://committees.parliament.uk/publications/40901/documents/199172/default/ )*
- A significant challenge is that dentists can hand back their contracts. A number of contracts have been handed back across the NENC area since the ICB took over commissioning responsibility
- This means local people across the NENC are experiencing problems accessing NHS dentists – areas of particular challenge include N Cumbria, North Northumberland, Darlington, parts of Co Durham and Sunderland

# Our approach to tackling these challenges - Three phases

Improving access to dentistry will not be a quick fix

We are tackling this in three streams:

Immediate actions to stabilise services

A more strategic approach to workforce and service delivery

Developing an oral health strategy to improve oral health and reduce the pressure on dentistry, this needs to be progressed with partners around awareness and promotion

# Immediate Actions Undertaken

- c£3.8m non-recurrent investment agreed to date for 2023-24 to:
  - Increase NHS 111 dental clinical assessment capacity
  - Increase out of hours dental treatment services
  - Extend access arrangements to provide where possible an additional 27.5k patient treatment slots between July 2023 and end of March 2024 (to supplement the circ 4.3k slots funded in Q1)

- Flexible commissioning arrangement offered to practices to provide a training grant to support the employment of overseas dentists

- Implemented a local commissioning process to re-provide (where possible) activity when contracts are handed back (see slide overleaf)

# Dental Access Recommissioning (UDAs)

| Locality | UDAs commissioned 2023-24 (recurrent) | UDAs commissoned 2023-24 (Non-recurrent) | UDAs commissioned 2024-25 (Non-recurrent)* |
|---|---|---|---|
| Durham | | 14,600 | 20,100 |
| North Tyneside | | 1,500 | 2,000 |
| Stockton on Tees | | 4,000 | 11,000 |
| Newcastle | | 3088 | 5,730 |
| South Tyneside | | 4185 | 10,000 |
| Darlington | | 4707 | 4,707 |
| N Cumbria (Carlisle) | | 3720 | 3,720 |
| N Cumbria (Eden) | 7,000 | | |
| TOTAL | **7,000** | **32,080** | **53,537** |

*** Commissioned capacity to be made recurrent if providers demonstrates they can deliver this additional activity**

# Further Action and Next Steps

- Funding earmarked to progress formal procurements to secure new market interest/NHS dental practices to address gaps in provision where is has not been possible to re-commission UDAs from existing NHS practices (inc. in the Darlington locality).
- Advert in British Dental Journal to attract overseas dentists and to support them through National Dental Performer List process (required to deliver NHS dental care).
- Work with key stakeholders on further local initiatives to improve workforce recruitment and retention, service delivery sustainability and improved access particularly within CORE20 areas and for disadvantaged groups.
- Work with Healthwatch to update patient and stakeholder comms.
- Work with local system partners to progress development of an oral health strategy to improve oral health and reduce the pressure on dentistry.
- Work with NHS England regional and national teams to influence national Dental System Reform.

# Advice for Patients with an Urgent Dental Treatment Need

- If you develop an **urgent dental issue** telephone your regular dental practice (or any NHS practice if you don't have a regular dentist).
- It is important that when you ring the practice, you fully explain the nature of your dental problem so that the urgency of your dental treatment need can be determined.
- If the practice is unable to offer an appointment because their NHS urgent access slots have already been taken up, they will advise you to ring another NHS dental practice, or alternatively you can visit www.111.nhs or call 111.
- The NHS111 health advisor will undertake a clinical triage and where the dental need is deemed to be clinically urgent, an appointment will be made at the nearest in-hours urgent dental care hub, or alternatively depending on the time of the call, into the dental out of hours treatment services.
- If the issue is not deemed urgent, patients will be signposted to another NHS dental practice and/or given self-care advice until an appointment can be offered.
- You should be advised to make contact again if your situation changes/worsens.

# Agenda Item 8

**Agenda Item**

**Tees Valley Joint Health Scrutiny Committee**

**15 December 2023**

## NHS ENGLAND / NORTHERN CANCER ALLIANCE: NON-SURGICAL ONCOLOGY OUTPATIENT TRANSFORMATION

### Summary

The Committee will receive a presentation on proposals for changes to non-surgical oncology services from representatives of NHS England and the Northern Cancer Alliance.

### Detail

1. Following a presentation given to the Joint Overview and Scrutiny Committee for the North East and North Cumbria Integrated Care System and North and Central Integrated Care Partnerships in September 2023, an approach was made to provide a similar briefing to the Tees Valley Joint Health Scrutiny Committee. Key information and subsequent discussion points from that September 2023 meeting can be found within the published minutes – see https://democracy.gateshead.gov.uk/ieListDocuments.aspx?CId=305&MId=3562&Ver=4 (item 15).

2. To provide some additional background context ahead of the consideration of this item, representatives from NHS England and the Northern Cancer Alliance have included a briefing report – see **Appendix 1**.

3. The Clinical Lead for the Northern Cancer Alliance is scheduled to be in attendance to lead on this item and will be supported by the Managing Director for the Northern Cancer Alliance, as well as the Head of Specialised Commissioning, NHS England. A presentation has been prepared and can be found at **Appendix 2**.

**Name of Contact Officer:** Gary Woods
**Post Title:** Senior Scrutiny Officer, Stockton-on-Tees Borough Council
**Telephone No:** 01642 526187
**Email Address:** gary.woods@stockton.gov.uk

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**Update on non-surgical oncology outpatient transformation in the North East**

**December 2023**

## Current challenges

Workforce challenges in oncology services are being felt across the entire NHS and nationally there is a predicted consultant oncologist workforce shortage of 28% (401 whole time equivalents) by 2025. We expect to feel the impact of this even more within the North East region in the years ahead.

The immediate workforce pressures being faced regionally are within the specialties of breast, lung and colorectal (bowel) cancer and since June 2022 NHS England Specialised Commissioning has seen a shortage of whole-time equivalent consultant oncologists. This is due to a combination of vacant posts (compounded by an inability to recruit) and planned retirements. This is coupled with a growing demand and complexity in non-surgical oncology treatments with for example chemotherapy use increasing significantly.

NHS England Specialised Commissioning are currently discussing the best way to address these immediate workforce challenges to ensure the continued safe delivery of specialist oncology services. As we manage this difficult position, we want to ensure that key stakeholders are well sighted on the issues being faced and the transformational programme of work that is being taken.

## Background

Consultant oncologists from Newcastle Hospitals and South Tees Hospitals travel across the whole of the North East and North Cumbria region to deliver specialist outpatient clinics at several local hospital sites.

Given the scale of the immediate challenge and gaps in the consultant oncologist workforce, it was necessary in 2022 for the North region to change the number of local outreach outpatient clinics on a temporary basis to ensure that all patients still have fast access to staging diagnostics and treatment. At the time, this was in relation to breast, lung and colorectal (bowel) cancer only.

This involved a phased approach to establishing fewer outreach outpatient clinics, that allow the consultant oncologists in post to see as many patients as possible who are on a breast, lung or colorectal (bowel) cancer pathway. This interim approach has increased resilience within the existing workforce as it has meant there are no longer lone workers which makes recruitment to vacant consultant oncologist posts more attractive.

Without consolidating the number of outreach outpatient clinics, patients in some areas would have been disadvantaged in how quickly they could be seen by the appropriate specialist consultant oncologist compared to other parts of the region. This means they would have waited longer to agree their initial treatment plan and their cancer treatment would have been delayed. This was not an acceptable position and the NHS worked as swiftly as possible to ensure there was no detrimental impact on patient care as a result of these difficult workforce challenges.

Lessons have been learnt from the interim services changes, and the wider region (including the South region) is now at a point of establishing a new service model that builds on the work to date.

**Principles for the strategic review and preferred model for taking forward**

The principles adopted for this programme of work ensure the future model is patient focused, clinically led, delivers care as close to home as possible with a view to reducing inequality in current service provision across the region. The view of patients or patient representatives has been integral to consideration of the proposed options.

It is the intention to ensure oncologist time is used to maximum efficiency recognising that the gap between supply and demand for the regional oncologist workforce is forecast to widen further in the next five years. There has been an increase in doctors training in the specialty (national training numbers) and seven additional trainees were secured in the region. These numbers do not close the gap and it takes 5-7 years to complete training. A broad range of alternate workforce options has been considered along with role allocation, training needs and skills required. However, there is a shortage of all staff groups that provide care for cancer patients including clinical nurse specialists as well as pharmacists. This means workforce shortages in these areas also need addressing as part of the long term plan. Future plans will see oncology teams' working arrangements designed in a way that ensures safe levels of specialised cover coupled with opportunities to enhance resilience through peer support and learning.

A number of strategic options have been taken through the relevant NENC boards including the Northern Cancer Alliance board, the Provider Collaborative, the Combined CCG forum (now the ICB) as well as the newly established NHS England and ICB Joint Committee. This has allowed an opportunity to model, travel, health inequality impact and co-dependencies.

The current phase of the project is focussing on further engaging on and developing the preferred model in detail prior to final sign off by March 2024. This preferred option will see the establishment of clinical teams working in tumour specific hubs for outpatient appointments with treatment as close to home as possible, delivering the following model of care:

- Tumour specific teams (multidisciplinary) across NENC for the major tumour groups (Breast, Lung, Colorectal, Urology). Every trust has at least one hub – therefore visiting oncologists.
- Centralisation of intermediate tumour groups to the two cancer centres and more collaborative working to build resilience in the services especially for the rarer tumour groups, supporting services and workforce.
- Hub sites chosen to reduce patient travel impact as much as possible, no immediate changes to co-dependencies such as the Multidisciplinary Teams (MDT), surgery, diagnostic services.

- Ensuring all chemotherapy can be delivered locally with increased services required at some sites thus reducing patient travel.
- Supporting new ways of working, digital solutions, new workforce models.
- Reducing inequity in waiting times, clinical trials access, supporting services.
- Improving patient safety and quality – communication, wrap around tumour specific model of care, acute oncology services and out of hours access to advice, guidance and support (professionals and patients).

The model will benefit the workforce by reducing single-handed clinicians – with a minimum of three oncology consultants per hub, resulting in improved cross cover and resilience. There will be wider multidisciplinary team support from prescribing pharmacists, clinical nurse specialists, care coordinators and administrators as well as new roles of advanced clinical practitioners.

This will support standardisation of clinical ways of working with more access to clinical trials, standardisation of clinical protocols and face to face appointments and an agreed regional model for out of hours access to advice, guidance and support (for professionals and patients).

The preferred model has been subject to an external peer review by two other systems, (South and North Yorkshire) with a senior external clinical chair to facilitate. The panel members were peer experts in non-surgical oncology – including patient representatives. The review team has fed back support in principle for the model, and suggested some further work to mitigate for the planned changes which is now being progressed.

**Communications and engagement**

All engagement activity to date regarding this programme of work has been conducted in line with the Cancer Alliance co-produced public engagement strategy.

Initial work adopted a three staged approach to understand what matters most to oncology patients, their families and their carers as well as potential future patients. This has focussed on:

- Understanding the potential impact of change on patient experience
- Addressing aspects of health inequalities and work towards improving equity of access for those members of the community who experience the greatest levels of disadvantage and health inequalities
- Ensuring transparency and an open dialogue with patient and the public at all stages of the review process
- Demonstrating how engagement activities have informed the oncology service review and new delivery model

***Stage one*** involved developing a framework for speaking to people with lived experience, members of the public and representatives from community

organisations who understand the impact of health inequalities on people living in some of our most vulnerable communities.

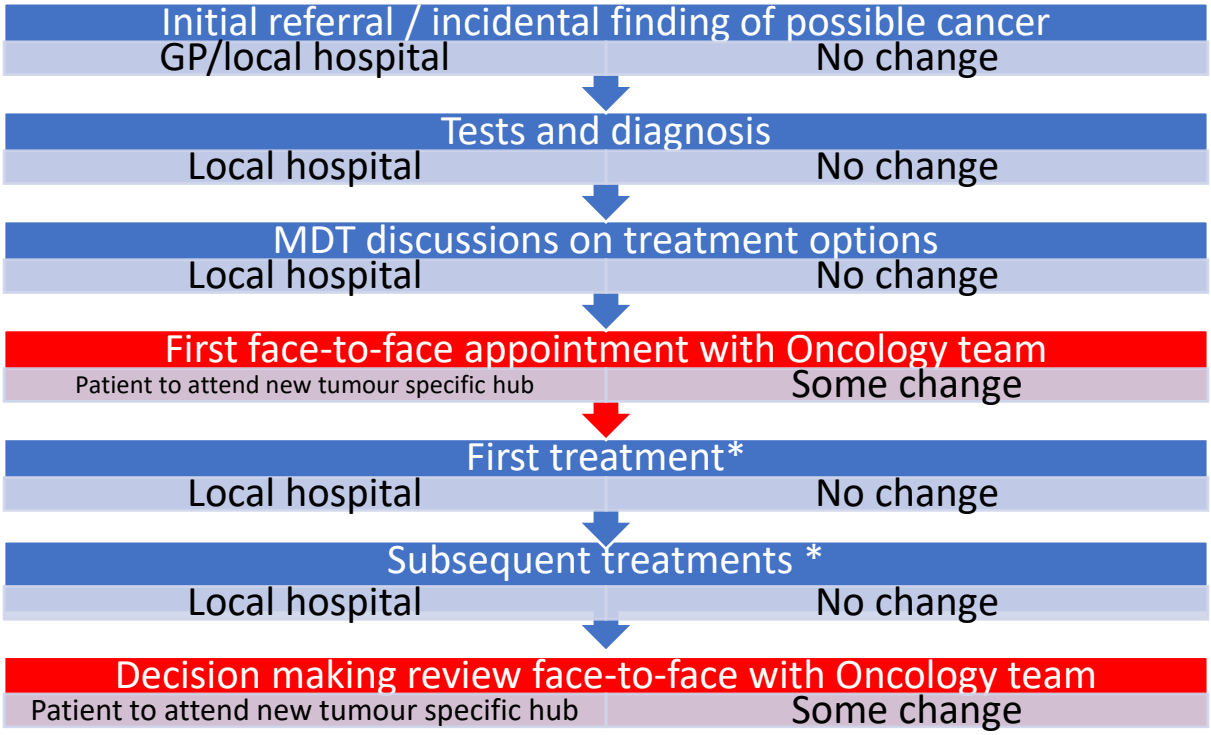
***Stage two*** of the engagement process involved holding three focus groups to explore the key themes identified in the data analysis along with the risks and benefits of the current service model and the pros and cons of any potential service changes.

***Stage three*** work had commenced, planning for future communication and engagement activities, being coordinated by a regional communications and engagement steering group. However, we then had to begin the temporary measures which offered further opportunity for engagement.

All engagement continues to be conducted in line with the Alliance co-produced public engagement strategy The NCA Framework for Public Involvement - Northern Cancer Alliance Northern Cancer Alliance. There are lay representative on all strategy groups and the Alliance Involvement Forum participation continues. A task and finish group has been established – to consider the proposed model and there are questionnaires in circulation as well as planned focus groups.

**Expected impact for patients**

Under the temporary arrangements in the North region the vast majority of patient care has continued to happen locally with no impact on the initial diagnostic pathway, local MDTs, local surgery and chemotherapy continuing at local hospital chemotherapy units.The example patient pathway under the preferred model of care for the wider region, highlighting the areas of potential change, is set out below:



For some patients the first face to face outpatient appointment with the consultant oncologist and any necessary face to face follow up appointments may be offered at a different site from their local hospital. The oncology service has continued to offer and maximise the use of virtual appointments where this is appropriate.

The attached Appendix A includes a table showing the service delivery model in 2020 when this work commenced (including populations by local authority area in 2018). It also includes a table of the proposed sites of the managed clinical network hubs by tumour speciality under the preferred future model.

Health impact assessments and travel impact assessments have been undertaken for the preferred model of care. These will be kept under review.

***Health impact assessment findings***

The health impact assessment indicates that the proposed model of care would support compliance with the public sector equality duty in advancing equality of opportunity and fostering good relations. It would also support reducing health inequalities faced by patients in reducing inequalities in access to health care and reducing inequalities in health outcomes.

***Travel impact assessment findings***

Pre engagement work “what matters to me" considered travel issues – with distance and parking informing the travel analysis.

Work to date has considered travel by car and by public transport - most people travel by car for cancer treatment.

The working group agreed that travel and parking became more of an issue when the other points were not delivered (communication and information, the importance of coordinated, efficient and timely care, knowing who to contact, seamless transfers between hospitals/departments, feeling involved and listened to at all stages of care)

A working group looking at this work considered reducing the number of journeys by using video consultations to reduce unnecessary travel if suitable for the individual and their clinical situation. Further consideration has been suggested for mitigations particularly increasing the use of "daft as a brush” or other voluntary transport schemes.

**Next steps**

While the temporary changes were requested by Newcastle Hospitals NHS Foundation Trust they were supported in principle by regional NHS England Specialised Commissioners, The Northern Cancer Alliance, the Integrated Care System leadership team for North East and Cumbria and the wider hospital network that are part of this system. The regional Provider Collaborative and the Cancer Board are also briefed regarding the challenging workforce position in non-surgical oncology services and the likely need to consolidate the number of outreach clinics as a temporary measure.

We are at a point when patient feedback to the temporary services in the North region is being carefully reviewed and used to inform considerations for the future model of service delivery.

Given the current workforce challenges we have already described, and which will continue beyond the temporary solution now in place, planning for the future model of service delivery across the whole of the ICS is continuing at pace.

We are seeking support from the JHOSC to progress plans for remodelling of the South region service, in line with the preferred option set out in this report.

Angela Wood – Clinical Lead Norther Cancer Alliance

Alison Featherstone – Cancer Alliance Managing Director

Julie Turner – Head of Specialised Commissioning

**APPENDIX A: Service delivery models non-surgical oncology outpatient transformation in the North East**

Table 1 below shows the service delivery model in 2020, when this work commenced including populations by local authority area (2018). It should be noted that the 152,000 population from the Hambleton, Richmondshire and Whitby area flow into James Cook Cancer Centre, and the population of County Durham and Darlington flow to both regional cancer centres.

***Table 1***

| Oncologist from | Trust | Site<br>Local Authority Population 2018 | Oncology Tumour Sites |
|---|---|---|---|
| Newcastle Hospitals NHS FT | Newcastle Hospitals NHS FT | Freeman Hospital Cancer Centre (300,196) | All tumour specific service provided |
| | North Cumbria Integrated Care | Cumberland Infirmary (324,000) | In 2020 provision was being reviewed as part of the Newcastle Carlisle work |
| | Northumbria Healthcare NHS FT | Wansbeck General Hospital (320,274) | Lung, breast, colorectal, upper gastrointestinal, cancer of unknown primary |
| | | North Tyneside General Hospital (205,985) | Lung, breast, colorectal, upper gastrointestinal |
| | Gateshead Health NHS FT | Queen Elizabeth Hospital (202,508) | Lung, breast, colorectal, cancer of unknown primary, gynaecological |
| | South Tyneside and Sunderland NHS FT | Sunderland Royal Hospital (277,417) | Lung, breast, colorectal, upper gastrointestinal, cancer of unknown primary, head & neck, urology |
| | | South Tyneside District Hospital (150,265) | Lung, breast, colorectal |
| | County Durham and Darlington NHS FT | Shotley Bridge Hospital | Breast |
| | | University Hospital North Durham (526,980) | Lung, breast, colorectal, |
| South Tees Hospitals NHS FT | | Bishop Auckland Hospital | Lung, breast, colorectal, |
| | | Darlington Memorial Hospital (106,695) | Lung, breast, colorectal, urology, head & neck |
| | | University Hospital Hartlepool (96,242) | Lung, colorectal urology |

| | | | |
|---|---|---|---|
| | North Tees and Hartlepool NHS FT | University Hospital North Tees (197,213) | Lung, breast, colorectal, urology |
| | South Tees Hospitals NHS FT | Friarage Hospital (91,134) | Lung, breast, colorectal, urology |
| | | James Cook Cancer Centre (277,263) | All tumour groups |

Table 2 below shows the proposed sites of the managed clinical network hubs by tumour speciality under the preferred future model.

***Table 2***

| **Oncologist provision from Newcastle Hospitals NHS FT** | | |
|---|---|---|
| **Trust** | **Hospital site** | **Tumour speciality** |
| **Newcastle Hospitals NHS Foundation Trust (NuTH)** | Freeman Hospital | All tumour groups |
| | North Cumbria Integrated Healthcare NHS FT Cumberland Infirmary, Carlisle | Service provided by Newcastle and Carlisle Partnership |
| **Northumbria Health Care NHS FT** | Wansbeck General Hospital | Breast |
| | North Tyneside General Hospital | Lung, colorectal |
| **Gateshead NHS FT** | Queen Elizabeth Hospital | Breast, lung, gynaecology |
| **South Tyneside and Sunderland NHS FT** | Sunderland Royal Hospital | Colorectal, urology, Head &Neck |
| | South Tyneside District Hospital | Lung |
| **County Durham and Darlington NHS FT** | University Hospital of North Durham | Lung, colorectal |

| **Oncologist provision from South Tees Hospitals NHS FT** | | |
|---|---|---|
| **Trust** | **Hospital site** | **Tumour speciality** |
| **County Durham and Darlington NHS FT** | Darlington Memorial Hospital | Head &Neck, lung |
| | Bishop Auckland Hospital | breast |
| **North Tees and Hartlepool NHS FT** | North Tees University Hospital | Breast, lung, colorectal, Urology |

| | | |
|---|---|---|
| **South Tees Hospital NHS Foundation Trust** | James Cook University Hospital | All tumour groups |
| | Friarage Hospital | Breast, lung, colorectal, urology |

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Northern Cancer Alliance

NHS North East and North Cumbria

NHS England

# Non-Surgical Oncology Out-patient Transformation

## Tees Valley Joint Health Scrutiny Committee

## 15th December 2023

Presented by:

**Angela Wood – Clinical Lead Norther Cancer Alliance**

APPENDIX 2

# Welcome and Introductions

Representative Officers:

Angela Wood – Clinical Lead, Northern Cancer Alliance

Alison Featherstone – Managing Director, Northern Cancer Alliance

Julie Turner – Head of Specialised Commissioning, NHS England

# Background

# Why non-surgical services need to change

- Nationally recognised shortage in oncologist workforce – national predicted shortage of **28%** by 2025, regional prediction of **43%** reduction when modelled in 2020, further modelling in progress
- Regional variation in service provision and access
- New patient activity is up **9%**
- Demand for SACT (chemotherapy related services) is growing by **c10%**
- Additionally new NICE approved drugs are likely to become available within this pathway in the next 12 months
- The general increase in cancer incidences is circa **3%** to **5%** year on year
- All the above adds to extra demand and the pressure on services

# Overview of oncology services



# Context

Within our North East and North Cumbria ICS we have:

- Two specialist cancer centres at Newcastle and South Tees which include Radiotherapy with some services also provided in North Cumbria by Newcastle.
- Chemotherapy delivery units at 19 sites
- This proposal does not change the sites for radiotherapy and chemotherapy services – they remain as close to home as possible
- Historical model of outpatient service delivery no longer fit for purpose:
  - Oncologists visiting multiple sites to deliver outpatient clinics around region. Inequity of access as model evolved over time with no strategic planning across whole region.
- Capacity and Demand
  - Lack of resilience in workforce inability to recruit and retain enough staff
  - Increase in referrals and an increase in the complexity of treatment and the amount of treatment available
- Temporary measures
  - Newcastle implemented temporary measures from March 2022, and we have learned from them
- New service provision requires a new workforce model
  - Advanced Clinical Practitioners – 2 qualified, 11 in training – new curriculum developed
  - Role extension for several other posts Pharmacists , Nurses and Therapy Radiographers

# Original outpatient appointment sites



| Oncologist from | Trust | Site<br>Local Authority Population 2018 | Oncology Tumour Sites |
|---|---|---|---|
| Newcastle upon Tyne Hospitals NHS FT | Newcastle upon Tyne Hospitals NHS FT | Freeman Hospital Cancer Centre (300,196) | All tumour specific service provided |
| | North Cumbria Integrated Care | Cumberland Infirmary (324,000) | In 2020 provision was being reviewed as part of the Newcastle Carlisle work |
| | Northumbria Healthcare NHS FT | Wansbeck General Hospital (320,274) | Lung, breast, colorectal, upper gastrointestinal, cancer of unknown primary |
| | | North Tyneside General Hospital (205,985) | Lung, breast, colorectal, upper gastrointestinal |
| | Gateshead Health NHS FT | Queen Elizabeth Hospital (202,508) | Lung, breast, colorectal, cancer of unknown primary, gynaecological |
| | South Tyneside and Sunderland NHS FT | Sunderland Royal Hospital (277,417) | Lung, breast, colorectal, upper gastrointestinal, cancer of unknown primary, head & neck, urology |
| | | South Tyneside District Hospital (150,265) | Lung, breast, colorectal |
| | County Durham and Darlington NHS FT | Shotley Bridge Hospital | Breast |
| | | University Hospital North Durham (526,980) | Lung, colorectal |
| South Tees Hospitals NHS FT | | Bishop Auckland Hospital | Lung, breast, colorectal, |
| | | Darlington Memorial Hospital (106,695) | Lung, breast, colorectal, urology, head & neck |
| | North Tees and Hartlepool NHS FT | University Hospital Hartlepool (96,242) | Lung, breast, colorectal |
| | | University Hospital North Tees (197,213) | Lung, breast, colorectal, urology |
| | South Tees Hospitals NHS FT | Friarage Hospital (91,134) | Lung, breast, colorectal, urology |
| | | James Cook Cancer Centre (277,263) | All tumour specific services provided |

# Strategic Review

# Principles for strategic review

- Any future model is patient focused, clinically led, delivers care as close to home as possible with a view to reducing inequality in current service provision across the region
- The view of patients or patient representatives are integral to proposed options
- Oncologist time is used to maximum efficiency recognising that the gap between supply and demand for the regional oncologist workforce is forecast to widen further in the next five years
- A broad range of alternate workforce options is considered along with role allocation, considering the ‘at risk’ groups, as well as training needs and skills required
- Oncology teams’ working arrangements are designed in a way that ensures safe levels of specialised cover coupled with opportunities to enhance resilience through peer support and learning

**These principles have been adopted for future work too.*

# Strategic model development

- Whole day meeting with all stakeholders – providers, commissioners, public in 2019.
- Steering group of all key stakeholders
- Task and Finish groups with relevant expertise to assess and evaluate the potential options
- Public Engagement through whole process

# Options considered

1. **Current model -No change**
   - Hub and spoke working for individual oncologists not wider system need - 16 geographical sites, specific tumour group offered at each site developed on an ad hoc basis.
   - No system wide service and workforce planning
   - Inequity of patient care and unsustainable due to increasing demand and complexity

2. **Centralisation to the cancer centres with treatment as close to home as possible**
   - Not viable for patient travel and new estate required

3. **A decentralised model**
   - Not viable due to potential lone working and inequity of service development - current model evolved from this

4. **Clinical networks with tumour specific hubs and treatment as close to home as possible**
   - Developed in conjunction with the oncologists and met the core principles agreed at the onset of the NSO review process
   - The main priorities were ensuring equity across the whole region in terms of service provision, the optimum use of the limited oncologist resource whilst most importantly guaranteeing that patients would continue to have their treatment and review as close to home as possible

# Decision making

The strategic options were taken through the relevant NENC Boards:

- Northern Cancer Alliance board
- Provider Collaborative
- Combined CCG forum (now ICB)
- Newly established NHS England and ICB Joint Committee

This allowed an opportunity to model, travel, health inequality impact and co-dependencies.

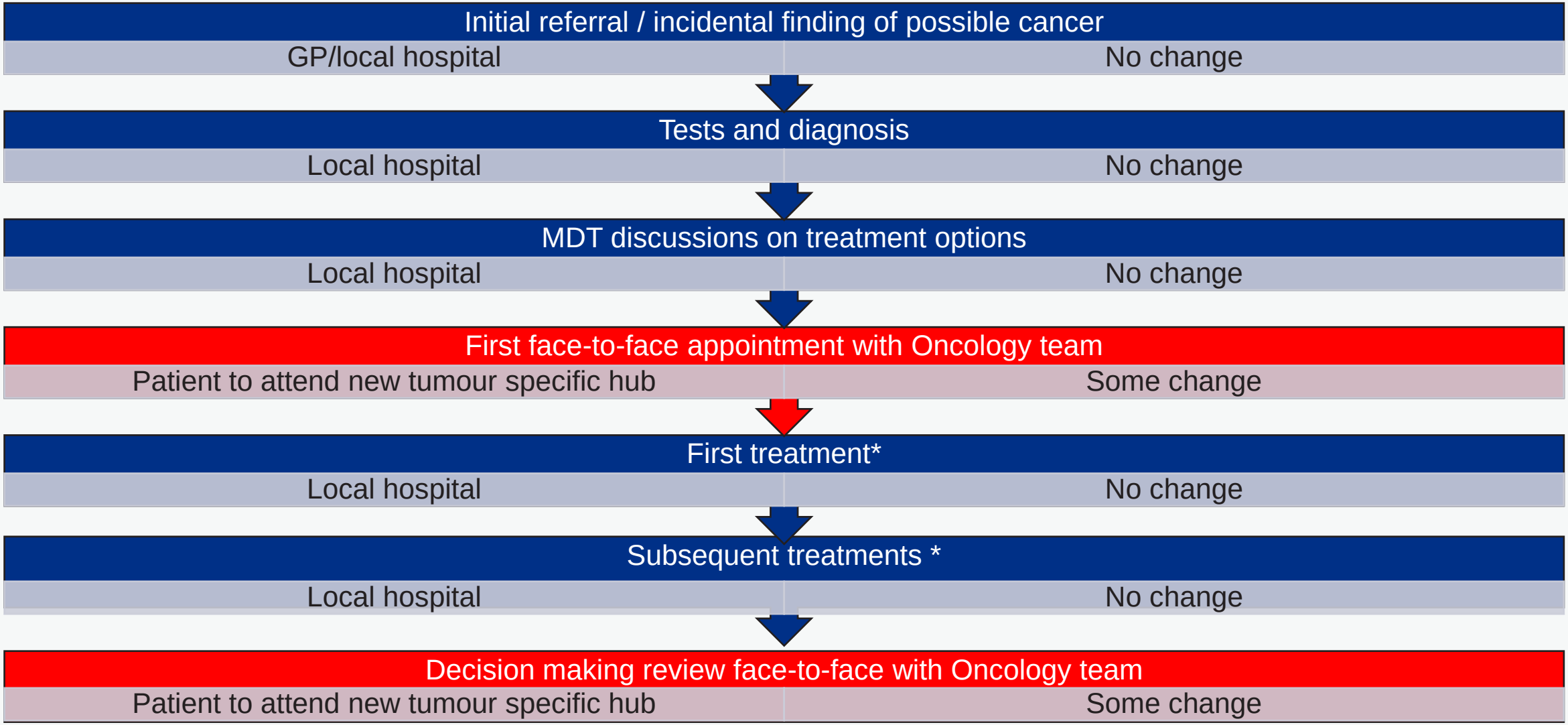
Current phase of the project to further engage on and develop the agreed model in detail prior to final sign off by March 24 will need to also go through all the respective boards/groups

# Preferred option (4)

**Clinical Networks of tumour specific hubs for outpatient appointments with treatment as close to home as possible**

- Tumour specific teams (multidisciplinary) across NENC ICS for the major tumour groups (Breast, Lung, Colorectal, Urology). Every trust has at least one hub – therefore visiting oncologists.
- Centralisation of intermediate tumour groups to the 2 cancer centres and more collaborative working to build resilience in the services especially for the rarer tumour groups, supporting services and workforce
- Hub sites chosen to reduce patient travel impact as much as possible, no immediate changes to co-dependencies such as the Multidisciplinary Teams (MDT), surgery, diagnostic services
- Ensure all chemotherapy can be delivered locally – increased services required at some sites thus reducing patient travel
- Supports new ways of working, digital solutions, new workforce models
- Reduce inequity – waiting times, clinical trials access, supporting services
- Improve patient safety and quality – communication, wrap around tumour specific model of care, Acute Oncology Services and out of hours access to advice, guidance and support (professionals and patients)

# Example patient pathway




** NB Radiotherapy and surgical treatments will continue to take place at major cancer centres as they do now. Chemotherapy will continue to take place locally as it does now.*

# Proposed hub locations



| Oncologist provision from James Cook University Hospital | | |
|---|---|---|
| **Trust** | **Hospital site** | **Tumour speciality** |
| **County Durham and Darlington NHS FT** | Darlington Memorial Hospital | Head &Neck, lung |
| | Bishop Auckland Hospital | breast |
| **North Tees and Hartlepool NHS FT** | North Tees University Hospital | Breast, lung, colorectal, Urology |
| **South Tees Hospital NHS Foundation Trust** | James Cook University Hospital | All tumour groups |
| | Friarage Hospital | Breast, lung, colorectal, urology |

| Oncologist provision from Newcastle Hospitals | | |
|---|---|---|
| **Trust** | **Hospital site** | **Tumour speciality** |
| **Newcastle Hospitals NHS Foundation Trust (NuTH)** | Freeman Hospital | All tumour groups |
| | North Cumbria Integrated Healthcare NHS FT Cumberland Infirmary, Carlisle | Service provided by Newcastle and Carlisle Partnership |
| **Northumbria Health Care NHS FT** | Wansbeck General Hospital | Breast |
| | North Tyneside General Hospital | Lung, colorectal |
| **Gateshead NHS FT** | Queen Elizabeth Hospital | Breast, lung, gynaecology |
| **South Tyneside and Sunderland NHS FT** | Sunderland Royal Hospital | Colorectal, urology, Head &Neck |
| | South Tyneside District Hospital | Lung |
| **County Durham and Darlington NHS FT** | University Hospital of North Durham | Lung, colorectal |

# Benefits of a tumour specific hub

## Workforce

- No single-handed clinicians - minimum of 3 Clinical and Medical Oncology Consultants
- Improved cross cover and resilience
- Multidisciplinary support - Prescribing Pharmacists, Clinical Nurse Specialists, Care Coordinators and admin are all essential
- New roles - Advanced Clinical Practitioners

## Standardisation of clinical ways of working

- More equitable access to clinical trials
- Standardisation of clinical protocols and face to face appointments
- Agreed regional model for out of hours access to advice, guidance and support (professionals and patients)

# Peer Review

# Clinical model – Peer review Sept 2023

The **purpose** of the Peer Review was to:

- Provide a clinical peer review of the proposed model – to “check and challenge”
- Check we have considered safety, sustainability, co dependencies, quality standards, workforce, equity, and access
- Challenge any thinking to ensure all options have been considered and to ensure plans are in place to address any potential issues

The **method**:

- External peer review by two other systems, (South and North Yorkshire) with a senior external clinical chair to facilitate
- The panel members were peer experts in non-surgical oncology – including patient representatives
- Use of national criteria to evaluate service models

*(The other systems do not have the same clinical models in place - to ensure a lack of any bias in this process*

# Clinical model peer review outcome

- Support in principle for model, more robust, removal of single-handed practitioners
- Understanding that pooling teams reduces risks of cancellations and more flexibility
- Broader skill mix and increased team numbers to enhance clinical safety and patient experience
- Acknowledgement and support for navigator/co-ordinator roles
- Acknowledgement  of consistency in user feedback to date
- Acknowledged proposed model still provides choices – hubs based on postcode, but patient can choose another hub
- Support for treatment as close to home as possible

On going work required to address and mitigate for changes:

- Concern over consultant workforce gap and reality of recruitment
- Acknowledged the need for robust out of hours provision and access to acute oncology
- Adoption of technology to enhance remote access to care
- Programme of involvement and engagement

Supported the suggested future work planning – task and finish groups in place to address all potential issues identified

# Engagement and Communications

# Engagement and communication

**3 years of listening**

## Engagement work

- ✓ Public engagement
- ✓ Clinical engagement
- ✓ Health impact assessment
- ✓ Travel assessment

## Temporary measures (for Newcastle)

- ✓ Patient feedback
- ✓ Staff feedback
- ✓ System feedback

## Continued public engagement

- ✓ Phased approach to listen to what matters to our patients
- ✓ Current questionnaires
- ✓ Planned focus groups

# Pre- engagement work -What mattered to our patients

All Engagement conducted in line with the Cancer Alliance co-produced public engagement strategy

Initial work adopted a three staged approach to understand what matters most to oncology patients, their families and their carers as well as potential future patients. So that Steering Group could:

- Understand the potential impact of change on patient experience
- Address aspects of health inequalities and work towards improving equity of access for those members of the community who experience the greatest levels of disadvantage and health inequalities
- Ensure transparency and an open dialogue with patient and the public at all stages of the review process
- Demonstrate how engagement activities have informed the oncology service review and new delivery model

***Stage one*** involved developing a framework for speaking to people with lived experience, members of the public and representatives from community organisations who understand the impact of health inequalities on people living in some of our most vulnerable communities.

***Stage two*** of the engagement process involved holding three focus groups to explore the key themes identified in the data analysis along with the risks and benefits of the current service model and the pros and cons of any potential service changes.

***Stage three*** work had commenced, planning for future communication and engagement activities, being coordinated by a regional communications and engagement steering group.  However, we then had to begin the temporary measures which offered further opportunity for engagement.

# Learning from Temporary Measures

## Clinical and System feedback experience

- Positive feedback from clinicians regarding peer support in clinic.
- Ability to cross cover when a member of hub is on annual leave or unwell thus reducing waiting times
- Support in clinics from clinical pharmacists and consultant nurses.
- Improved opportunities for trainees as able to attend clinic supported even when their own supervisor is not present.
- Clinic co-ordinators have been valuable in ensuring all capacity is used
- Operational issues to work through

## Responding to patient feedback

- Generally positive
- Essential to have good communication between services
- Information leaflet produced to explain the changes
- Changes and adaptations of the service made based on feedback such as virtual appointments
- Questionnaire feedback informed next stage of the engagement work

# Virtual Appointments

**47%** of patients had a virtual appointment (by telephone or video call) with the oncology team

Of those who had virtual appointment:

- ✓83% were very satisfied/satisfied with their experience
- ✓Dissatisfaction/concerns related to:
  - ✓Not receiving the call on time
  - ✓Confusion about what would happen (in advance of appointment)
  - ✓Age of patient; computer literacy and hearing difficulties
  - ✓Communication difficulties (perceived as more of a ‘listening experience’)
- ✓10% received support from a family member / friend to access this

Of those who did not have a virtual appointment 15% would consider having a telephone appointment and 23% a video consultation

# Current and planned engagement for preferred model

**The aims of the engagement strategy are as follows:**

1. Continue to understand what matters most to oncology patients, their families, and their carers as well as potential patients in the future
2. Address health inequalities and ensure equity of access
3. Ensure transparency and an open dialogue with patients and the public at all stages of the review process
4. Demonstrate how engagement activities have informed the oncology service review and new delivery model

**This will be achieved through the following objectives:**

1. Engaging with people who have a lived experience of oncology services
2. Engaging with people who are more likely to experience the greatest level of health inequalities and inequity of access to health care services
3. Ensuring communication activities are accessible to the target audience
4. Development of appropriate feedback mechanisms to everyone involved in the engagement process

# Current and planned engagement

**Ongoing work:**

- All Engagement continues to be conducted in line with the Alliance co-produced public engagement strategy The NCA Framework for Public Involvement - Northern Cancer Alliance Northern Cancer Alliance
- Lay representative on all strategy groups and the Alliance Involvement Forum participation continues
- Task and finish group established – to consider the proposed model
- Current questionnaires and planned focus groups (based on learning from the questionnaires)

# Impact Assessments

# Impact assessments to date

| Health Inequalities | Travel |
| --- | --- |
| • Potential impact – positive and negative<br>• Multiple evidence sources<br>• Results inform process<br>• Results support improving access and outcomes<br>• No evidence it improves (or worsens) discrimination | • Potential impact – positive and negative. Used adding an extra 15mins as a baseline.<br>• Evidence sources (real time data)<br>• Car and public transport<br>• Hub positions informed by the travel assessments |

**Continuous review and monitor**

# Health impact assessment for preferred option

**Completed to assess likely impacts of the proposed service change and provide further insight to reduce potential barriers/discrimination**

The impact assessment outlines:

- What impact (or potential impact) service review outcomes will have on those within protected characteristics groups
- The main potential positive or adverse impact for people who experience health inequalities
- What engagement and consultation has taken place
- The key sources of evidence that have informed the impact assessment
- An understanding that this will need to be

**updated throughout the course of development and continuously updated as the piece of work progresses**

**monitored regularly to ensure the intended outcomes are achieved**

# Health Impact Assessment findings

- ✓ Will support compliance with the Public Sector Equality Duty in
  - advancing equality of opportunity and
  - fostering good relations
- ✓ Unsure it will address
  - tackling discrimination
- ✓ Proposal will support reducing health inequalities faced by patients in
  - Reducing inequalities in access to health care
  - Reducing inequalities in health outcomes

# Travel Impact Assessment

- Pre – engagement work “what matters to me" considered travel issues – distance and parking which informed the travel analysis
- The working group agreed  that travel and parking became more of an issue when the other points were not delivered (Communication and information, the importance of coordinated, efficient and timely care, knowing who to contact, seamless transfers between hospitals/departments, feeling involved and listened to at all stages of care)
- Considered reducing number of journeys by using video consultations to reduce unnecessary travel if suitable for the individual and their clinical situation
- Consider mitigations particularly increasing the use of "daft as a brush“ or other voluntary schemes.

# Travel Impact Assessment for preferred model

Considered travel by car and by public transport

- Please note - most people travel by car for cancer treatment

The average travel time for patients is for the average amount of time it took patients to get to the site that they originally attended.

- For example, the average travel time for patients to get to the Friarage by car was 28 minutes and the average by public transport was 62 minutes
- Travel to attend  oncology out-patient  appointments was not uncommon in the original service model

The percentage of the cohort of patients who can travel to a specified hospital within no more than an extra 15 minutes

Decisions for hub locations considered travel as well as other factors such as services already at that site, estate and other service co-dependencies

# Next steps – high level

- Support from JHOSC to progress modelling and new service
- Continue work to standardise clinical pathways
- Continue contractual and commissioning conversations
- Mobilise changes from April 2024

# Thank You and Questions

# Agenda Item 9

**Agenda Item**

**Tees Valley Joint Health Scrutiny Committee**

**15 December 2023**

## NORTH EAST AND NORTH CUMBRIA INTEGRATED CARE BOARD: TEES VALLEY WINTER PLANNING UPDATE

### Summary

The Committee will receive its annual winter planning update from representatives of the North East and North Cumbria Integrated Care Board (NENC ICB).

### Detail

1. The NENC ICB Director of Place Based Delivery is scheduled to be in attendance to provide this latest update and will be accompanied by the NENC ICB Head of Commissioning – Unplanned Care. A presentation has been prepared and can be found at **Appendix 1**.

2. Members are reminded of the previous update which was considered by the Committee in December 2022. Key information and subsequent discussion points can be found within the published minutes – please see https://democracy.darlington.gov.uk/mgAi.aspx?ID=8903).

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APPENDIX 1



NHS
North East and North Cumbria

# Tees Valley Winter Planning Update

Craig Blair – Director of Place Based Delivery

Andrew Rowlands – Head of Commissioning Unplanned Care

# Overview

**To advise stakeholders of:**

- **Context**
- **National Guidance**
- **23/24 Winter Planning**
  - Local Accident & Emergency Delivery Board (LADB)
  - System Control Centre (SCC)
  - Tees Valley Incident Command Coordination Centre (ICCC)
  - Urgent and Emergency Care Highlight Report
  - 23/24 Winter Plans and Business Cases
- **Risks and Challenges**

# Context

The Tees Valley UEC System, like UEC services in the rest of the region and the country, remains under significant and sustained pressure. This pressure is across all parts of the Tees Valley system and all partners, from Primary Care and Out of Hours (OOH), Acute and Ambulance Providers, to Social Care and Mental Health Services.

This is inevitably impacting on performance across all providers, particularly impacting on flow through our hospitals, creating a blockage in the Emergency Department (ED) and resulting in long ED waits and ambulance handover delays which in turn creates unacceptable long waits for people in the community waiting for an emergency response.

The pressure across our system is created by:

- Staffing issues across all partners
- Pathways and Estate limitations at some sites
- High/increased activity levels within Primary and Secondary Care (linked to Elective backlog and Primary Care access)
- Higher acuity of patients resulting in longer Length of Stay (LOS) also impacting on flow
- Discharge delays (Internal Trust delays along with Social Care and Home Care Staffing pressures)
- Bed pressures and flow issues through hospitals (linked to all the above)

This makes it a complex system problem, requiring a system response.

# National Guidance

- NHS 2023/24 priorities and operational planning guidance – 23rd December 2022
- Delivery Plan for recovering urgent and emergency care services – January 2023
- Delivery Plan for recovering access to primary care – May 2023
- NHS England letter to Senior Health Leaders across the country – 27th July

# National Guidance

## Delivery plan for recovering urgent and emergency care services

### Key Ambitions

- Patients to be seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25.
- Ambulances attending to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.

To succeed and enable the improvement of waiting times and patient experience, the NHS is committed to sustaining focus across the heath and social care sectors on five key areas:

1. Increasing urgent and emergency care capacity

2. Increase workforce size and flexibility

3. Improving discharge

4. Expanding care outside hospital

5. Making it easier to access the right care

# National Guidance

The 10 high-impact interventions are:

1) **Same Day Emergency Care (SDEC)**: **reducing variation in SDEC** provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.

2) **Frailty: reducing variation in acute frailty service provision**. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.

3) **Inpatient flow and length of stay (acute): reducing variation in inpatient care** (including mental health) **and length of stay** for key integrated UEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.

4) **Community bed productivity and flow**: reducing variation in inpatient care and length of stay, including mental health, by implementing in-hospital efficiencies and bringing forward discharge processes.

5) **Care transfer hubs**: implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.

6) **Intermediate care demand and capacity**: supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.

7) **Virtual wards: standardising and improving care across all virtual ward services** to improve the level of care to prevent admission to hospital and help with discharge.

8) **Urgent Community Response**: increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid admission.

9) **Single point of access**: driving standardisation of urgent integrated care co-ordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time. This should include mental health crisis pathways and alternatives to admission, eg home treatment

10) **Acute Respiratory Infection (ARI) Hubs**: support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.

# 23/24 Winter Planning

**Tees Valley Local Accident & Emergency Delivery Board (LADB)**

- The LADB acts as a forum where partners across health and social care come together to collaborate on the integration of high-quality services in support of the wider urgent emergency care system and find ways to develop the local system in relation to improving emergency care delivery, this includes responsibility for the monitoring and delivery of all relevant performance metrics.

**System Control Centres (SCC)**

- The SCC exists to be a central co-ordination service to providers of care across the ICB footprint, with the aim to support patient access to the safest and best quality of care possible.

**Incident Command Coordination Centre (ICCC) – Tees Valley**

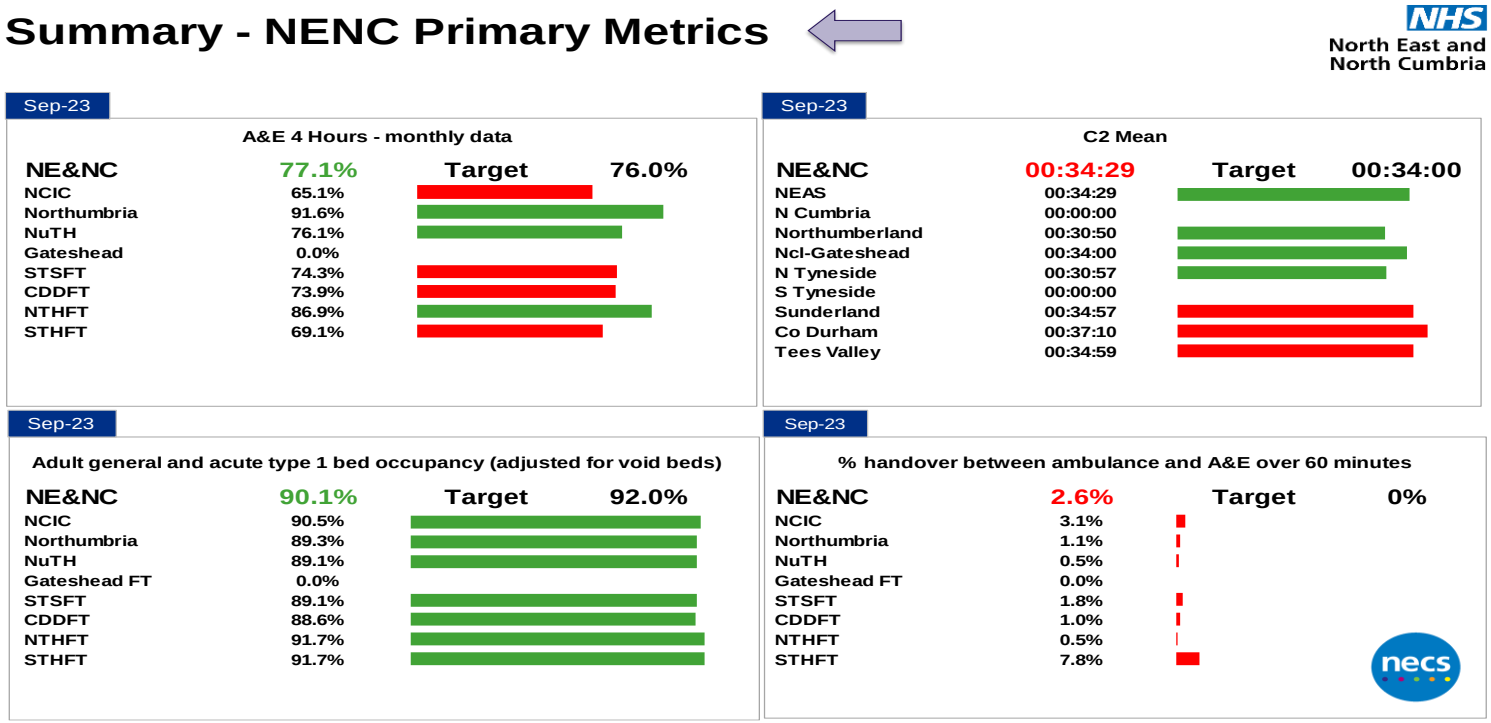
- The ICCC will consider current and predicted capacity and demand pressures supporting stakeholders on how best to navigate pressures across the Tees Valley ICP footprint. The ICCC will use their collective expertise with the support of the NECS Surge Team to agree a plan of action to manage the here and now and the potential surge over an agreed period of time.

# 23/24 Winter Planning

**Tees Valley Local Accident & Emergency Delivery Board (LADB)**

To support the LADB in monitoring the key performance metrics we have developed a UEC Highlight Report which pulls data from each partner along with supporting narrative to determine key risks for discussion within the meeting.

Performance summary for Sep-23:



# 23/24 Winter Planning

**Winter Plans**

Working alongside Tees Valley LADB partners we developed a system resilience template to ensure our system was sighted on risks ahead of this coming winter. This template built in Key Lines of Enquiries (KLOE's), based upon the asks within the various planning guidance documents, alongside other local intelligence.

This template mapped the KLOE's against the 10 high impact interventions, ensuring we were/are responding to each.

We requested TV LADB system partners to self-assess against the range of KLOE's, providing a RAG risk rating. This was then consolidated into a TV system RAG risk rating.

From the 66 KLOE's identified the TV system rated 12 as amber (In plans, but risks associated with delivery) and 0 as red (No evidence of existing implementation or in system plans).

The Amber KLOE's are detailed on the following slide and the LADB will ensure monitoring and delivery against each over the coming months.

# 23/24 Winter Planning

## Winter Plans – system risks

| Priority Area | Assurance Check | TV LADB |
|---|---|---|
| **Ambulance Handover Delays** | Ambulance Handover delays, plans in place to ensure no delays > 59 minutes | |
| **Improving the primary-secondary care interface** | Trust plans are in place to implement the capability to issue fit notes and discharge letters electronically upon discharge from hospital by 30 November 2023. | |
| | Trust plans are in place to manage onward referrals and to establish their own call/recall systems for patients requiring follow-up tests or appointments by 30 November 2023. | |
| **Improving Joint Discharge Processes** | Trusts have worked with providers in mental health, learning disability and autism settings to make sure that we develop a metric that can help focus on reducing the longest stays. | |
| | Surge plans support the implementation of the best practice interventions set out in the '100-day discharge challenge' across NHS settings | |
| | There are plans to flex staffing capacity in the event of surge across the acute, community, residential / home care sectors and packages of care. This should include agreed multi-agency triggers for extending and withdrawing this extra capacity. | |
| **Expanding & better joining up new types of care outside of hospital** | Plans are in place ahead of Winter to further increase the utilisation of Urgent Community Response Services via all referral sources. | |
| **Expand Virtual Wards** | Virtual Ward capacity will be scaled up to support patients with Frailty and Acute Respiratory Infections. | |
| | Plans are in place to increase the utilisation of Virtual Wards from around 65% to 80% by September 2023. Local clinical and operational teams have a standard approach across their area to enable referrals, build patient engagement and benefit from economies of scale. | |
| | Plans are in place to implement new Virtual Ward Models, in more clinical areas, including for patients with a broader range of conditions. Local plans adhere to clinically-led guidance and guidelines to allow providers to scale up ahead of winter for priority pathways including Heart Failure and Paediatrics. | |
| **Making it easier to access the right care** | Plans support more patients being seen in emergency departments with the ambition to improve to 76% of all patients being admitted, transferred or discharged within four hours by March 2024. | |
| | Acute trusts have processes in EDs to prevent avoidable breaches, particularly amongst 'minors' and non-admitted patients referred for specialist assessment. | |

# 23/24 Winter Planning

## Winter Plans – Business Cases

Working with TV LADB system partners we commenced a process in June requesting system partners to submit proposed business cases that would have a measurable impact on our system this winter. At the LADB on 20th September we approved a fully prioritised list of schemes that can quickly be utilised to draw down any available funding.

**Additional schemes/developments to support the system this winter:**

- Urgent Community Response - fully operational to receive Category 3&4 NEAS e-referrals and have access to the Ambulance Stack ahead of Winter 23/24
- Virtual Wards (Hospital @ Home) - 40/50 Hospital @ Home beds per 100K population
- GP in ED at JCUH to create additional capacity and to commence from 1st December
- Moving Out of Hours (OOH) in Middlesbrough to be co-located with ED in JCUH from 1st December
- ARI (Acute Respiratory Infection) funding approved for implementation of ARI hubs across Northeast & North Cumbria (NENC) in Dec-23
- Funding approved for Front of House Navigation across all Trusts in NENC

**Longer Term development to support the system:**

- Procurement process underway to commission a standardised Integrated Urgent Care (IUC) model across North and South Tees from 1st April 2024, creating a new Urgent Treatment Centre (UTC) at James Cook University Hospital (JCUH) and extending the opening hours of the UTC at Redcar Primary Care Hospital (RPCH).

# Risks & Challenges

**Performance Specific Risks**

- Ambulance Handover Delays at South Tees FT
- Cat 2 Ambulance Responses times

**Risks & Challenges**

- The on-going key risk across all system partners is staffing, with workforce being the limiting factor with most issues across Health and Social Care
- Competing priorities – for example from a health perspective Elective Recovery versus Urgent and Emergency Care, we need to balance the priorities and not create or increase inequalities
- Capacity to deliver services and respond to the demand from our population to access services across both Health (Primary and Secondary Care) and Social Care
- Further variants or waves of Covid and how we respond to these at both local and national levels
- Further Industrial Action

# Agenda Item 10

## TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE

Work Programme 2023-2024

| Meeting Date | Topic | Attendance |
|---|---|---|
| 28 July 2023 | TVJHSC: Appointment of Chair & Vice-Chair<br><br>TVJHSC: Protocol / Terms of Reference<br><br>TVJHSC: Work Programme Timetable<br><br>North East Ambulance Service: CQC Inspection / Independent Review<br><br>North East and North Cumbria Integrated Care Board: Community Diagnostic Centres<br><br>North East and North Cumbria Integrated Care Board: Breast Services<br><br>Tees, Esk and Wear Valleys NHS Foundation Trust: Lived Experience Directors Update | Helen Ray / Mark Cotton<br><br>Charlotte Bourke / Ruth Dalton / Phil Woolfall / Richard Morris / Simon Milburn<br><br>Craig Blair / Rowena Dean / Kevin Etherson / Stuart Finn / Mike Carr<br><br>Mike Brierley / Belinda Brooks / Dominic Gardner / Chris Morton / Leigh Trimble / Catherine Wakeling |
| 6 October 2023 | North East and North Cumbria Integrated Care Board: Integrated Care Strategy Implementation / Joint Forward Plan<br><br>Tees, Esk and Wear Valleys NHS Foundation Trust: CAMHS Update<br><br>Tees, Esk and Wear Valleys NHS Foundation Trust: Adult Learning Disability Respite Services Update | Peter Rooney / Craig Blair<br><br>James Graham / Patrick Scott<br><br>Jamie Todd / Patrick Scott |
| 2 November 2023 (informal) | North Tees and Hartlepool NHS Foundation Trust & South Tees Hospitals NHS Foundation Trust: Group Model Development & Partnership Agreement | James Bromiley / Ann Baxter |
| 15 December 2023 | Office for Health Improvement & Disparities: Community Water Fluoridation<br><br>North East and North Cumbria Integrated Care Board: NHS Dentistry Update<br><br>NHS England – North East and Yorkshire: Strategic Options for Non-Surgical Oncology Services<br><br>North East and North Cumbria Integrated Care Board: Winter Plan Update | Professor Peter Kelly CBE / Dr Kamini Shah<br><br>Craig Blair<br><br>Angela Wood / Julie Turner / Gill Galt / Alison Featherstone<br><br>Craig Blair / Andrew Rowlands |

# TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE

Work Programme 2023-2024

| | | |
|---|---|---|
| 15 March 2024 | Tees, Esk and Wear Valleys NHS Foundation Trust: Quality Account 2023-2024<br>(to include performance updates) | TBC |
| | North East Ambulance Service: Quality Account 2023-2024<br>(to include performance updates) | TBC |
| | North East and North Cumbria Integrated Care Board: Palliative and End-of-Life Care Strategy (development / implementation)<br>(TBC) | TBC |

**To be scheduled**

- NENC ICB: Opioid prescribing and dependency across the Tees Valley
- NENC ICB: Clinical Services Strategy Update (last considered in Mar 23)
- NENC ICB: Community Diagnostic Centres Update (last considered in Jul 23)
- NENC ICB: NTHFT / STHFT 'Group' Update (last considered in Nov 23)
- TEWV: Physical Restraints / Interventions (briefing / workshop)