North East Joint Health Scrutiny Commitee

Meeting on 31 July 2015, 10.30 am
Committee Room B, Hartlepool Civic Centre

Agenda

1. **Chairman's Welcome**

2. **Apologies for absence**

3. **To Receive any Declarations of Interest by Members**

4. **Resignation of Vice Chair (Cllr Richards) and Appointment of Replacement**

5. **Minutes of the meeting held on 24 February 2015**

6. **Terms of Reference for the North East Joint Health Scrutiny Committee** - Chair of the North East Joint Health Scrutiny Committee

7. **Introduction and Performance Update** - Yvonne Ormston, Chief Executive, North East Ambulance Service

8. **Selection of Potential Topics for Inclusion in the Committee's 2015/16 Work Programme** - Joan Stevens, Scrutiny Manager

9. **Chairman's urgent items**

10. **Any other business**

11. **Date and time of next meeting - 1 October 2015 at 2pm - Committee Room B, Hartlepool Civic Centre**

Contact Officer, Joan Stevens, Scrutiny Manager – (01429) 284142

North East Joint Health Scrutiny Commitee

North East Joint Health Scrutiny Committee

Minutes of meeting held on 24 February 2015 at Hartlepool Civic Centre

Present:

Councillors Todd (Durham), Green (Gateshead), Martin-Wells (Hartlepool), Mendelson (Newcastle), Waggott-Fairley (North Tyneside), Nisbet (Northumberland), Richards (Northumberland), Brady (South Tyneside), Leask (South Tyneside)

Also in attendance:

Joan Stevens (Hartlepool), Laura Stones (Hartlepool), Peter Mennear (Stockton), Angela Frisby (Gateshead), Karen Christon (Newcastle), Paul Allen (Northumberland), Stephen Gwillym (Durham), Paul Baldasera (South Tyneside), Sharon Ranade (North Tyneside)

Mike Prentice, Medical Director and Lesley Kay, Vice Chair for the Northern Clinical Senate and Mark Cotton, NEAS, Assistant Director of Communications and Engagement

1. **Chairman's Welcome**

   The Vice Chair welcomed everyone and thanked everyone for attending.

2. **Apologies for absence**

   Councillors Taylor (Darlington), McCabe (South Tyneside), Faulks (Stockton), Dryden (Middlesbrough), Wall (Redcar), Jeffrey (Redcar), Simpson (Northumberland), Newall (Darlington)

3. **Appointment of Chair and Vice Chairs**

   Cllr R Martin-Wells was appointed as Chair of the Committee

   Cllrs Richards and Mendelson were appointed as Vice Chairs of the Committee

4. **Minutes of the meeting held on 20 November 2014**

The minutes of the meeting held on 20 November 2014 were agreed with no matters arising.

5. Update from NHS England (Mike Prentice Medical Director and Lesley Kay, Vice Chair for the Northern Clinical Senate)

The Scrutiny Manager introduced this item and informed the Committee that this discussion is a continued dialogue from the Committee's previous discussion at its meeting held in November relating to health services in the northern region.

The Medical Director opened his presentation by commenting that following on from the previous meeting, Members requested more detailed information and therefore he would talk about winter pressures, the urgent and emergency care review and the changes that have already happened and the Vice Chair for the Northern Clinical Senate would talk about the work that the Senate has been involved in.

The surge of winter pressure started building from December 2014 onwards with the crisis happening at the beginning of January 2015. The Medical Director stated that the surge in demand probably was not picked up early enough and that this is a learning point for NHS England to try and pick up surges in demand earlier.

The NEEP levels across the region are a reflection of pressure in the system with this year resulting in more services coming under extreme pressure than in comparison to previous years.

In relation to Urgent Care, the Medical Director informed Members that it is complicated, with the leading brand being A&E, but there are other Urgent Care Services offered. Urgent and Emergency Care is currently under review. One of the issues is access to regular GP services, for example, over bank holidays, holiday periods etc. The evidence shows that there is poor access to GPs through the week and this does correlate with an increase in A&E attendance, although the Medical Director was not sure why.

The other factor is who treats a patient when they arrive at A&E. At best there is a consultant around 12 hours a day. If cover was increased to seven days a week, as opposed to 5 days a week, across the country 4,419 lives could be saved.

A new urgent and emergency care system needs to be developed to deliver as much care as close to home as possible. The structure for the future is about making good choices, for example, people suffering with chronic chest pain should be going into winter with a good supply of medication. Problems occurred this winter as people did not have this option available and therefore people were being admitted to hospital. It is about receiving treatment as soon as possible which results in better outcomes, and using services such as 111. Urgent care is not all about hospitals, it is about accessing other appropriate urgent care services, such as GPs, urgent care centres etc.

The Committee was informed about trauma networks. The evidence shows that if a patient is treated at a trauma centre then their chances of survival are significantly higher than if treated elsewhere. Another example cited was stroke care, which is provided by specialised centres across the country. Expertise in areas is needed in order to keep clinical skills at the correct level.

In relation to GP services, NHS England is starting to see GPs working together and CCGs taking on funding for GP practices. The key to making changes is to get better outcomes.

The Vice-Chair from the Northern Clinical Senate informed members that it has been running for over a year and is a reactive body that are requested by CCGs to look at specific areas/projects. There have been two reports produced so far:-

1) Cumbria – representatives from the Senate were asked to review draft service proposals. They met with representatives from CCGs, Trusts etc and considered specific issues i.e stroke, unstable illnesses. At the Trust the representatives spoke to all members of staff in the related departments and recruitment of staff and the use of locums was highlighted. The representatives reviewed the proposals for pathways and looked at the differences in the models for stroke, questions were asked about rehabilitation and whether to deliver services on two sites or one. A report was then produced and provided to the CCG.
2) Children's services at Cramlington – an external review was commissioned and a group of representatives including expert paediatricians' scrutinised plans looking at issues such as if a child is admitted who will be there to treat the child.

A number of questions were asked by Members, as detailed below.

A member questioned why young people who were suffering with anorexia had been sent to Edinburgh and asked if provision could not be provided closer to home? In response, Dr Prentice stated that there were significant pressures on anorexia beds, although the problem was that only a relatively small number of beds were required. There was a big change happening in eating disorders to improve outcomes by intervening earlier. There would be investment in the eating disorder service from April, although a model was not in place yet. The service was not as robust in Tyne and Wear as it was in Teesside but the desire was to have fewer beds. Members were advised that there had been discussion in Newcastle about the importance of good inpatient and outpatient care, and it seems as though the importance of beds may be undervalued.

A Councillor questioned how easy it was going to be to utilise services such as GPs to reduce admissions to A&E. In response to this, Dr Prentice informed the Committee that when funding was available it was easy to carry on year on year doing the same as there was no reason to change or invest in other parts. However, when funding was tightened people focused and it was hard to change something on the belief that a new service would cope with extra demand. However, it would be difficult to run two services concurrently to show that one service was not needed. It was also about empowering patients as health champions.

In relation to the rationalisation of urgent care services, a Councillor stated that the implications would seem to be moving towards GP activity and concerns were raised in relation to the recruitment and retention of GPs. In response, Dr Prentice highlighted that recruitment of GPs, in general, was not going well. One practice failed to recruit in

two years and then called on the help of the community who made a video and marketed the vacancies via twitter, and this method worked. Traditionally doctors would stay at one practice for their entire career, but this is not the case these days therefore GP practices have to adapt to this. Members were informed that General Practice has to be made more attractive.

A Councillor acknowledged that the integration of healthcare services was long overdue and questioned how GPs of the future were going to engage. In response, Members were advised that however structures were changed; the same people were staying but transferring to different roles. It was commented that if the NHS stopped restructuring then more would get done. As the NHS is a tax funded system, a consequence is that it will keep changing.

It was questioned whether more women were choosing to work part in GP practices and men were choosing to work in hospitals. This didn't seem to be the case as many male GPs were now working part time and of the medical graduates 70 percent were women.

It was questioned whether too much pressure was being placed on paramedics to make decisions. In response, Members were informed that paramedics were trained to a high level and if they were going to take a patient to a specialised centre there were ways to share information with the centre to confirm the best course of action/appropriateness. Paramedics worked safely in a defined pathway and the performance was very good. A skilled person can make a good assessment and were trained to do so therefore mistakes are reduced. In relation to the availability of paramedics and ambulances waiting at A&E it was acknowledged that the system needs to start flowing, as paramedics need to be free to respond as quickly as possible after a hospital drop off. The Assistant Director of Communications and Engagement at the North East Ambulance Service (NEAS), who was in attendance at the meeting confirmed that NEAS had introduced a new initiative over winter, which involved a person being located in hospitals to help in the smooth transfer of patients from ambulance to A&E.

Agreed – That members note the update and further updates be provided as and when required.

6. Emergency Ambulance Transport – update (Mark Cotton, Assistant Director of Communications and Engagement)

The Assistant Director of Communications and Engagement from NEAS provided the Committee with an update on Emergency Ambulance Transport. The Assistant Director reiterated that it had been a very challenging winter for A&E services and ambulance services. NEAS has been under pressure over winter, starting from the beginning of December through to January, with some evident pressure before this period. There had been a 10% increase in demand and hand over delays at hospitals had been an issue.

In relation to the overall performance (week commencing 16 February 2015), Red 1 calls were performing at 74.8%, with the target being 75%. Red 1 calls still remained a challenge, percentages could fluctuate due to the low number of Red 1 calls received, each time a Red 1 call was not attended within the target time, it resulted in a significant change in the percentages.

Red 2 calls were performing at 84% since early January, which was an indication that the winter pressure was reducing. Of particular concern was the delay to red calls, Members were informed that 368 patient waited longer than 20mniutes for a Red 1 call.

Rural ambulance performance continued to struggle at 60 – 66%.

There were no targets in relation to green calls and NEAS had seen a slow recovery in green calls, with 53% being responded to within the specified timescale and for green 3 calls, these were being responded to within the specified timescale 71% of the time.

Members were informed that activity levels had calmed down, although demand was still higher than previous years. One of the challenges was that if demand spiked early in the day, then time after this was spent catching up.

NEAS had introduced a number of new initiatives to help relieve the winter pressures, these included:-

- the introduction of Hospital Ambulance Liaison Officers (HALOs) who are deployed within the NEAS operational region to assist both hospitals and ambulance crews during times of pressure;
- An increase of clinicians in the call centre; and
- Introduction of 'Flight Desk', which is a real time database of hospital bed availability across the region

Members questioned whether NEAS had developed the Flight Desk system and commented that it should be available to Doctor's surgeries. In response, this is something that NEAS had thought about and is something that would be explored in order to try and take forward. It was an innovative system and NEAS had led the system. Members agreed to write to NHS England to emphasis the impact of the system and its success and encourage NHS to champion the system to other organisations such as GP practices.

Members questioned the use of third party providers. It was confirmed that NEAS were still using third party providers because there were still paramedic vacancies at NEAS, there were 126 whole time equivalent vacancies across the North East. There was a national shortage of paramedics, with the North East and London having the highest vacancy rate. Filling vacancies was a top priority and the quicker the vacancies could be filled then the quicker pressure would be eased and also this would reduce the reliance on third party providers. NEAS were actively looking to recruit qualified paramedics. Members were informed that paramedic training was changing and it would now be provided directly by University rather than through NEAS and accredited by Universities. A member questioned how students could be retained in the North East. In response to the question, Members were informed that NEAS would like the

Universities to recruit students with a view to coming to work in the North East. It was questioned whether NEAS could sponsor students, with a tie in period following qualification to aid their retention as a NEAS employee. The Assistant Director stated that he thought this had already been looked, however, he was more than happy to take the suggestion back to the NEAS Board for further consideration.

Members welcomed indications that the suggestion was to be explored further and looked forward to receiving feedback on its viability as a way forward. Members questioned the student dropout rate, the Assistant Director said that he did not have the figures with him but would provide them following the meeting.

The Chair congratulated NEAS for the introduction of the initiatives and requested that a representative attend a meeting of the Committee in 12months to provide an update on paramedic training to reassure members that training is underway.

Members asked about how local scrutiny committees could receive updates from NEAS. The Assistant Director commented that NEAS do attend some Committees on a regular basis but one of the issues is about time/capacity to attend all Scrutiny Committees. However, Members were advised that NEAS would consider developing a quarterly report for each local authority.

A Member congratulated NEAS staff and asked if the Assistant Director would pass this onto the staff on the Committee's behalf.

Agreed - That Members note the update;

- **That the Joint Committee write to NHS England to emphasis the impact of the Flight Desk system and its success to encourage NHS England to champion the system to other organisations such as GP practices;**
- **That an update be provided to the Committee in 12 months regarding paramedic training and its progress;**
- **That feedback be provided on the viability of student sponsorship, with a tie in period, as a means of addressing the paramedic shortfall and aid staff retention; and**
- **That details of the student dropout rate be provided following the meeting.**

7. **NEAS Quality Account** (Mark Cotton, Assistant Director of Communications and Engagement)

Members received a presentation on NEAS's Quality Report from the Assistant Director of Communications and Engagement. The presentation outlined what is a Quality Report; the reporting process; progress against priorities for 2014/15; mandatory

indicators for 2014/15; proposals for 2015/16 and next steps. Members were informed that the five priorities identified last year were:-

- **Use of alternatives:** '*where appropriate, drive up the use of treatment other than conveyance to an Emergency Department'.* The progress made against this priority was outlined to the Committee which included, services continued to be added to the Directory of Services, an Advanced Practice Paramedic role had been developed and training had been provided to paramedics to increase the number of patients who could be managed on scene/in their own home. Hear and Treat and See and Treat volumes and rates were shared with Members of the Committee.
- **Reduce Hospital Delays**: *'To improve the average hospital turnaround time at target hospitals'.* The progress made against this priority was outlined to the Committee which included, gaining a better understanding of the drivers; HALOs and Flight Deck in place using winter funding; standardising handover procedures and a revised escalation and divert policy drafted (to deflect ambulances to alternative hospitals).
- **Staff Satisfaction***: 'To reduce the frequency of extended shifts across all of NEAS to optimise patient care and staff welfare.* The progress made against this priority was outlined to the Committee which included, recruitment being pursued as the top priority for the Trust; and information being monitored using the Emergency Care Management Dashboard.
- **Mandatory Checks:** *'Set up systems in NEAS that demonstrate all mandatory requirements are being met that could impact on the safety of patients and staff'.* The progress made against this priority was outlined to the Committee which included, work had started on the development of an e-ledger; first phase focus on staff related checks started; future phases to include compliance requirements in respect of vehicles and buildings; and monthly 'Delivering Consistently' meetings have been implemented and are being used to provide assurance that checks were being completed.
- **High Intensity Users:** 'Lead the work with those with long term conditions to make sure they get the most appropriate response in the most appropriate place to meet their needs. The progress made against this priority was outlined to the Committee which included, an increase in resource to flag these users on NEAS systems had been secured as part of the winter schemes funding; and a review of the work needed to deliver this priority was underway as there were improvements needed to capture the data in the most appropriate way.

The Committee were informed of the Mandatory Indicators and the progress made against them, as outlined in the presentation.

The proposals for 2015/16 were to continue to make progress with the existing priorities; improve the performance for the mandatory indicators and seek feedback from stakeholders on what is important to them.

In relation to Mandatory Indicator 6 'Patient Reported Safety Incidents', a Member raised concerns about the increase in incidents compared to the previous year. The Assistant Director responded and stated that NEAS had one of the safest records and they were certainly not complacent. The Assistant Director said that he would provide further detail on the types of incidents.

A member questioned why paramedic recruitment was not included as a priority in the Quality Account. In response, the Assistant Director stated that this was not being ignored and was included within the 'Staff Satisfaction' priority, although it could be made more explicit.

The Committee thanked the Assistant Director for his attendance.

Members agreed to formulate a response to the Quality Account and following the publication of the draft Quality Account, Members were asked to feed comments to their Scrutiny Support Officers who would pass these onto the host authority for inclusion within the response.

Agreed – That the comments from today's meeting be utilised to formulate a response to the Quality Account and further comments be sought from Committee Members following publication of the draft Quality Account.

8. Chairman's urgent items

Work Programme

The Scrutiny Manager suggested to Members that at the next meeting, the Committee may want to consider developing a work programme for the coming year and identify a topic for investigation for inclusion within the work programme. The Scrutiny Manager sought permission from the Committee to attend a meeting of the Directors of Public Health to ask if they had any topic suggestions. Any topic suggestions identified would be fed back to the next meeting of the Committee.

Agreed – The Committee agreed that the Scrutiny Manager attend a meeting of the Directors of Public Health to seek topic suggestions for the 2015/16 Municipal Year.

9. Any other business

No items

10. Date and time of next meeting

To be confirmed – agreed to look at a date in June

Joint Health Overview and Scrutiny Committee of:

Darlington Borough Council, Durham County Council, Gateshead Council, Hartlepool Borough Council, Middlesbrough Council, Newcastle upon Tyne City Council, North Tyneside Council, Northumberland County Council, Redcar and Cleveland Borough Council, South Tyneside Council, Stockton-on-Tees Borough Council and Sunderland City Council

TERMS OF REFERENCE AND PROTOCOLS

Establishment of the Joint Committee

1. The Committee is established in accordance with section 244 and 245 of the National Health Service Act 2006 ("NHS Act 2006") and regulations and guidance with the health overview and scrutiny committees of Darlington Borough Council, Durham County Council, Gateshead Council, Hartlepool Borough Council, Middlesbrough Council, Newcastle upon Tyne City Council, North Tyneside Council, Northumberland County Council, Redcar and Cleveland Borough Council, South Tyneside Council, Stockton-on-Tees Borough Council and Sunderland City Council ("the constituent authorities") to scrutinise issues around the planning, provision and operation of health services in and across the North-East region, comprising for these purposes the areas covered by all the constituent authorities.

2. The Committee will hold two full committee meetings per year. The Committee's work may include activity in support of carrying out:

   (a) Discretionary health scrutiny reviews, on occasions where health issues may have a regional or cross boundary focus, or

   (b) Statutory health scrutiny reviews to consider and respond to proposals for developments or variations in health services that affect more than one health authority area, and that are considered "substantial" by the health overview and scrutiny committees for the areas affected by the proposals.

   (c) Monitoring of recommendations previously agreed by the Joint Committee.

For each separate review the Joint Committee will prepare and make available specific terms of reference, and agree arrangements and support, for the enquiry it will be considering.

Aims and Objectives

3. The North East Region Joint Health Overview and Scrutiny Committee aims to scrutinise:

   (a) NHS organisations that cover, commission or provide services across the North East region, including and not limited to, for example, NHS North East, local primary care trusts, foundation trusts, acute trusts, mental health trusts and specialised commissioning groups.

   (b) Services commissioned and/or provided to patients living and working across the North East region.

   (c) Specific health issues that span across the North East region.

   Note: Individual authorities will reserve the right to undertake scrutiny of any relevant NHS organisations with regard to matters relating specifically to their local population.

4. The North East Region Joint Health Overview and Scrutiny Committee will:

   (a) Seek to develop an understanding of the health of the North East region's population and contribute to the development of policy to improve health and reduce health inequalities.

   (b) Ensure, wherever possible, the needs of local people are considered as an integral part of the commissioning and delivery of health services.

   (c) Undertake all the necessary functions of health scrutiny in accordance with the NHS Act 2006, regulations and guidance relating to reviewing and scrutinising health service matters.

   (d) Review proposals for consideration or items relating to substantial developments/substantial variations to services provided across the North East region by NHS organisations, including:

(i) Changes in accessibility of services.
(ii) Impact of proposals on the wider community.
(iii) Patients affected.

(e) Examine the social, environmental and economic well-being responsibilities of local authorities and other organisations and agencies within the remit of the health scrutiny role.

Membership

5. The Joint Committee shall be made up of 12 Health Overview and Scrutiny Committee members comprising 1 member from each of the constituent authorities. In accordance with section 21(9) of the Local Government Act 2000, Executive members may not be members of an overview and scrutiny committee. Members of the constituent local authorities who are Non-Executive Directors of the NHS cannot be members of the Joint Committee.

6. The appointment of such representatives shall be solely at the discretion of each of the constituent authorities.

7. The quorum for meetings of the Joint Committee is one-third of the total membership, in this case four members, irrespective of which local authority has nominated them.

Substitutes

8. A constituent authority may appoint a substitute to attend in the place of the named member on the Joint Committee. The substitute shall have voting rights in place of the absent member.

Co-optees

9. The Joint Committee shall be entitled to co-opt any non-voting person as it thinks fit to assist in its debate on any relevant topic. The power to co-opt shall also be available to any Task and Finish/Working Groups formed by the Joint Committee. Co-option would be determined through a case being presented to the Joint Committee or Task and Finish Group/Working Group, as appropriate. Any supporting information regarding co-option should be made available for consideration by Joint Committee members at least 5 working days before a decision is made.

Formation of Task and Finish/Working Groups

10. The Joint Committee may form such Task and Finish/Working Groups of its membership as it may think fit to consider any aspect or aspects within the scope of its work. The role of any such Group will be to consider the matters referred to it in detail with a view to formulating recommendations on them for consideration by the Joint Committee. The precise terms of reference and procedural rules of operation of any such Group (including number of members, chairmanship, frequency of meetings, quorum etc.) will be considered by the Joint Committee at the time of the establishment of each such Group. The Chair of a specific Task and Finish Group will act in the manner of a Host Authority for the purposes of the work of that Task and Finish Group, and arrange and provide officer support for that Task and Finish Group. These arrangements may differ if the Joint Committee considers it appropriate. The meetings of such Groups should be held in public except to the extent that the Group is considering any item of business that involves the likely disclosure of exempt information from which the press and public could legitimately be excluded as defined in Part 1 of Schedule 12A of the Local Government Act 1972 as amended by the Local Government (Access to Information) (Variation) Order 2006.

11. The Chair of the Joint Health Overview and Scrutiny Committee may not be the Chair of a Task and Finish Group.

Chair and Vice-Chairs

12. The Chair of the Joint Committee will be drawn from the membership of the Joint Committee, and serve for a period of 12 months, from a starting date to be agreed. A Chair may not serve for two consecutive twelve-month periods. The Chair will be agreed through a consensual process, and a nominated Chair may decline the invitation. Where no consensus can be reached then the Chair will be nominated through a ballot system of one Member vote per Authority only for those Members present at the meeting where the Chair of the Joint Health Overview and Scrutiny Committee is chosen.

13. The Joint Committee may choose up to two Vice-Chairs from among any of its members, as far as possible providing a geographic spread across the region. A Vice-Chair may or may not be appointed to the position of Chair or Vice-Chair in the following year.

14. If the Chair and Vice-Chairs are not present, the remaining members of the Joint Committee shall elect a Chair for that meeting.

15. Other than any pre-existing arrangements within their own local authority, no Special Responsibility Allowances, or other similar payments, will be drawn by the Chair, Vice Chairs, or Tasking and Finish Group Chairs in connection with the business of the Joint Committee.

Host Authority

16. The local authority from which the Chair of the Joint Committee is drawn shall be the Host Authority for the purposes of this protocol.

17. Except as provided for in paragraph 10 above in relation to Task and Finish Groups, the Host Authority will service and administer the scrutiny support role and liaise proactively with the other North East local authorities and the regional health scrutiny officer network. The Host Authority will be responsible for the production of reports for the Joint Committee as set out below, unless otherwise agreed by the Joint Committee. An authority acting in the manner of a Host Authority in support of the work of a Task and Finish Group will be responsible for collecting the work of that Group and preparing a report for consideration by the Joint Committee.

18. Meetings of the Joint Committee may take place in different authorities, depending on the nature of the enquiry and the potential involvement of local communities. The decision to rotate meetings will be made by members of the Joint Committee.

19. Documentation for the Joint Committee, including any final reports, will be attributed to all the participating member authorities jointly, and not solely to the Host Authority. Arrangements will be made to include the Council logos of all participating authorities.

Work planning and agenda items

20. The Joint Committee may determine, in consultation with health overview and scrutiny committees in constituent authorities, NHS organisations and partners, an annual work programme. Activity in the work programme may be carried out by the Joint Committee or by a Task and Finish/Working Group under the direction of the Joint Committee. A work programme may be informed by:

    (a) Research and information gathering by health scrutiny officers supplemented by presentations and communications.

    (b) Proposals associated with substantial developments/substantial variations.

21. Individual meeting agendas will be determined by the Chair, in consultation with the Vice-Chairs where practicable. The Chair and Vice-Chairs may meet or conduct their discussions by email or letter.

22. Any member of the Joint Committee shall be entitled to give notice, with the agreement of the Chair, in consultation with the Vice-Chairs, where practicable, of the Joint Committee, to the relevant officer of the Host Authority that he/she wishes an item relevant to the functions of the Joint Committee to be included on the agenda for the next available meeting. The member will also provide detailed background information concerning the agenda item. On receipt of such a request (which shall be made not less than five clear working days before the date for despatch of the agenda) the relevant officer will ensure that it is included on the next available agenda.

Notice and Summons to Meetings

23. The relevant officer in the Host Authority will give notice of meetings to all Joint Committee members, in line with access to information rules of at least five clear working days before a meeting. The relevant officer will send an agenda to every member specifying the date, time and place of each meeting and the business to be transacted, and this will be accompanied by such reports as are available.

Attendance by others

24. The Joint Committee and any Task and Finish/Working Group formed by the Joint Committee may invite other people (including expert witnesses) to address it, to discuss issues of local concern and/or to answer questions. It may for example wish to hear from residents, stakeholders and members and officers in other parts of the public sector and shall invite such people to attend.

Procedure at Joint Committee meetings

25. The Joint Committee shall consider the following business:

    (a) Minutes of the last meeting (including matters arising).
    (b) Declarations of interest.
    (c) Any urgent item of business which is not included on an agenda but the Chair agrees should be raised.
    (d) The business otherwise set out on the agenda for the meeting.

26. Where the Joint Committee wishes to conduct any investigation or review to facilitate its consideration of the health issues under review, the Joint Committee may also ask people to attend to give evidence at Joint Committee meetings which are to be conducted in accordance with the following principles:

    (a) That the investigation is conducted fairly and all members of the Joint Committee be given the opportunity to ask questions of attendees, and to contribute and speak.

    (b) That those assisting the Joint Committee by giving evidence be treated with respect and courtesy.

    (c) That the investigation be conducted so as to maximise the efficiency of the investigation or analysis.

Voting

27. Any matter will be decided by a simple majority of those Joint Committee members voting and present in the room at the time the motion is put. This will be by a show of hands or if no dissent, by the affirmation of the meeting. If there are equal votes for and against, the Chair or other person chairing the meeting will have a second or casting vote. There will be no restriction on how the Chair chooses to exercise a casting vote.

Urgent Action

28. In the event of the need arising, because of there not being a meeting of the Joint Committee convened in time to authorise this, officers administering the Joint Committee from the Host Authority are generally authorised to take such action, in consultation with the Chair, and Vice-Chairs where practicable, to facilitate the role and function of the Joint Committee as they consider appropriate, having regard to any Terms of Reference or other specific relevant courses of action agreed by the Joint Committee, and subject to any such actions being reported to the next available meeting of the Joint Committee for ratification.

Final Reports and recommendations

29. The Joint Committee will aim to produce an agreed report reflecting a consensus of its members, but if consensus is not reached the Joint Committee may issue a majority report and a minority report.

    (a) If there is a consensus, the Host Authority will provide a draft of both the conclusions and discursive text for the Joint Committee to consider.

    (b) If there is no consensus, and the Host Authority is in the majority, the Host Authority will provide the draft of both the conclusions and discursive text for a majority report and arrangements for a minority report will be agreed by the Joint Committee at that time.

    (c) If there is no consensus, and the Host Authority is not in the majority, arrangements for both a majority and a minority report will be agreed by the Joint Committee at that time.

    (d) In any case, the Host Authority is responsible for the circulation and publication of Joint Committee reports. Where there is no consensus for a final report the Host Authority should not delay or curtail the publication unreasonably.

    The rights of the health overview and scrutiny committees of each local authority to make reports of their own are not affected.

30. A majority report may be produced by a majority of members present from any of the local authorities forming the Joint

Committee. A minority report may be agreed by any *[number derived by subtracting smallest possible majority from quorum: e.g. if quorum is 4, lowest possible majority is 3, so minority report requires 1 members' agreement]* or more other members.

31. For the purposes of votes, a "report" shall include discursive text and a list of conclusions and recommendations. In the context of paragraph 29 above, the Host Authority will incorporate these into a "final report" which may also include any other text necessary to make the report easily understandable. All members of the Joint Committee will be given the opportunity to comment on the draft of the final report. The Chair in consultation with the Vice-Chairs, where practicable, will be asked to agree to definitive wording of the final report in the light of comments received. However, if the Chair and Vice-Chairs cannot agree, the Chair shall determine the final text.

32. The report will be sent to *[name of the NHS organisations involved]* and to any other organisation to which comments or recommendations are directed, and will be copied to NHS North East, and to any other recipients Joint Committee members may choose.

33. The *[name of the NHS organisations involved]* will be asked to respond within 28 days from their formal consideration of the Final Report, in writing, to the Joint Committee, via the nominated officer of the Host Authority. The Host Authority will circulate the response to members of the Joint Committee. The Joint Committee may (but need not) choose to reconvene to consider this response.

34. The report should include:

    (a) The aim of the review – with a detailed explanation of the matter under scrutiny.

    (b) The scope of the review – with a detailed description of the extent of the review and it planned to include.

    (c) A summary of the evidence received.

    (d) An evaluation of the evidence and how the evidence informs conclusions.

(e) A set of conclusions and how the conclusions inform the recommendations.

(f) A list of recommendations – applying SMART thinking (Specific, Measurable, Achievable, Realistic, Timely), and how these recommendation, if implemented in accordance with the review outcomes, may benefit local people.

(g) A list of sources of information and evidence and all participants involved.

Timescale

35. The Joint Committee will hold two full committee meetings per year, and at other times when the Chair and Vice-Chairs wish to convene a meeting. Any three members of the joint committee may require a special meeting to be held by making a request in writing to the Chair.

36. Subject to conditions in foregoing paragraphs 29 and 31, if the Joint Committee agrees a report, then:

    (a) The Host Authority will circulate a draft final report to all members of the Joint Committee.

    (b) Members will be asked to comment on the draft within a period of two weeks, or any other longer period of time as determined by the Chair, and silence will be taken as assent.

    (c) The Chair and Vice-Chairs will agree the definitive wording of the final report in time for it to be sent to *[name of the NHS organisations involved].*

37. If it believed that further consideration is necessary, the Joint Committee may vary this timetable and hold further meetings as necessary. The *[name of the NHS organisations involved]* will be informed of such variations in writing by the Host Authority.

Guiding principles for the undertaking of North East regional joint health scrutiny

38. The health of the people of North East England is dependent on a number of factors including the quality of services provided by the NHS, the local authorities and local partnerships. The success of joint health scrutiny is dependent on the members of the Joint Committee as well as the NHS and others.

39. Local authorities and NHS organisations will be willing to share knowledge, respond to requests for information and carry out their duties in an atmosphere of courtesy and respect in accordance with their codes of conduct. Personal and prejudicial interests will be declared in all cases in accordance with the Members' Code of Conduct of each constituent authority.

40. The scrutiny process will be open and transparent in accordance with the Local Government Act 1972 and the Freedom of Information Act 2000 and meetings will be held in public. Only information that is expressly defined in regulations to be confidential or exempt from publication will be considered in private. The Host Authority will manage requests and co-ordinate responses for information considered to be confidential or exempt from publication in accordance with the Host Authority's legal advice and guidance. Joint Committee papers and information not being of a confidential nature or exempt from publication may be posted on the websites of the constituent authorities as determined by each of those authorities.

41. Different approaches to scrutiny reviews may be taken in each case. The Joint Committee will seek to act as inclusively as possible and will take evidence from a wide range of opinion including patients, carers, the voluntary sector, NHS regulatory bodies and staff associations, as necessary and relevant to the terms of reference of a scrutiny review. Attempts will be made to ascertain the views of hard to reach groups, young people and the general public.

42. The Joint Committee will work to continually strengthen links with the other public and patient involvement bodies such as PCT patient groups and Local Involvement Networks, where appropriate.

43. The regulations covering health scrutiny allow an overview and scrutiny committee to require an officer of a local NHS body to

attend before the committee. This power may be exercised by the Joint Committee. The Joint Committee recognises that Chief Executives and Chairs of NHS bodies may wish to attend with other appropriate officers, depending on the matter under review. Reasonable time will be given for the provision of information by those asked to provide evidence.

44. Evidence and final reports will be written in plain English ensuring that acronyms and technical terms are explained.

45. Communication with the media in connection with reviews will be handled in conjunction with the constituent local authorities' press officers.

Conduct of Meetings

46. The conduct of Joint Committee meetings shall be regulated by the Chair (or other person chairing the meeting) in accordance with the general principles and conventions which apply to the conduct of local authority committee meetings.

47. In particular, however, where any person other than a full or co-opted member of the Joint Committee has been allowed or invited to address the meeting the Chair (or other person chairing the meeting) may specify a time limit for their contribution, in advance of its commencement which shall not be less than five minutes. If someone making such a contribution exceeds the time limit given the Chair (or other person chairing the meeting) may stop him or her.

48. The Chair (or other person chairing the meeting) may also structure a discussion and limit the time allowed for each agenda item and questioning by members of the Joint Committee.

NORTH EAST JOINT HEALTH SCRUTINY COMMITTEE

31 July 2015

Report of: Scrutiny Manager

Subject: SELECTION OF POTENTIAL TOPICS FOR INCLUSION IN THE 2015/16 JOINT HEALTH SCRUTINY COMMITTEE'S WORK PROGRAMME

1. PURPOSE OF REPORT

1.1 To seek consideration of potential topics for inclusion into the Work Programme for the North East Joint Health Scrutiny Committee for the 2015/16 Municipal Year.

2. BACKGROUND INFORMATION

2.1 In considering the development of a potential work programme item, the Directors of Public Health across the region and each Local Authority representative has been consulted and the potential topics that have been suggested are outlined in sections 2.2 and 2.3 of this report to enable the Committee to compile its Work Programme.

2.2 In order for the Committee to identify a suitable topic for investigation a PICK scoring system has been utilised which measures each topic using 4 areas, public interest; impact; council performance and efficiency; and keep in context. An explanation of the scoring system is attached as **Appendix A.** The key factors in choosing a topic are:-

- The issue must be relevant across the region and an issue that the Committee can influence;
- Can be broken down into slices of work that could potentially be undertaken by smaller groups; and
- The topic produces a set of recommendations / outcomes that can add value.

TOPIC	Regional Directors of Public Health Suggestion	Local Authority Suggestion	Matrix Score
Healthy Eating To explore:- - How to prevent duplication across the region - Sugar tax – what we are doing and how to lobby for legislative change For further details see **Appendix B**	X		9
Transport and Health To explore: - Active travel For further details see **Appendix C**	X		6
Housing and Health To explore: - Houses of multiple occupation - Private rented accommodation (stress of short term tenancies) For further details see **Appendix D**	X		8
Homelessness and Health For further details see **Appendix E**	X		10
Poverty To explore: - Health inequalities and their impact on health **For further details see Appendix F**	X		10
Child Poverty To explore: - Health inequalities and their impact on health - Good practice **For further details see Appendix G**	X		10

The wider model of health service provision / Long term pattern of acute service provision in the North East To explore: - Raising awareness of national funding position - Difficulties in the rationalisation of services (what to change/stop in the centralisation of services) - What is the right regional footprint **For further details see Appendix H**	**X**	South Tyneside	8
End of Life Care **For further details see Appendix I**		North Tyneside Middlesbrough Darlington	9
Health and Social care Integration **For further details see Appendix J**		South Tyneside Darlington	8
Urgent care and the development of better access to GP services **For further details see Appendix K**		South Tyneside	6
GP Recruitment **For further details see Appendix L**		South Tyneside	9
Encouraging people to use pharmacies for minor ailments and other services where provided **For further details see Appendix M**		South Tyneside Darlington	10
One of the priorities from the 5 Year Forward View **For further details see Appendix N**		Hartlepool	9
7 day NHS working **For further details see Appendix O**		Middlesbrough	9
Maternity Services **For further details see Appendix P**		Middlesbrough	9

2.3 The Committee is also advised to be cautious in setting an overly ambitious Work Programme for which it may be unable to deliver. The below are updates which, in addition to a topic of investigation, are due to be considered by the Committee throughout the course of the year.

National Heart Review – Position statement and Outcome (if available)	October 2015
NEAS midyear Quality Accounts priorities / key performance update	October 2015
NEAS Patient Transport	October 2015
Update from NHS England / Senate (to build on	October 2015 or February / March 2016
Update on paramedic training and its progress	February / March 2016
NEAS Quality Accounts	February / March 2016
Monitoring of NEAS performance on a regular basis	TBC

2.4 Once the Committee has identified its topic, anticipated time frames need to be applied. It is recognised that the Committee's workload needs to be managed carefully, with due consideration given to the allocation of appropriate time to allow effective exploration of the identified health topic. In order to assist in achieving this, it is suggested that the Committee considers the potential value of exploring alternative methods of gathering information / evidence, such as small groups, full/half day conference style events, informal sessions, in order to maximise member and officer time.

2.5 It is also suggested to the Committee that a standard template for applying time allocations should be treated with caution as when scoping a subject a number of complexities may arise, therefore the anticipated duration should be allocated to the subject on an individual basis.

3. RECOMMENDATIONS

3.1 The North East Joint Health Scrutiny Committee is requested to:

(a) consider the wide range of information detailed within this report to assist in the determination of its 2015/16 Work Programme, utilising the tables provided; and

(b) consider choosing a maximum of one topic for the coming year, which will allow for flexibility in its work programme for emerging issues and referrals

4. REASONS FOR RECOMMENDATIONS

4.1 To develop an effective Work Programme which will also complement the work of other bodies?

BACKGROUND PAPERS

The following backgrounds papers were used in the preparation of this report:-

Contact Officer:- Joan Stevens – Scrutiny Manager
Chief Executive's Department – Legal Services
Hartlepool Borough Council
Tel: 01429 284142
Email: joan.stevens@hartlepool.gov.uk

Appendix A

PICK Priority Setting

P for Public Interest

Members' representative roles are an essential feature of Scrutiny. They are the eyes and ears of the public, ensuring that the policies, practice and services delivered to the people of the District, by both the Council and external organisations, are meeting local needs and to an acceptable standard. The concerns of local people should therefore influence the issues chosen for scrutiny. This could include current issues. For example, dignity is consistently cited as a high priority for service users (e.g. Mid Staffordshire Enquiry, care in Winterbourne hospital) and scrutiny committees are well placed to influence the agenda locally and drive forward better quality services). Members themselves will have a good knowledge of local issues and concerns. Surgeries, Parish Councils, Residents Associations and Community Groups are all sources of resident's views. Consultation and Surveys undertaken by the Council and others can also provide a wealth of information.

I for Impact

Scrutiny is about making a difference to the social, economic and environmental well-being of the area. Not all issues of concern will have equal impact on the well-being of the community. This should be considered when deciding the programme of work, giving priority to the big issues that have most impact. To maximise impact, particularly when scrutinising external activity, attention should also be given to how the committee could influence policy and practice. Sharing the proposed programme of reviews with Members, officer and key partners will assist this process.

C for Council Performance

Scrutiny is about improving performance and ensuring the Council's customers are served well. With the abolition of external inspection regimes, scrutiny has an even more important role to play in self regulation. Members will need good quality information to identify areas where the Council, and other external organisations, are performing poorly. Areas where performance has dropped should be our priority. As well as driving up Council performance, scrutiny also has an important role in scrutinising the efficiency and value for money of Council services and organizational development.

K for Keep in Context

To avoid duplication or wasted effort priorities should take account of what else in happening in the areas being considered. Is there another review happening or planned? Is the service about to be inspected by an external body? Are there major legislative or policy initiatives already resulting in change? If these circumstances exist Members may decide to link up with other approaches or defer a decision until the outcomes are known or conclude that the other approaches will address the issues. Reference should also be made to proposed programmes of work in the Council's plans and strategies

PICK Scoring System

- **P**ublic Interest: the concerns of local people should influence the issues chosen

Score	Measure
0	no public interest
1	low public interest
2	medium public interest
3	high public interest

- **I**mpact: priority should be given to the issues which make the biggest difference to the social, economic and environmental well-being of the area

Score	Measure
0	no impact
1	low impact
2	medium impact
3	high impact

- **C**ouncil Performance and efficiency: priority should be given to the areas in which the Council, and other agencies, are not performing well or proposals which will support the current Efficiency, Improvement and Transformation Programme.

Score	Measure
0	'Green' on or above target performance
1	'Amber',
2	low performance 'Red'

- **K**eep in Context: work programmes must take account of what else is happening in the areas being considered to avoid duplication or wasted effort.

Score	Measure
0	Already dealt with/ no priority
1	Longer term aspiration or plan
2	Need for review acknowledged and worked planned elsewhere
3	Need for review acknowledged

Each topic will be scored under each category as indicated above. Where a category is not applicable, no score will be given.

Topic: Healthy Eating

Background Information

Good nutrition has a key role to play both in the prevention and management of diet-related diseases such as cardiovascular disease (CVD), cancer, diabetes and obesity (WHO, 2003). Healthy eating during childhood and adolescence is vital as a means to ensure healthy growth and development and to set up a pattern of positive eating habits into adult life. The promotion of evidence-based healthy eating messages is fundamental. Alongside this, it is necessary to ensure that guidelines concerning a nutritionally adequate diet are implemented to help prevent diet-related deficiencies and malnutrition in vulnerable infants, children and adults.

In the UK, the poorer people are, the worse their diet, and the more diet-related diseases they suffer from. This is known as food poverty. Poor diet is a risk factor for the UK's major causes of death: cancer; coronary heart disease (CHD); and diabetes. It is only recently that the immense contribution it makes to poor health has been quantified: poor diet is related to 30% of life years lost in premature death and disability (De Rose et al, 1998).

Areas to consider:-

(a) Promotion of healthy eating and sharing good practice. How do we make better use of national campaigns and brands, and develop joint working with key sectors, such as planning and transport departments, to ensure the potential for physical activity and healthy eating is maximised.

How do we promote healthy eating in 'at risk' groups:
- Age (children, young adults aged 19-24 years, and adults aged 65 years)
- Gender
- Socioeconomic status
- Ethnicity
- Vulnerable groups

(b) Sugar Tax – what are we doing and how to lobby for legislative change

AREAS FOR CONSIDERATION	**PICK Scoring System**
Public **Interest** – the concerns of local people should influence the issues chosen Data shows that 22% of people in the North East have a healthy diet which compares to an England average of 28%.	**2** **Medium public interest**
Impact – priority should be given to the issues which make the biggest difference to the social, economic and environmental, and health and well-being of the area Raising awareness of healthy eating in the North East and the services available will contribute to improving the health and wellbeing of residents.	**3** **High impact**

Council Performance and Efficiency – priority should be given to the areas in which the Council, and other agencies, are not performing well or proposals which will support budget proposals Performance is below the England average.	**1** **Amber**
Keep in Context – work programmes must take into account of what else is happening in the areas being considered to avoid duplication or wasted effort This topic has not been considered in previous years.	**3** **Need for review**

TOTAL SCORE: 9

Topic: Transport and Health

Background Information

Transport has an impact on health through transport-related accidents, active travel, public transport, air quality and access to a range of services.

Transport can affect people by giving access to employment opportunities, education, leisure, healthcare and diverse food supplies. The development of an efficient transport network and vehicles has the potential to benefit health.

Increasing levels of motorised traffic have contributed to air pollution, noise, vibration, danger from vehicles and an increased fear of traffic. These issues particularly affect the most deprived and most vulnerable people in communities.

The rise in personal car use has meant liberation for people who are young and more affluent. More deprived, elderly and disabled people can become trapped in 'residential islands' surrounded by dense traffic, or without the means to access more distant facilities and services in out-of-town developments. This also applies to people in rural areas faced with dwindling local facilities and longer travel times.

Road traffic casualties are still one of the main public health challenges in the UK particularly for children and young adults.

The rise in personal car ownership levels has contributed to people being less active. This is a significant contributor to obesity, diabetes and cardiovascular disease.

Areas to consider:-

(a) Establish and integrate a culture of safe and active travel into communities, businesses, schools and for leisure purposes. This includes all new developments to include sustainable travel infrastructure to reduce reliance on the motor vehicle where walking and cycling become the acceptable norm;

(b) Identifying barriers to the adoption of sustainable travel alternatives to the motor car including increases in walking, cycling and public transport use. Engagement with key agencies to address barriers and ensure that safe and active travel is marketed and promoted effectively

AREAS FOR CONSIDERATION	**PICK Scoring System**
Public Interest – the concerns of local people should influence the issues chosen High Public Interest	**3**

Impact – priority should be given to the issues which make the biggest difference to the social, economic and environmental, and health and well-being of the area A good opportunity to influence transport authorities/providers.	**3** **High Impact**
Council Performance and Efficiency – priority should be given to the areas in which the Council, and other agencies, are not performing well or proposals which will support budget proposals N/A	**N/A**
Keep in Context – work programmes must take into account of what else is happening in the areas being considered to avoid duplication or wasted effort The North East Combined Authority are exploring the issue of transport, therefore this topic would potentially duplicate work.	**0** **Already dealt with/no priority**

TOTAL SCORE: 6

Appendix H

Topic: The Wider Model of Health Service Provision / Long term pattern of acute service provision in the North East

Background Information

This topic links to Priority 9 of the Five Year Forward View – whole system change for future clinical and financial sustainability).

Areas to cover/examine could be:

- Raising awareness of national funding position
- Difficulties in the rationalisation of services (what to change / stop in the centralisation of services)
- What is the right regional footprint?

Also, it links to the following suggested topic:

- Health and Social Care Integration – picture across the North East

AREAS FOR CONSIDERATION	**PICK Scoring System**
Public Interest – the concerns of local people should influence the issues chosen	**3 High public interest**
Impact – priority should be given to the issues which make the biggest difference to the social, economic and environmental, and health and well-being of the area.	**3 High impact**
Council Performance and Efficiency – priority should be given to the areas in which the Council, and other agencies, are not performing well or proposals which will support budget proposals N/A	**N/A**
Keep in Context – work programmes must take into account of what else is happening in the areas being considered to avoid duplication or wasted effort The Regional Committee has received presentations from NHS England on this area and the Committee may welcome further updates /presentations from NHS England.	**2 Need for review acknowledged**

TOTAL SCORE: 8

Appendix G

Topic: Child Poverty (0-5) - Health Inequalities and their impact on health - Good practice	
Background Information The number of children in relative poverty in the UK is forecast to rise from 2.6 million in 2009/10 to 3.3 million by 2020/21 (measuring income before housing costs), and that of working-age adults from 5.7 million in 2009/10 to 7.5 million by 2020/21. The proportion of children in absolute poverty (using the 2010/11 poverty line fixed in real terms) is forecast to rise to 23 per cent by 2020/21, compared with the 5 per cent target. (Joseph Rowntree Foundation, 2011).	
AREAS FOR CONSIDERATION	**PICK Scoring System**
Public Interest – the concerns of local people should influence the issues chosen Poverty, especially child poverty is of concern to local people, as many people in the North East have or are experiencing poverty.	**3** **High public interest**
Impact – priority should be given to the issues which make the biggest difference to the social, economic and environmental, and health and well-being of the area The number of children in poverty is increasing.	**3** **High impact**
Council Performance and Efficiency – priority should be given to the areas in which the Council, and other agencies, are not performing well or proposals which will support budget proposals High levels of deprivation and poverty.	**Low performance** **2**
Keep in Context – work programmes must take into account of what else is happening in the areas being considered to avoid duplication or wasted effort Many national and regional organisations are considering poverty, such as the North East Child Poverty Commission; therefore the Regional Committee may be able to contribute to ongoing work.	**2** **Need for review acknowledged and work ongoing elsewhere**

TOTAL SCORE: 10

Topic: Poverty - Health inequalities and their impact on Health

Background Information

The Institute for Fiscal Studies (IFS) show that about 17.5% of children in the UK grow up in relative poverty (household income below 60% of the median) compared with 16.1% of the general population. Similarly, about 17.5% of pensioners are in relative poverty. 14.6% of working age non-parents are in relative poverty (IFS, 2012). A million young economically active people aged 16 to 24 years were unemployed in the first half of 2012. That is 22%, compared with 6% for those aged 25 to 64 years (Joseph Rowntree Foundation, 2012).

Pensioner poverty has fallen from 29% in 1998/99 to 18% in 2007/08. However, many pensioners remain with incomes at, or just above, 60% of median income and there are still about 1.1million pensioners living in poverty (Work and Pensions Committee, 2009).

The composition of those in poverty is very different today than 10 or 20 years ago. The proportion of pensioners in poverty has halved since the early 1990s, while that of working age adults without children has risen by one third (Joseph Rowntree Foundation, 2012)

The Marmot Review ('Fair Society, Healthy Lives')

In November 2008, Professor Sir Michael Marmot was asked by the then Secretary of State to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010.

The final report was published in February 2010 (Marmot Review, 2010) and concluded that reducing health inequalities would require action on six policy objectives:-

1. Give every child the best strat in life;
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives;
3. Create fair employment and good work for all;
4. Ensure healthy standard of living for all;
5. Create and develop healthy and sustainable places and communities; and
6. Strengthen the role and impact of ill-health prevention.

Each of these policy objectives is influenced by the scale and distribution of poverty.

AREAS FOR CONSIDERATION	**PICK Scoring System**
Public Interest – the concerns of local people should influence the issues chosen Poverty is of concern to local people, as many people in the North East have been in or are experiencing poverty.	**3** **High public interest**

Impact – priority should be given to the issues which make the biggest difference to the social, economic and environmental, and health and well-being of the area The number of people in poverty is increasing.	**3** **High impact**
Council Performance and Efficiency – priority should be given to the areas in which the Council, and other agencies, are not performing well or proposals which will support budget proposals High levels of deprivation and poverty.	**2** **Low performance**
Keep in Context – work programmes must take into account of what else is happening in the areas being considered to avoid duplication or wasted effort Many national and regional organisations are considering poverty, such as the North East Child Poverty Commission; therefore the Regional Committee may be able to contribute to ongoing work.	**2** **Need for review acknowledged and work ongoing elsewhere**

TOTAL SCORE: 10

Topic: Homelessness and Health

Background Information

There is a strong overlap between experiences of more extreme forms of homelessness and other support needs, with nearly half of service users reporting experience of institutional care, substance misuse, and street activities (such as begging) , as well as homelessness. Traumatic childhood experiences such as abuse, neglect and homelessness are part of most street homeless people's life histories. Most complex needs were experienced by homeless men aged 20-49, and especially by those in their 30s (Joseph Rowntree Trust, 2011).

The life expectancy of homeless people is 30 years less than the rest of the population. On average, homeless people live until the age of 47, and for homeless women, it is further reduced to just age 43. They are consistently less likely to take up routine screening, health checks, and vaccinations and it is essential to engage this group with existing public health programmes. Ill health is more likely within homeless households, including those in temporary accommodation. School absenteeism is more prevalent amongst children in homeless households; and they are more prone to delayed development of communication skills (Shelter, 2006b).

Homelessness is linked to nutritional deficiencies, and obesity is increasingly common (Food Standards Agency, 2007). Rough sleeping is accepted to be inherently harmful to good health, and either contributes to, or exacerbates, health problems such as physical and mental health issues, and drug and alcohol misuse (Crisis, 2011; Department of Health, 2010).

AREAS FOR CONSIDERATION	**PICK Scoring System**
Public Interest – the concerns of local people should influence the issues chosen**.**	**3 High Public Interest**
Impact – priority should be given to the issues which make the biggest difference to the social, economic and environmental, and health and well-being of the area. Reducing homelessness will have an impact on the social, economic and environmental, and health and well-being of the area.	**3 High Impact**
Council Performance and Efficiency – priority should be given to the areas in which the Council, and other agencies, are not performing well or proposals which will support budget proposals. **Households found to be homeless, by region (over the page)**	**1 Amber**

Region **Number of Households 2013/14** East Midlands 5,440 East of England 7,864 London 24,543 North East 2,912 North West 7,907 South East 10,021 South West 4,745 West Midlands 11,901 Yorkshire and the Humber 6,663	
Keep in Context – work programmes must take into account of what else is happening in the areas being considered to avoid duplication or wasted effort. Healthwatch Middlesbrough has recently undertaken a survey across the Tees Valley on homelessness and therefore the information gathered may be useful.	**3** **Need for review acknowledged**

TOTAL SCORE: 10

Topic: Housing and Health

Background Information

Housing has an important impact on health and well-being: good quality, appropriate housing in places where people want to live has a positive influence on reducing deprivation and health inequalities by facilitating stable/secure family lives. This in turn helps to improve social, environmental, personal and economic well-being. Conversely, living in housing which is in poor condition, overcrowded or unsuitable will adversely affect the health and well-being of individuals and families.
The value of good housing needs to been seen as more than 'bricks and mortar'. The Department for Communities and Local Government (DCLG, 2006) define a decent home as 'a home that is warm, weatherproof and has reasonably modern facilities'. Failure to address the investment needs of poor housing conditions will have a detrimental impact on the occupiers' health and well-being.
Areas to consider:

- Houses of multiple occupation
- Private rented Accommodation (stress of short term tenancies)

AREAS FOR CONSIDERATION	**PICK Scoring System**
Public Interest – the concerns of local people should influence the issues chosen Medium public interest	**2** Medium public interest
Impact – priority should be given to the issues which make the biggest difference to the social, economic and environmental, and health and well-being of the area Housing has an important impact on health and well-being: good quality, appropriate housing in places where people want to live has a positive influence on reducing deprivation and health inequalities by facilitating stable/secure family lives	**3** **High Impact**
Council Performance and Efficiency – priority should be given to the areas in which the Council, and other agencies, are not performing well or proposals which will support budget proposals N/A	**N/A**
Keep in Context – work programmes must take into account of what else is happening in the areas being considered to avoid duplication or wasted effort	**3** **Need for review acknowledged**

TOTAL SCORE: 8

Topic: Homelessness and Health

Background Information

There is a strong overlap between experiences of more extreme forms of homelessness and other support needs, with nearly half of service users reporting experience of institutional care, substance misuse, and street activities (such as begging) , as well as homelessness. Traumatic childhood experiences such as abuse, neglect and homelessness are part of most street homeless people's life histories. Most complex needs were experienced by homeless men aged 20-49, and especially by those in their 30s (Joseph Rowntree Trust, 2011).

The life expectancy of homeless people is 30 years less than the rest of the population. On average, homeless people live until the age of 47, and for homeless women, it is further reduced to just age 43. They are consistently less likely to take up routine screening, health checks, and vaccinations and it is essential to engage this group with existing public health programmes. Ill health is more likely within homeless households, including those in temporary accommodation. School absenteeism is more prevalent amongst children in homeless households; and they are more prone to delayed development of communication skills (Shelter, 2006b).

Homelessness is linked to nutritional deficiencies, and obesity is increasingly common (Food Standards Agency, 2007). Rough sleeping is accepted to be inherently harmful to good health, and either contributes to, or exacerbates, health problems such as physical and mental health issues, and drug and alcohol misuse (Crisis, 2011; Department of Health, 2010).

AREAS FOR CONSIDERATION	**PICK Scoring System**
Public Interest – the concerns of local people should influence the issues chosen**.**	**3 High Public Interest**
Impact – priority should be given to the issues which make the biggest difference to the social, economic and environmental, and health and well-being of the area. Reducing homelessness will have an impact on the social, economic and environmental, and health and well-being of the area.	**3 High Impact**
Council Performance and Efficiency – priority should be given to the areas in which the Council, and other agencies, are not performing well or proposals which will support budget proposals. **Households found to be homeless, by region (over the page)**	**1 Amber**

Region **Number of Households 2013/14** East Midlands 5,440 East of England 7,864 London 24,543 North East 2,912 North West 7,907 South East 10,021 South West 4,745 West Midlands 11,901 Yorkshire and the Humber 6,663	
Keep in Context – work programmes must take into account of what else is happening in the areas being considered to avoid duplication or wasted effort. Healthwatch Middlesbrough has recently undertaken a survey across the Tees Valley on homelessness and therefore the information gathered may be useful.	**3** **Need for review acknowledged**

TOTAL SCORE: 10

Topic: Poverty - Health inequalities and their impact on Health

Background Information

The Institute for Fiscal Studies (IFS) show that about 17.5% of children in the UK grow up in relative poverty (household income below 60% of the median) compared with 16.1% of the general population. Similarly, about 17.5% of pensioners are in relative poverty. 14.6% of working age non-parents are in relative poverty (IFS, 2012). A million young economically active people aged 16 to 24 years were unemployed in the first half of 2012. That is 22%, compared with 6% for those aged 25 to 64 years (Joseph Rowntree Foundation, 2012).

Pensioner poverty has fallen from 29% in 1998/99 to 18% in 2007/08. However, many pensioners remain with incomes at, or just above, 60% of median income and there are still about 1.1million pensioners living in poverty (Work and Pensions Committee, 2009).

The composition of those in poverty is very different today than 10 or 20 years ago. The proportion of pensioners in poverty has halved since the early 1990s, while that of working age adults without children has risen by one third (Joseph Rowntree Foundation, 2012)

The Marmot Review ('Fair Society, Healthy Lives')

In November 2008, Professor Sir Michael Marmot was asked by the then Secretary of State to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010.

The final report was published in February 2010 (Marmot Review, 2010) and concluded that reducing health inequalities would require action on six policy objectives:-

1. Give every child the best strat in life;
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives;
3. Create fair employment and good work for all;
4. Ensure healthy standard of living for all;
5. Create and develop healthy and sustainable places and communities; and
6. Strengthen the role and impact of ill-health prevention.

Each of these policy objectives is influenced by the scale and distribution of poverty.

AREAS FOR CONSIDERATION	**PICK Scoring System**
Public Interest – the concerns of local people should influence the issues chosen Poverty is of concern to local people, as many people in the North East have been in or are experiencing poverty.	**3** **High public interest**

Impact – priority should be given to the issues which make the biggest difference to the social, economic and environmental, and health and well-being of the area The number of people in poverty is increasing.	**3** **High impact**
Council Performance and Efficiency – priority should be given to the areas in which the Council, and other agencies, are not performing well or proposals which will support budget proposals High levels of deprivation and poverty.	**2** **Low performance**
Keep in Context – work programmes must take into account of what else is happening in the areas being considered to avoid duplication or wasted effort Many national and regional organisations are considering poverty, such as the North East Child Poverty Commission; therefore the Regional Committee may be able to contribute to ongoing work.	**2** **Need for review acknowledged and work ongoing elsewhere**

TOTAL SCORE: 10

Appendix G

Topic: Child Poverty (0-5) - Health Inequalities and their impact on health - Good practice	
Background Information The number of children in relative poverty in the UK is forecast to rise from 2.6 million in 2009/10 to 3.3 million by 2020/21 (measuring income before housing costs), and that of working-age adults from 5.7 million in 2009/10 to 7.5 million by 2020/21. The proportion of children in absolute poverty (using the 2010/11 poverty line fixed in real terms) is forecast to rise to 23 per cent by 2020/21, compared with the 5 per cent target. (Joseph Rowntree Foundation, 2011).	
AREAS FOR CONSIDERATION	**PICK Scoring System**
Public Interest – the concerns of local people should influence the issues chosen Poverty, especially child poverty is of concern to local people, as many people in the North East have or are experiencing poverty.	**3** **High public interest**
Impact – priority should be given to the issues which make the biggest difference to the social, economic and environmental, and health and well-being of the area The number of children in poverty is increasing.	**3** **High impact**
Council Performance and Efficiency – priority should be given to the areas in which the Council, and other agencies, are not performing well or proposals which will support budget proposals High levels of deprivation and poverty.	**Low performance** **2**
Keep in Context – work programmes must take into account of what else is happening in the areas being considered to avoid duplication or wasted effort Many national and regional organisations are considering poverty, such as the North East Child Poverty Commission; therefore the Regional Committee may be able to contribute to ongoing work.	**2** **Need for review acknowledged and work ongoing elsewhere**

TOTAL SCORE: 10

Appendix H

Topic: The Wider Model of Health Service Provision / Long term pattern of acute service provision in the North East

Background Information

This topic links to Priority 9 of the Five Year Forward View – whole system change for future clinical and financial sustainability).

Areas to cover/examine could be:

- Raising awareness of national funding position
- Difficulties in the rationalisation of services (what to change / stop in the centralisation of services)
- What is the right regional footprint?

Also, it links to the following suggested topic:

- Health and Social Care Integration – picture across the North East

AREAS FOR CONSIDERATION	**PICK Scoring System**
Public Interest – the concerns of local people should influence the issues chosen	**3 High public interest**
Impact – priority should be given to the issues which make the biggest difference to the social, economic and environmental, and health and well-being of the area.	**3 High impact**
Council Performance and Efficiency – priority should be given to the areas in which the Council, and other agencies, are not performing well or proposals which will support budget proposals N/A	**N/A**
Keep in Context – work programmes must take into account of what else is happening in the areas being considered to avoid duplication or wasted effort The Regional Committee has received presentations from NHS England on this area and the Committee may welcome further updates /presentations from NHS England.	**2 Need for review acknowledged**

TOTAL SCORE: 8

Appendix I

Topic: End of Life Care

Background Information

Improving end of life care will involve working in partnership to consider how best to engage with local communities to raise the importance of end of life care. This may involve engagement with schools, faith groups, funeral directors, care homes, hospices, independent and voluntary sector providers and employers amongst others.

Although individuals may have different ideas about what would, for them, constitute a 'good death', for many this would involve:

- being treated as an individual, with dignity and respect;
- being without pain and other symptoms;
- being in familiar surroundings; and
- being in the company of close family and/or friends.

Areas for consideration:

- An update on how far the regional Good Death Charter has been implemented.

AREAS FOR CONSIDERATION	**PICK Scoring System**
Public Interest – the concerns of local people should influence the issues chosen This is in the public interest.	**3** **High public interest**
Impact – priority should be given to the issues which make the biggest difference to the social, economic and environmental, and health and well-being of the area This issue will have a high impact as outcomes will contribute to improving end of life care pathways.	**3** **High impact**
Council Performance and Efficiency – priority should be given to the areas in which the Council, and other agencies, are not performing well or proposals which will support budget proposals N/A	**N/A**
Keep in Context – work programmes must take into account of what else is happening in the areas being considered to avoid duplication or wasted effort Scrutiny has not investigated this topic in previous years.	**3** **Need for review acknowledged**

TOTAL SCORE: 9

Topic: Health and Social Care Integration

Background Information

The number of people in England who have health problems requiring both health and social care is increasing. For example, in the next 20 years, the percentage of people over 85 will double. This means there are likely to be more people with 'complex health needs' - more than one health problem - who require a combination of health and social care services.

But these services often don't work together very well. For example, people are sent to hospital, or they stay in hospital too long, when it would have been better for them to get care at home. Sometimes people get the same service twice - from the NHS and social care organisations - or an important part of their care is missing.

This means patients do not get the joined-up services they need, leaving them at increased risk of harm. Health and care staff may miss opportunities to make things better for patients and service users, and taxpayers' money is not being used as effectively as possible.

Also, it links to the following suggested topic:-

- The Wider Model of Health Service Provision / Long term pattern of acute service provision in the North East

This topic could be provided as an update to the Committee.

AREAS FOR CONSIDERATION	**PICK Scoring System**
Public Interest – the concerns of local people should influence the issues chosen**.**	**3 High public interest**
Impact – priority should be given to the issues which make the biggest difference to the social, economic and environmental, and health and well-being of the area.	**3 High impact**
Council Performance and Efficiency – priority should be given to the areas in which the Council, and other agencies, are not performing well or proposals which will support budget proposals N/A	**N/A**
Keep in Context – work programmes must take into account of what else is happening in the areas being considered to avoid duplication or wasted effort The Regional Committee has received presentations from NHS England on this area and the Committee may welcome further updates /presentations from NHS England.	**2 Need for review acknowledged**

TOTAL SCORE: 8

Appendix K

Topic: Urgent Care and the development of better access to GP Services	
Background Information Due to the nature of how the NHS delivers these services it may be difficult to review this topic on a regional basis. As it is a broad topic, it could lend itself to looking at good practice including why GP access is better in some places than others.	
AREAS FOR CONSIDERATION	**PICK Scoring System**
Public Interest – the concerns of local people should influence the issues chosen**.**	**3** **High public interest**
Impact – priority should be given to the issues which make the biggest difference to the social, economic and environmental, and health and well-being of the area.	**2** **Low impact**
Council Performance and Efficiency – priority should be given to the areas in which the Council, and other agencies, are not performing well or proposals which will support budget proposals.	**N/A**
Keep in Context – work programmes must take into account of what else is happening in the areas being considered to avoid duplication or wasted effort	**1** **Longer term aspiration or plan**

TOTAL SCORE: 6

Appendix L

Topic: GP Recruitment	
Background Information Areas to cover: - Update to the Committee / one-off piece of work to look at how GP recruitment is handled across the North East.	
AREAS FOR CONSIDERATION	**PICK Scoring System**
Public Interest – the concerns of local people should influence the issues chosen**.**	**2** **Medium public interest**
Impact – priority should be given to the issues which make the biggest difference to the social, economic and environmental, and health and well-being of the area.	**2** **Medium impact**
Council Performance and Efficiency – priority should be given to the areas in which the Council, and other agencies, are not performing well or proposals which will support budget proposals. One in three posts for trainee GPs across the country has not been filled.	**2** **Low performance**
Keep in Context – work programmes must take into account of what else is happening in the areas being considered to avoid duplication or wasted effort Some Local Authorities may have considered this issue locally.	**3** **Need for review acknowledged**

TOTAL SCORE: 9

Appendix M

Topic: Encouraging people to use pharmacies for minor ailments.	
Background Information The greater use of local pharmacies as the first port of call for minor ailments should be encouraged. The aim is to improve access to healthcare and importantly save the patient time. Local pharmacies can advise patients on a wide range of minor ailments and either recommend treatment or refer the patient to another healthcare professional.	
AREAS FOR CONSIDERATION	**PICK Scoring System**
Public Interest – the concerns of local people should influence the issues chosen	**2** **Medium Public Interest**
Impact – priority should be given to the issues which make the biggest difference to the social, economic and environmental, and health and well-being of the area An area which is established and may need better promotion.	**3** **Medium Impact**
Council Performance and Efficiency – priority should be given to the areas in which the Council, and other agencies, are not performing well or proposals which will support budget proposals An increase in people using pharmacies would be beneficial.	**2** **Low performance**
Keep in Context – work programmes must take into account of what else is happening in the areas being considered to avoid duplication or wasted effort	**3** **Need for review acknowledged**

TOTAL SCORE: 10

Topic: One of the priorities from the NHS 5 year forward view

Background Information

The 10 priorities are:-

1. Improving the quality of care and access to cancer treatment
2. Upgrading the quality of care and access to mental health and dementia services
3. Transforming care for people with learning disabilities
4. Tackling obesity and preventing diabetes
5. Redesigning urgent and emergency care services
6. Strengthening primary care services
7. Timely access to high quality elective care
8. Ensuring high quality and affordable specialised care
9. Whole system change for future clinical and financial sustainability
10. Foundations for improvement

Some of the areas form part of other topic suggestions.

AREAS FOR CONSIDERATION	**PICK Scoring System**
Public Interest – the concerns of local people should influence the issues chosen**.**	**3 High public interest**
Impact – priority should be given to the issues which make the biggest difference to the social, economic and environmental, and health and well-being of the area.	**3 High Impact**
Council Performance and Efficiency – priority should be given to the areas in which the Council, and other agencies, are not performing well or proposals which will support budget proposals. N/A	**N/A**
Keep in Context – work programmes must take into account of what else is happening in the areas being considered to avoid duplication or wasted effort.	**3 Need for review acknowledged**

TOTAL SCORE: 9

Appendix O

Topic: 7 day NHS Working	
Background Information Patients need the NHS every day. Evidence shows that the limited availability of some hospital services at weekends can have a detrimental impact on outcomes for patients, including raising the risk of mortality. NHS England is committed to offering a much more patient-focussed service. Part of this commitment will be fulfilled by moving towards routine NHS services being made available seven days a week. This area is still in development and it might be useful for the Committee to discuss this area later in the year to see how the region is prepared for 7 day working.	
AREAS FOR CONSIDERATION	**PICK Scoring System**
Public Interest – the concerns of local people should influence the issues chosen	**3** **High public interest**
Impact – priority should be given to the issues which make the biggest difference to the social, economic and environmental, and health and well-being of the area	**3** **High impact**
Council Performance and Efficiency – priority should be given to the areas in which the Council, and other agencies, are not performing well or proposals which will support budget proposals N/A	**N/A**
Keep in Context – work programmes must take into account of what else is happening in the areas being considered to avoid duplication or wasted effort	**3** **Need for review acknowledged**

TOTAL SCORE: 9

Appendix P

Topic: Maternity Services	
Background Information Following the report on Furness General Hospital and the Government's review of maternity of maternity services, a snapshot of how things are in the North East might be useful, including issues such as recruitment and retention of midwives and if the system is coping with demand.	
AREAS FOR CONSIDERATION	**PICK Scoring System**
Public Interest – the concerns of local people should influence the issues chosen	**3** **High public interest**
Impact – priority should be given to the issues which make the biggest difference to the social, economic and environmental, and health and well-being of the area	**3** **High Impact**
Council Performance and Efficiency – priority should be given to the areas in which the Council, and other agencies, are not performing well or proposals which will support budget proposals N/A	**N/A**
Keep in Context – work programmes must take into account of what else is happening in the areas being considered to avoid duplication or wasted effort	**3** **Need for review acknowledged**

TOTAL SCORE: 9