North East Joint Health Scrutiny Commitee

Meeting on Thursday 2nd June 2016 at 10.00 am in Committee Room B, Civic Centre, Hartlepool

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Agenda

1. **Chairman's Welcome**

2. **Apologies for absence**

3. **Appointment of Chair and Vice Chair 2016/17**

4. **To receive any Declarations of Interest by Members**

5. **Minutes of the meeting held on 6 January 2016**

6. **Terms of Reference and Protocols for the North East Joint Health Scrutiny Committee**

7. **Regional Back Pain Programme - North of England Commissioning Support Unit (NECS)**

8. **Neonatal Intensive Care Transport (to follow) – NHS England North**

9. **Update on Congenital Heart Disease (to follow) – NHS England North**

10. **Vascular Surgery (to follow) – NHS England North**

11. **Chairman's urgent items**

12. **Any other business**

13. **Date and time of next meetings:**

    - **Thursday 27 October 2016 at 10am, Hartlepool Civic Centre**

    - **Thursday 2 March 2017 at 10am, Hartlepool Civic Centre**

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

NORTH EAST JOINT HEALTH SCRUTINY COMMITTEE

MINUTES

6 January 2016

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

Present:

Chair: Councillor Ray Martin-Wells, Hartlepool Borough Council

Durham County Council:
Councillor Robinson

Northumberland County Council:
Councillors Sambrook

Redcar Borough Council:
Councillor Kay

Stockton Borough Council:
Councillor Javed

In accordance with Council Procedure Rule 5.2 (ii), Councillor Schofield was in attendance as substitute for Councillor Mendelson (Newcastle City Council).

Also Present: David Hambleton, Transforming Care Programme
Gail Bayes, Northumberland, Tyne and Wear NHS Foundation Trust
Ahmad Khouja, Levi Buckley, Dave Banks and Glenn Havelock, Tees, Esk and Wear Valley NHS Foundation Trust
Sam Harrison, North East Commissioning Service
Lesley Jeavons, Head of Adult Care, Durham County Council / Association of Directors of Adult Social Services Regional Lead

Officers: Jane Bowie, Northumberland County Council
Paul Allen, Northumberland County Council
Alison Pearson, Redcar and Cleveland Borough Council
Peter Mennear, Stockton Borough Council
Paul Baldesera, South Tyneside Council
Stephen Gwillym, Durham County Council
Joan Stevens, Scrutiny Manager (HBC)
Angela Armstrong, Principal Democratic Services (HBC)

27. Apologies for Absence

Apologies for absence were received from Councillors Dryden (Middlesbrough Borough Council), Newall (Darlington Borough Council), Green (Gateshead Borough Council), Brooks (North Tyneside Council), Brady (South Tyneside Council), and Mendelson (Newcastle City Council).

28. Declarations of Interest

None.

29. Minutes of the meeting held on 17 December

The Chair highlighted to the Committee that an amendment had been suggested by NHS England to Minute 24, decision (ii). However, the Committee did not agree with the amendment and confirmed the minutes as submitted.

30. North East and Cumbria Learning Disabilities Fast Track Transformation Plan

Representatives from the North of England Commissioning Support Unit (NECS) were in attendance and jointly provided a detailed and comprehensive presentation on the Learning Disabilities Fastrack Programme. The presentation showed how learning disability beds had been reducing since 1986 in line with Government Guidance with the aim of bringing an end to the model of institutionalisation as a model of care and providing more choice for people with learning disabilities. It had been recognised that the pace of change was too slow and a National Task Force had been created to drive this change forward. An overview of the current picture across admissions, discharges and care and treatment reviews was provided along with the targets, aims and ambitions for the future.

It was noted that the Including North Partnership had been created involving Local Authorities, Community and Voluntary Sector, Housing Providers, the Association of Directors of Adult Social Services and a number of NHS organisations to develop the community model of the Fastrack Programme. The aim of the Programme was to reduce learning disability beds from 277 in 2014/15 to 104 in 2018/19 through the provision of more appropriate support for people with learning disabilities within their own home or a community based setting. It was proposed that dowries would be available to Local Authorities for the care and support of each individual with learning disabilities discharged into their own home or a community based setting, although the detail of this provision had yet to be finalised.

In conclusion, it was noted that there was always the intention to maintain a

limited number of in-patient learning disability beds within the region for cases where this was the most appropriate care for an individual.

A service user with learning disabilities who had previously utilised the in-patient beds gave the Committee a brief overview of his experience of the care and support provided during what had been a troubled period in his life. He added that he was now living in the community and was fully discharged and had a much better car plan in place with a very supportive staff team around him. A fact sheet had been produced which highlighted some of the key facts that service users of learning disabilities care and support thought were really important for to enable effective planning to meet their individual needs. The service user was thanked for his attendance and heartfelt presentation, it was much appreciated by the Committee.

There was some concern expressed by Members that there was no Elected Member representation on the North East and Cumbria Learning Disability Transformation Board. A discussion ensued during which it was considered appropriate to appoint two Elected Member representatives to the Board, one from the Northumbria and Tyne and Wear NHS Foundation Trust area and one from the Tees, Esk and Wear Valley NHS Foundation Trust area and this was welcomed by the health representatives in attendance. A Member questioned whether the fact that learning disability in-patient beds occupied by patients from out of the area were limiting the use of patients from within the north east area. The representative from the Transforming Care Programme confirmed that the majority of beds in the north east region were occupied by patients from within this region but support was provided to people from outside the region when this was appropriate.

Members sought reassurance that the proposed ‘dowry’ funding would follow patients and that Local Authorities would not be faced with additional costs for these patients when their budgets were already under considerable strain. The representative from the Transforming Care Programme, who chaired the Northern CCG Forum reassured Members that Clinical Commissioning Groups fully supported the principle of the dowry following the patient to fund their care and were not looking to Local Authorities to take on these costs. Further reassurance was provided that the provision of care and support to people with learning disabilities was monitored and regulated by the Care Quality Commission. It was highlighted that further Government guidance was awaited on the provision of individual dowries and whether they would fund part or all of the individual’s ongoing care as there remained the need to provide further investment in future service provision.

In response to a question from a Member, a representative from Tees, Esk and Wear Valley NHS Foundation Trust reassured Members that this Transformation Plan was not about moving to zero beds, there was always the intention to have a limited number of beds available within the north east to meet that particular need and demand.

A Member sought clarification on the rationale for the implementation of these changes and whether it was due to financial reasons or the best interests of the patients. A representative from Tees, Esk and Wear Valley NHS Foundation Trust indicated that this was an opportunity to make system wide transformational change whilst recognising that this may not be the most appropriate solution for everyone. In view of this any care packages put in place would be led by the individual and their needs and preferences from a range of choices. To support this process it was highlighted that there would be enhanced Community Teams to visit people living in their own homes and within the community to provide support and ensure an individualised and appropriate approach to their care and support package.

Decision

1) In acknowledging that this was a complex piece of work the Committee supported the principles within the North East and Cumbria Learning Disability Transformation Programme.
2) That further updates on the progress of the Programme be submitted to this Committee on a regular basis providing details of:
   a) The development of proposals and any associated consultation/engagement plans;
   b) Financial aspects of the project, including the proposed dowry arrangements for the care and support of individuals with learning disabilities within their own home and in community based settings; and
   c) Statistics in respect of Learning Disability bed occupancy rates throughout the lifespan of the project proposals.
3) That the Chair liaise with the Vice Chair to progress Member observer representation from the Northumberland, Tyne and Wear NHS Foundation Trust and Tees, Esk and Wear Valley NHS Foundation Trust areas on the North East and Cumbria Learning Disability Transformation Board.
4) The presentation and additional information from service users provided at this meeting be circulated to all Members of the Committee.

31. Chairman's Urgent Items

None.

32. Any Other Business – Better Health Programme Forum Event (formerly SeQIHS) – 27 January 2016

The Chair informed Members of the Committee that the SeQIHS Programme had now evolved into the Better Health Programme and a second forum event was being held on 27 January 2016 6pm-8pm at Sedgefield Racecourse to give stakeholders the opportunity to hear a

programme update and participate in discussion workshop.

All Members of the Committee were encouraged to attend this event.

33. Date and Time of Next Meeting

The date and time of the next meeting was yet to be confirmed.

The meeting concluded at 12 noon.

CHAIR

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 Regional Joint Health Scrutiny Committee

Regional Back Pain Programme

May 2016

The purpose of this paper is to provide a briefing to the DPH on the implementation of the Regional Back Pain Pathway Programme and to update members on current progress.

Background

Back pain is a major cause of disability in the UK. The 2010 Global Burden of Disease results for the UK estimates that musculoskeletal (MSK) diseases cause the third greatest loss of disability-adjusted life years (DALYs) after cardiovascular diseases and cancers, and that 71% of these lost DALYs result from back and neck pain. One of the most common reasons for seeing a doctor is spinal problems, and it is a frequent reason for lost working days and low worker productivity.

Most people who have acute lower back pain recover within three months, while others do not and progress to chronic (lasting longer than three months) back pain. The majority of CCGs in the region have an above national average prevalence for both this general and severe back pain.

A significant proportion of back pain morbidity is preventable. Modifiable lifestyle risk factors are shared with other chronic diseases, including obesity, socioeconomic class and occupation (in particular occupational physical demands), psychosocial factors and smoking.

National Institute for Clinical Excellence (NICE) guidance in 2009 made recommendations on acute back pain management based on best evidence that nationally and regionally have been poorly implemented.

The information available to commissioners suggests that how patients are currently managed is not based on best practice in many cases and - there is wide variation in how patients are referred into hospital for back pain and sciatica (leg pain) for both planned and emergency care services. This leads to a poor targeting of NHS resources and poor patient experience and poor outcomes from their back pain.

Regional developments

In 2012, the Northern Clinical Commissioning Group (CCG) forum representing all of the CCGs in the North East and Cumbria agreed to support the development of a pathway at scale across the region to improve the way in which these patients are managed.

Clinical support was achieved through a multi-stakeholder clinical event was held in Gosforth March 2013 which included GPs, physiotherapists, orthopaedic surgeons, neurosurgeons and pain management specialists.

There is a regional ‘sponsor’ group is led by Professor Charles Greenough, Consultant Spinal Surgeon at South Tees Hospital NHS Foundation Trust and NHS England National Clinical Director for Spinal Disorders and Dr Andrea Jones, Chair of NHS Darlington CCG as the GP clinical sponsor.

CCGs in the North East and Cumbria will adopt the pathway in waves, and learning as it is rolled out. This will make sure the process is adapted appropriately and effectively to fit local NHS commissioned services.

Funding

The Academic Health Science Network (AHSN) for the North East and North Cumbria has funded the initial ‘early implementer’ areas, which has been used to develop the local pathway in NHS South Tees and NHS Hambleton Richmondshire and Whitby CCGs and local project management carried out by South Tees NHS Foundation Trust.

The full programme is supported by the Health Foundation, an independent charity working to improve the quality of health care in the UK. The learning from the implementation of service improvement at scale across CCG areas in the North East and Cumbria is an important part of the programme and, subject to positive evaluation in the early sites, the pathway should be fully implemented across all the North Est and Cumbria by 2019.

About the pathway

The pathway is based on NICE guidance (2009) and patients will be directed through a managed service:

- All healthcare professionals involved will receive education and training prior to the launch in their area.
- All patients will receive the same advice and guidance to help manage their condition effectively.
- All clinicians using the pathway will be applying right care/right time/right place principles.

The evidence shows that most people get better from the acute episode of back pain in the first 6 weeks and there is no evidence to support physical interventions such as physiotherapy during this period. Patients are encouraged to keep active and moving and use painkiller s as and when necessary.

The GP will assess the patient at approximately 2 weeks if they are still experiencing symptoms. They will use a questionnaire assessment tool called STaRT Back, which has been developed to stratify the patients into low, medium and high risk of the episode not resolving in the expected 6 weeks. The medium and high risk patients will then be referred to a ‘Triage and Treat’ practitioner. The ‘Triage and Treat’ practitioners will help the

patients' journey through the pathway. These 'Triage and Treat' practitioners are either experienced specialist nurses or physiotherapists. They will assess, advise and treat the patient, making sure there are no barriers to other services and treatments that the patient might need.

There will also be a Combined Physical and Psychological Programme (CPPP) in place recommended by NICE, for the small proportion of patients with significant problems in managing their back pain, which up until this programme, has not been available to patients in the North East. This is an intensive programme with approximately 100 hours (over a 2-3 week period) of graduated exercises, work simulated tasks, pharmacological and psychological support, in a non-NHS location. Evidence shows this is effective, particularly for patients in relation to return to work, sick leave and their view of their own disability..

The pathway expects this CPPP to be offered and the course undertaken before the patient is considered for surgery. For those who do not sufficiently improve following CPPP, a multidisciplinary team of experts including physiotherapists, spinal surgeons and pain specialists will meet with the patient and discuss fully the pros and cons with each patient of surgery or continuing on other chronic pain programmes.

Patients presenting with worrying "'red flag"' symptoms such as a past history of cancer will be referred urgently at any stage of the pathway to the right service for their symptoms.

The over-arching aim is to improve patient outcomes and experience reduce disability and personal and societal costs of chronic back pain, with the expectation that expenditure will be re-directed to evidenced based interventions provided in a more timely manner.

Progress

South Tees and Hambleton, Richmond and Whitby CCG are the 'early implementer' areas and they launched the pathway on 3 August 2015 following a period of awareness raising and education with local health professionals.

NHS Darlington CCG and NHS Hartlepool and Stockton-on-Tees CCG launched the pathway on 1st March 2016 as part of Wave 1 of the Health Foundation supported Programme. Wave 1 is currently part of a post implementation period, whereby a continued clinical engagement plan is in place to support frontline staff who are delivering the pathway. Developing a robust post implementation plan followed the learning from the early implementer site.

There have been a few queries in the first few months of the launch across all sites, which is to be expected when delivering a new patient pathway of care. These have involved mostly technical queries, such as how the electronic template works on the local GP system and from individual members of staff developing understanding of how the pathway works.

Wave 2, identified as NHS Newcastle Gateshead CCG, will go-live from October 2016. An engagement plan is in place to commence in the next few weeks. A third wave is planned,

following the successes of wave 1 and 2, in 2017 as the remaining CCGs mainstream the programme. Learning from each phase will help evolve the pathway and ensure the patient voice is heard, and responded to, as the programme progresses. Each launch will be preceded by education sessions with local healthcare professionals on how to use the pathway.

Myths about back pain

What patients and the public know about back pain is poor, resulting in unrealistic expectations and demands on healthcare systems. This demand is met by varied advice and guidance, and treatment, of patients with back pain problems by both professional groups in NHS and those working in the private sector. Many myths exist about what patients should and should not do when they experience back pain. The result is expensive investigations and ineffective care leading to poor outcomes and patient experience. If patients are given the right advice early enough, significant long-term problems can be avoided.

Education and promotion of the regional back pain programme is taking place for professionals prior to each launch. In addition, the programme will be supported by campaigns in each area on the “normality” of simple back pain and measures that can be taken in self-management to prevent or limit the experience. A public health representative is a member of the sponsor group.

Plans are currently underway to promote general myth-busting messages about back pain. A social media campaign to deliver these key messages about back pain started in March 2016 as part of the launch of the main programme, Wave 1. People are being asked to re-tweet and promote messages such as #factsaboutbacks and #justhurtmyback and the golden rules for back pain through their own social media accounts. The sponsor group communications lead will work continue with the usual communications and public health networks in each area.

Baseline data and evaluation of the project

Patients are being asked to give their experiences of their back pain generally, through surveys, focus groups and feedback forms. This will also help with the development of public information about back pain.

North East Quality Observatory System (NEQOS) are undertaking some detailed work on behalf of South Tees NHS Foundation Trust to understand the current data available on NHS national systems about referral patterns.

NEQOS are an important contributor establishing a baseline data set to enable impact to be evaluated and allow national benchmarking to take place.

Patient experience will be closely monitored in the implementing sites. A comprehensive evaluation is being conducted by Teesside University who will look at measuring and explain changes in clinical and social outcomes for patients as a result of the programme.

They will also look at health service elements and provide an assessment of how well the implementation of this programme has worked.

Further information on the Programme is currently available from:
www.noebackpainprogramme.nhs.uk

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ITEMS 8, 9 AND 10

NHS England

NHS England North - North East and Cumbria

Specialised Commissioning Update

presented to

North East Joint Health Scrutiny Committee

2nd June 2016

Neonatal Services

As agreed with the North East Joint Health Scrutiny Committee, the proposed configuration of neonatal services will be included in the Better Health Programme consultation.

In the interim North Tees and South Tees Neonatal units are working closely and have agreed that babies below 27 weeks gestation should be cared for at South Tees and this proposal has been endorsed by the clinical network.

Discussions about implementation and timescale are continuing between both Tees Trusts.

Neonatal Transport

The Northern Neonatal Network (NNN) covers the geographical area from Northallerton in North Yorkshire up to the Scottish border and across into North Cumbria as far south as Whitehaven. This has a population of over 3 million people, with an annual birth rate of around 35000, just over 3500 of which will need admission to one of the 11 neonatal units serving them. Four of these units (Neonatal Intensive Care Units – NICUs) currently provide the highest level of intensive care. 7 of them (Special Care Baby Units – SCBUs) provide short-term intensive/high dependency care, usually pre-transfer to a NICU.

Neonatal transport services are currently provided from two hospitals; Newcastle and Middlesbrough. At a national level the main recent key documents that address neonatal transport are as follows:

- “Toolkit for High Quality Neonatal Services” (DH 2009)
- “NICE Specialist Neonatal Care Quality Standards” (2010)
- “Service Specifications for Neonatal Intensive Care Transport E08b” (NHS England)

The Network has recommended that the transport service should be provided from a single site, by a dedicated team utilising a new staffing model of Advanced Neonatal Nurse Practitioners (ANNP). The service will provided from the RVI because the number of transports currently run at approximately 3:1 in favour of the RVI.

NHS England has agreed to fund the cost of the service at a full year effect of £1.25m, as well as non-recurrently funding additional ANNP training to reduce the lead time to achieve a fully compliant service.

Job descriptions are being finalised. Network awaiting confirmation from Health Education North East about a possible local ANNP course, otherwise trainees will have to train outside the North East.

Interviews are expected to be held between June and August 2016, and by September 2016 ANNP trainees should start training and nurses recruited to post.

The first phase of the service should hopefully begin in September 2016 to a fully functional standalone ANNP delivered service over the next few years to ensure safe deilvery.

Congenital Heart Disease (CHD)

Congenital heart disease relates to heart conditions or defects that develop in the womb, before a baby is born. In most cases, something has gone wrong in the early development of the foetus., and in the UK up to 9 in every 1,000 babies born in the UK are affected. About 80% of children with congenital heart disease will survive into adulthood. Many cases of congenital heart disease are diagnosed by an ultrasound scan in pregnancy. However, it is not always possible to detect congenital heart defects in this way.

In July 2013, after discussions with key stakeholders, NHS England established the New Congenital Heart Disease Review and agreed that CHD services should be commissioned against the new standards and service specifications during 2016. Hospitals providing CHD services were asked to consider whether or not they are able to meet the revised standards, and if not to propose the mitigation they would put in place. Provider trusts, working alongside commissioners, have been working together since April 2015 :

- To enable each provider/network to begin to assess themselves against the standards and service specifications, to understand their own strengths and limitations, and to create plans for achieving the standards including risk management in areas where the standards are not yet met.
- To allow NHS England to consider whether the emerging delivery models will, with the appropriate mitigations, produce an acceptable solution, in the best interests of patients. This will in turn enable NHS England to make a decision as to whether to continue with the current commissioning approach.

Submissions from providers and networks were submitted to NHS England in October 2015. After several reviews by regional and national panels, the national panel has completed its evaluation of the self-assessment returns and are preparing a report for the Specialised Services Commissioning Committee (SSCC) which is a sub-committee of the NHS England board, which next meets at the end of June, and no information will be released before this time.

Further information on the current review available @ https://www.england.nhs.uk/ourwork/qual-clin-lead/chd/

Vascular

Vascular disease relates to disorders of the arteries, veins and lymphatics. Conditions requiring specialised vascular care include: abdominal aortic aneurysm (AAA); stroke prevention (carotid artery intervention); venous access for haemodialysis; vascular trauma; lower limb amputation; deep vein reconstruction for deep vein thrombosis (DVT); but excludes varicose veins.

The national service specification requires that in order to maintain a 24/7 in-patient arterial surgery and vascular interventional radiology, a centre will require a minimum of 6 vascular surgeons and 6 vascular interventional radiologists to ensure comprehensive out of hours emergency cover.

Each surgeon will need to undertake at least 10 AAA procedures per year and commensurate numbers of lower limb and carotid procedures, which will necessitate an appropriate catchment area to generate sufficient case volume. A minimum population of 800,000 would be appropriate but for a world class service a larger catchment area will be required, which for the North East would equate to no more than 2 or 3 centres. Currently, the following Trusts offer a full vascular service in the North East :

- City Hospital Sunderland NHS Foundation Trust
- County Durham and Darlington NHS Foundation Trust
- South Tees Hospital NHS Foundation Trust
- The Newcastle Hospitals NHS Foundation Trust

The North East vascular surgeons through the Vascular Advisory Group have expressed a preference for the service to be re-configured to a maximum of three centres, but a configuration below three centres was not ruled out.

The affected Hospital Trusts asked NHS England to fund an Independent Review, which was carried out by two prominent Vascular surgeons nominated by the Vascular Society of Great Britain and Ireland.

The reviewers draft recommendation is for the 4 Vascular Centres (Newcastle, Sunderland, Durham, and Middlesbrough) to be reduced to 3 Centres (Newcastle, Sunderland, and Middlesbrough). This recommendation is subject to ongoing discussions between NHS England, the Vascular Network, and the affected NHS Trusts.

Arterial Activity 2014/15

Clinical Commissioning Group	No. of Specialised Procedures				
	Newcastle	South Tees	City Hospitals Sunderland	County Durham & Darlington	Total
Cumbria	26	1	0	1	**28**
Darlington	7	7	0	8	**22**
Durham Dales	10	9	8	12	**39**
Hambleton & Richmondshire	1	25	0	0	**26**
Harrogate	0	2	0	0	**2**
Hartlepool & Stockton	6	35	0	0	**41**
Newcastle & Gateshead	24	0	0	10	**34**
North Durham	9	0	3	24	**36**
North Tyneside	24	0	0	0	**24**
Northumberland	65	1	0	0	**66**
South JCUH	1	37	0	0	**38**
South Tyneside	12	0	10	0	**22**
Sunderland	11	0	30	2	**43**
Out of Area	5	0	0	0	**5**
Total	**201**	**117**	**51**	**57**	**426**