Tees Valley Joint Health Scrutiny Committee

A meeting of the Tees Valley Joint Health Scrutiny Committee was held on Friday 15 December 2023.

Present: Cllr Rachel Creevy (HBC) (Vice-Chair, acting as Chair), Cllr Brian Cowie (HBC), Cllr Lynn Hall (SBC), Cllr Mary Layton (DBC), Cllr Paul McInnes (R&CBC), Cllr Susan Scott (SBC)

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

Also in attendance: Dr Kamini Shah, Julie Turner (NHS England); Craig Blair (North East and North Cumbria Integrated Care Board); Alison Featherstone, Angela Wood (Northern Cancer Alliance); Professor Peter Kelly CBE (Office for Health Improvement & Disparities); Sarah Bowman-Abouna (Stockton-on-Tees Borough Council)

Apologies: Cllr Marc Besford (SBC) (Chair), Cllr Jonathan Brash (HBC), Cllr Ceri Cawley (R&CBC), Cllr Christine Cooper (MC), Cllr Neil Johnson (DBC), Cllr Vera Rider (R&CBC), Cllr Jan Ryles (MC), Cllr Jeanette Walker (MC)

1	**Evacuation Procedure** The evacuation procedure was noted.
2	**Declarations of Interest** There were no interests declared.
3	**Minutes of the Meeting held on 28 July 2023** Consideration was given to the minutes from the Committee meeting held on 28 July 2023. AGREED that the minutes of the Committee meeting on 28 July 2023 be approved as a correct record.
4	**Notes of the Meeting held on 6 October 2023** Consideration was given to the notes from the Committee meeting (not quorate) held on 6 October 2023.

	AGREED that the record of the Committee meeting (not quorate) on 6 October 2023 be noted for information.
5	**Office for Health Improvement & Disparities - Community Water Fluoridation** The Committee received a presentation on updated plans for community water fluoridation for the North East of England. Led by the Office for Health Improvement and Disparities (OHID) Regional Director / NHS Regional Director of Public Health (North East & Yorkshire), and supported by the Consultant in Dental Public Health, NHS England (North East & Yorkshire) and the Stockton-on-Tees Borough Council (SBC) Director of Public Health, content included: ➢ Outline of current status ➢ Oral health across Tees Valley 2019-2022 ➢ Significant inequalities across Local Authorities ➢ General Anaesthetic (GA): Numbers and rates (2022-2023) ➢ Evidence-based interventions to improve oral health ➢ Consultation narrative ➢ Achieving consensus across the North East ➢ Where are we now? ➢ Recommendations Summarising the existing position with regards this initiative (which included Government support and funding, the preparation of the statutory 12-week consultation requirement, and communication / decision-making responsibilities), it was noted that Hartlepool and some parts of County Durham already had naturally fluoridated water, and other areas (Newcastle, North Tyneside and parts of Northumberland) had artificial water fluoridation. Significantly, associated capital and revenue costs (which previously sat with Local Authorities under the Public Health grant) for expanding this across the North East would be the responsibility of the Department of Health and Social Care (DHSC). Outlining the changes in prevalence of dental decay in 5-year-olds across the North East between 2019 and 2022, officers stated that there could be up to 134 teeth being extracted under general anaesthetic in a single day within County Durham for Durham and Darlington children. Reference was made to a table which compared the most and least deprived wards in Teesside (without fluoridated water) with Hartlepool (which already had fluoridated water) – this 2017 data demonstrated the positive impact of fluoridation which was particularly significant for those in the most deprived areas. In terms of inequalities, it was also noted that there can be up to a ten-fold difference in decayed, missing or filled teeth (DMFT) rates between the most and least deprived wards within a single Teesside Local Authority footprint. The use of general anaesthetic in relation to dental decay during 2022-2023 was highlighted. The wider impacts of this were also emphasised, with children usually requiring at least three days off school, around 38% enduring sleepless nights, and around 70% reporting pain. Public Health England data was provided which showed the return on investment of oral health improvement programmes for 0-5-year-olds. Targeted supervised

	toothbrushing and fluoride varnish programmes, as well as the provision of toothbrushes / paste by post and by health visitors, were all found to effectively reduce tooth decay. However, by a very significant margin (nearly three times more than the second most effective), water fluoridation had the greatest impact. Detail was provided on the rationale, aims and next steps around the proposed expansion of water fluoridation across the North East. Ultimately, this initiative would help everyone (especially those who needed it the most), would lead to positive changes in oral health for young children, and would reduce the number undergoing general anaesthetic (a large majority of which were likely avoidable). Officers welcomed Government support for such a population health measure and noted that the new Secretary of State for Health and Social Care had expressed a desire to launch a consultation in early-2024. An outline of the broad consultation and engagement plans (including with parents and communities) associated with this scheme was given. It was stated that these proposals were planned prior to the emergence of the COVID-19 pandemic (at which point Health and Wellbeing Boards across the region had endorsed), and that dentists were hugely supportive of them. Consultation was on track to commence before the end of 2023, and a communication plan (involving Local Authority colleagues) was in the final stages of preparation. Reflecting on the contents of the presentation, the Committee pointed to the somewhat overwhelming nature of the quoted statistics and the adverse impact of the pandemic in inhibiting improvements to dental health. Highlighting that Hartlepool still had apparent issues despite water fluoridation, Members added that there were objections to these proposals out in the community. In response, officers emphasised that water (like other drinks and foods) was already treated to ensure it was safe to consume, and that fluoridation would reduce dental caries by around 25% in the most deprived areas. That said, whilst fluoridation would reduce severity of dental decay, it would not eliminate bad health / dietary decisions – there was, therefore, a significant requirement for education around the benefits and limitations of the initiative. Ultimately, there was always likely to be objections to any proposal, but it was known that parents of those children suffering from dental decay were broadly supportive as they had witnessed the pain their children had endured. Assurance was given that Local Authorities would be encouraged to robustly consult with their communities. Continuing the theme of unease around introducing fluoridation to the water supply, the Committee asked for clarity on potential side-effects. Officers drew attention to a dental monitoring report which was published every four years and included analysis of general and dental health and the impact of fluoridation – the last report in 2022 showed no differences between fluoridated and non-fluoridated water in terms of adverse health side-effects. Fluorosis was a dental side-effect. Responding to those who were concerned about side-effects, Members drew attention to the impact of dental caries and the risks faced by children who required treatment under general anaesthetic, the use of which, it was felt, should be minimised as far as was safely possible. Officers reiterated that fluoridation was not a panacea for poor dental health, but would reduce severity.

	The Committee was informed that there had been some areas across the country where fluoridation schemes had stopped for technical reasons by water companies. It was subsequently evidenced that this led to a dip in the standard of oral health. A query was raised around how fluoride was best absorbed into the body and whether people had to drink it for optimum effect (e.g. would brushing teeth still provide benefits?). Officers confirmed that drinking fluoridated water would make the biggest difference and agreed that this message needed to be widely communicated to the public. This proposed initiative aside, the Committee asked if enough was being done to address what, for many, were avoidable dental issues. Officers acknowledged that there was always more that could be achieved (e.g. increased number of fluoride varnish schemes) and that this was not limited to children and young people – vulnerable adults and older people in care homes could also be targeted further. Local Authority Public Health functions were fully supportive of the drive to improve the existing situation, with oral health packs, healthy school nutrition programmes, and supervised toothbrushing within schools demonstrating this (Members stressed the need to keep pushing the latter as a number of schools were not participating). Ultimately, however, a key message that must be continually emphasised was that sugary drinks should be a rare treat for children, not, as had become for many, the norm. Concluding the item, the Committee sought clarity around consultation plans. It was confirmed that each Local Authority could decide how it wished to conduct this, but that a significant response was anticipated (including some push-back). AGREED that the community water fluoridation information be noted, and the stated recommendations be supported.
6	**North East and North Cumbria Integrated Care Board - NHS Dentistry Update** Further to a presentation given to the Committee in March 2023, Members received an update on NHS primary care dental services and dental access recovery developments. The North East and North Cumbria Integrated Care Board (NENC ICB) Director of Place Based Delivery provided information on: ➢ Summary Overview of NHS Dentistry ➢ Context ➢ Commissioned Capacity ➢ Other Primary and Community Dental Services ➢ Urgent Dental Care Services ➢ Challenges to Access ➢ Our Approach to Tackling These Challenges – Three Phases ➢ Immediate Actions Undertaken ➢ Dental Access Recommissioning (UDAs) ➢ Further Action and Next Steps ➢ Advice for Patients with an Urgent Dental Treatment Need

	NHS England delegated responsibility to the North East and North Cumbria Integrated Care Board (NENC ICB) for commissioning dental services from 1 April 2023 (with professionals who had previously led on this transferring to the ICB). Whilst private dental services were not commissioned, regulations did not prohibit the provision of private dentistry by NHS dental practices. From a purely NHS perspective, although patients could contact any practice to access care, the issue remained that not all practices could meet demand, and the backlog of treatment needs (involving increased complexity) arising as a result of the COVID-19 pandemic remained high. It was emphasised that whilst the relevant NHS webpage may indicate a practice was not taking on new patients for NHS treatment, individuals were encouraged to contact a practice to confirm this was the latest position as the website was not always up-to-date and availability was often changing. Given the existing pressures, practices were 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 still be delayed. That said, if teeth and gums were healthy, a check-up or scale and polish may not be needed every six months. Regarding NHS dental contracts, commissioned capacity for 2023-2024 was just under 1.3 million units of dental activity (UDAs) across the Tees Valley – this should be sufficient if it could be accessed. In addition to routine general dental practice, other commissioned provision included urgent dental care services (in-hours and out-of-hours appointments via NHS 111), community dental services (CDS – for vulnerable patients with additional needs that cannot be met within high street practices), advanced mandatory (minor oral surgery services), and domiciliary care, sedation and orthodontic services. Access challenges were outlined, including the pandemic legacy and ensuing backlog, recruitment and retention of dentists remaining an issue (particularly for NHS provision) which inhibits a practice's ability to deliver full commissioned capacity, and the ongoing need for national contract reform (the NENC ICB cannot control this but would welcome change). A significant factor (replicated across the UK) was the handing back of contracts, a number of which had been returned since the ICB took over commissioning responsibilities from April 2023 – this had created difficulties in accessing NHS dentists across many areas of the North East (including, from a Tees Valley perspective, Darlington). Three distinct streams were being pursued to tackle these challenges – immediate actions to stabilise services, a more strategic approach to workforce and service delivery, and developing a strategy (linked to the previous water fluoridation item) to improve oral health and reduce the pressure on dentistry. A number of immediate actions undertaken were noted (though were restricted by the number of dentists available), including the recommissioning of UDAs resulting in a significant uplift in non-recurrent capacity across the ICB footprint. Further proposed actions and steps to continue addressing existing NHS dentistry issues were referenced, a key part of which was anticipated work alongside Healthwatch to update patient and stakeholder communications – this was reflected within the final presentation slide which provided advice for patients with

	an urgent dental treatment need. It was acknowledged that the current situation was not ideal, but the ICB was trying to do the best with the resources available, and within the confines of overarching national challenges linked to this sector. The Committee expressed frustration that concerns over the state of NHS dentistry had been flagged for some time now, yet effective action from those in authority continued to be slow. In contrast to the apparent decline of NHS provision, private dentistry appeared to be flourishing, and it seemed clear that payments for NHS work (UDAs) was insufficient to cover costs. Previous discussions on the reasons for challenges in finding / accessing NHS services had indicated that contracts were being handed back by dentists because of frustrations over personal development opportunities (not, as was often thought, for financial motives). Officers agreed that there was a need to sell the broader offer for individual dentists as part of recruitment and retention efforts – as was the case with GPs, a system-wide approach to make the region more attractive for prospective professionals was required (this was not purely an NHS issue). Discussion continued around the provision of an appropriate workforce within dentistry, with Members being informed of recruitment / employment offers which combined working in practices with career development (this had been done in other parts of the UK). It was felt that helping dentists acquire specialist skills could aid in efforts to keep them within the NHS, and that once someone moved to private provision, it was rare that they returned. Similarly, career development of dental nurses was being explored in order to keep them in the NHS system. Referencing the use of the NHS 111 service following a recent poor dental care experience (which worked well but led to the need to travel further for treatment), officers were asked to clarify how a UDA was defined. Members heard that this was a payment measure which involved different treatment bands (e.g. a check-up was one UDA for all practices; a filling (requiring more time) would be classed as three UDAs). Essentially, the more complex the treatment, the more payment units received. With regards the commissioned NHS capacity for 2023-2024, the Committee raised the point that this would provide approximately two UDAs per head of the Tees Valley population – the equivalent of only two check-ups. Observing that only around half the population access dentists, officers acknowledged that there was a need for greater capacity given the existing issues previously highlighted and that it would take some time before demand for services returned to what could be deemed ‘normal’. Members added that it would be helpful if the status of practices on the NHS website was updated more regularly (the lack of a distinction between those taking on routine and / or urgent care was also noted). Returning to recruitment and retention matters, the Committee wondered if an increasing number of professionals were sharing the perception that it was no longer financially viable to work in the NHS system. Officers recognised that practices were under pressure and that payments for treatment were not keeping up with inflation – indeed, many of those who stayed within the NHS did so by supplementing their incomes with private activity. Work was ongoing around ensuring the sustainability of practices.

	AGREED that the NHS dentistry update be noted.
7	**NHS England / Northern Cancer Alliance - Non-Surgical Oncology Outpatient Transformation** Consideration was given to proposals for changes to non-surgical oncology (Systemic Anti-Cancer Treatment (SACT) (chemotherapy-related) and radiotherapy) services across the North East. Supplemented by additional background context outlining challenges associated with the existing offer and the preferred model for future delivery, representatives of NHS England and the Northern Cancer Alliance gave a presentation which included the following: ➢ Why non-surgical services need to change ➢ Overview of oncology services and original outpatient appointment sites ➢ Principles for strategic review and strategic model development ➢ Options considered, decision-making, and preferred option ➢ Example patient pathway and proposed hub locations ➢ Benefits of a tumour-specific hub ➢ Clinical model – peer review (September 2023) and outcomes ➢ Engagement and communication ➢ Impact assessments – health and travel (to date and for preferred option) ➢ Next steps The rationale for altering the existing service model was outlined, a key aspect of which was the nationally recognised shortage in oncologist workforce (identified as far back as 2020). Other factors included a regional variation in current provision and access, the anticipation of new drugs associated with this pathway causing increased demand, and the general increase in cancer incidences. Mapping the present offer across the North East and North Cumbria Integrated Care System (NENC ICS) footprint, two specialist cancer centres at Newcastle (Freeman Hospital) and South Tees (James Cook) included radiotherapy treatment, with chemotherapy delivery units based at 19 sites (the proposals did not change the sites for these services). However, the historical model of outpatient provision was no longer fit for purpose, with inequity of access developing over time, a lack of resilience within the workforce, and an increase in referrals and complexity of cases contributing to delivery pressures. The principles underpinning a strategic review of these services was noted, with key features including the need for patient-focused, clinically-led, care which was delivered as close to home as possible. Given the expected widening of the gap between supply and demand for the regional oncology workforce in the next five years, ensuring oncologist time was used for maximum efficiency was crucial, as was providing safe levels of specialist cover alongside opportunities to enhance resilience through peer support and learning. Following various consultation and engagement with stakeholders (including the public), four future options were identified, one of which was to continue with the current model (already established as unviable). Two others involved either centralisation to the existing cancer centres or a decentralised model – however, these were both problematic due to travel / estate implications and lone-working /

	inequity of service development concerns respectively. The fourth option – clinical networks with tumour-specific hubs and treatments as close to home as possible – was therefore the preferred choice. Once the ongoing engagement and further development phase had concluded, it was intended that the agreed model would be signed off by March 2024. The preferred option was explored in more detail, with example patient pathways, proposed hub locations, and the benefits of a tumour-specific hub demonstrated. Assurance was given that the original diagnostic pathways would not change, though an individual may need to travel further to see a non-surgical oncology doctor. The introduction of hub locations would create a more resilient workforce that provided better patient care, and only a small number of patients (around 15 per week) would need to receive their face-to-face appointments at an alternative site. It was felt that people were less concerned about travelling further if the service they receive was good. Details of a 2023 peer review to check and challenge the proposed model were relayed – this was initiated to ensure safety, sustainability, co-dependencies, quality standards, workforce, equity, and access were appropriately considered. Review outcomes showed support in principle for the preferred option, though work required to mitigate the impact of these changes was identified around workforce levels, out-of-hours provision and access to acute oncology, technology adoption to enable remote access to care, and a programme of involvement / engagement. Regarding this latter finding, extensive engagement and communication efforts were documented in order to seek the views of the public, patients, professionals and partners. Future consultation plans around the proposed new model were also listed – this included the involvement of those with lived experience of oncology services, and activity that engaged people with the greatest level of inequity of access / health inequalities. Health and travel impact assessments had also been undertaken for the preferred option – this was done to identify likely impacts of the proposed service change and provide further insight to reduce potential barriers / discrimination. Concluding the presentation, the next steps around the development of these services were highlighted. Further to securing support for these proposals and the continuation of clinical pathway standardisation work and contract / commissioning conversations, it was hoped that change would start to be implemented from April 2024. The Committee referenced its awareness of feedback on the value of familiarity in terms of contact with professionals and attendance at treatment locations. Officers confirmed that the proposals for the future model would indeed assist in this regard, with professionals to be based within the hubs who patients would be able to repeatedly access, and a co-ordinator to be available for individuals to contact in relation to their ongoing care. One issue that had proved challenging was when people become ill out-of-hours, and much consideration had gone into how best to manage these situations. Work around a regional outreach model was taking place to ensure a more robust out-of-hours structure – Members welcomed this and felt it may also assist in identifying other wraparound care

	requirements (e.g. the need for social care input). Instances of waits for radiotherapy services were raised by the Committee. Officers agreed to follow this up after the meeting, though reiterated that if the workforce was limited and too far spread across a wide geographic area, there was little resilience within the system and delays would inevitably occur. The NENC ICB representative present noted the targeted lung health check work across the region and indicated the support of the ICB for the preferred option. The key issue of transport links to services was discussed, with Members querying whether patient transport options would be available for the revised hub locations, and questioning if the criteria for accessing this was clear. Officers responded by expressing their desire to get input from all parties on the clinical model proposal, and that discussions were being held with voluntary transport providers. Criteria for its use was considered clear, and options were and would still be available. Whilst transport-related conversations needed to continue (and were reviewed on an annual basis anyway), the NENC ICB representative added that spending on transport assistance initiatives diverted funds away from clinical patient care. It was acknowledged, however, that it was important to ensure equitable transport provision across the five Local Authority areas. AGREED that the non-surgical oncology outpatient transformation information be noted, and the preferred option (clinical networks with tumour-specific hubs and treatments as close to home as possible) be supported.
8	**North East and North Cumbria Integrated Care Board - Tees Valley Winter Planning Update** The Committee received its annual winter planning update. Provided by the North East and North Cumbria Integrated Care Board (NENC ICB) Director of Place Based Delivery, key aspects included: ➢ Context ➢ National Guidance ➢ 2023-2024 Winter Planning o Local Accident & Emergency Delivery Board (LADB) o System Control Centre (SCC) o Tees Valley Incident Command Coordination Centre (ICCC) o Urgent and Emergency Care Highlight Report o Winter Plans and Business Cases ➢ Risks and Challenges Like all services up and down the country, the Tees Valley health system remained under significant and sustained pressure – this was impacting upon performance, particularly on flow through hospitals. Influencing factors included staffing issues across all partners, pathway and estate limitations at some sites, increased demand (linked to the elective backlog), higher acuity of patients (resulting in longer stays in hospital), and discharge delays (due to NHS Trust issues and social care / home care staffing pressures). This demonstrated a complex system-wide problem which required a system-wide response.

	National guidance to address these widespread challenges was outlined, including delivery plans for recovering urgent and emergency care (January 2023), and recovering access to primary care (May 2023). Regarding the former, focus on five key areas was highlighted: increasing capacity, increasing workforce size / flexibility, improving discharge, expanding care outside hospital, and making it easier to access the right care. In addition, 10 high-impact interventions had been worked through and implemented in some form – this included reducing variation in same day emergency care (SDEC), acute frailty service provision, and in-patient care / length of stay, as well as virtual wards, single point of access, and acute respiratory infection (ARI) hubs. From a sub-regional perspective, several entities were in place to respond to the additional challenges brought on by the winter season. The Tees Valley Local Accident & Emergency Delivery Board (LADB), System Control Centres (SCC), and the Incident Command Co-ordination Centre (ICCC) – Tees Valley (established as a result of COVID-19 and maintained to ensure connectivity between partners) were all highlighted. Specific attention was drawn to the LADB which was supported in monitoring key performance metrics via the development of an urgent and emergency care (UEC) highlight report – this pulled data from each partner along with supplementary narrative to determine key risks for discussion within the meeting. Robust data helped make good, informed decisions, and the LADB had access to real-time information. Further detail on the process behind planning for the winter period was relayed, a key element of which was the development of a system resilience template (building in Key Lines of Enquiries (KLOEs)) to identify risks. A red / amber / green (RAG) rating was then given based on perceived risk, with the amber elements (in plans, but risks associated with delivery) highlighted in greater depth (note: there were no KLOEs marked red (no evidence of existing implementation or in system plans)). For each priority area listed, a clear Action Plan lay behind it and the overarching risk register was routinely monitored. A prioritised list of agreed schemes / developments following the submission of proposed business cases by partners that would have a measurable impact on the health and care system over the winter was provided. Longer-term proposals involving the commissioning of a standardised Integrated Urgent Care (IUC) model across North and South Tees from the start of April 2024 was also noted. Finally, risks and challenges associated with service delivery and performance were highlighted, with ambulance handover delays at South Tees Hospitals NHS Foundation Trust (STHFT) and category 2 ambulance response times specifically emphasised. Other issues included staffing / workforce limitations for all system partners, competing priorities (e.g. elective versus urgent / emergency care), and service demand pressures across both health (primary and secondary care) and social care. Further waves of COVID and / or industrial action also threatened the ability to meet the needs of the Tees Valley population (e.g. planned treatment may be delayed). Discussions began with Members requesting clarity over the Tees Valley LADB. It was explained that this was a system group that met routinely, and that any single partner could request specific agenda items for discussion at any meeting.

	The Board enabled the identification of critical actions which relevant partners were then responsible for acting upon. On a daily basis, partners are able to initiate Incident Command and Coordination Calls should pressures experienced warrant a system response. The Committee asked if there was an issue across Tees Valley with patients having to wait a long time on trolleys before being seen by an appropriate health professional. Officers stated that there had been some cases of this occurring (though not to the extent as was being experienced in other areas of the country), and that such events were treated as incidents. Continuing the theme of ambulance handovers, Members queried if mechanisms were in place to evaluate measures to make this a more efficient process. Assurance was given that real-time information was available to assess performance, and that a formal period of evaluation would take place in the new year in order to formulate plans for future arrangements. NHS 111 staffing capacity was probed by the Committee, with officers confirming that resources had indeed been strengthened. The importance of clinical hub staff supporting call-handlers was stressed, as was the need for any additional investment to have a positive impact on the wider system. Questioning concluded with Members asking about the impact of COVID and flu during the current season. The Committee was informed of a significant wave of acute respiratory cases across the region (with plans subsequently put in place to mitigate this), with norovirus also present on some hospital wards (with some needing to be temporarily closed to visitors and, on occasion, admissions). The importance of public communications was emphasised in order to promote the right messages to keep people safe and well, as well as reflect the pressures on the system. Ultimately, COVID was not as visible in the news nowadays and was therefore less likely to be in the public psyche. AGREED that the Tees Valley winter planning update be noted.
9	**Work Programme 2023-2024** Consideration was given to the Committee's work programme for 2023-2024. The next formal meeting was scheduled for 15 March 2024, with intended items including both the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) and North East Ambulance Service NHS Foundation Trust (NEAS) Quality Accounts, as well as developments around palliative and end-of-life care. Regarding the 'To be scheduled' section, Members requested that TEWV be approached in relation to the previously suggested briefing on the use of physical restraint / intervention – it was proposed that an informal (remote) session be arranged which should take place prior to the next formal Committee meeting in March 2024. AGREED that:

	1) the Committee's work programme for 2023-2024 be noted. 2) Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) be contacted regarding the scheduling of an informal (remote) session in relation to the Trust's use of physical restraint / intervention (to take place before the next formal Committee meeting in March 2024).