North East Joint Health Scrutiny Commitee

Meeting on Thursday 27 October 2016 at 10.00 am in the Council Chamber, Civic Centre, Hartlepool

Agenda

1. **Chairman's Welcome**

2. **Apologies for absence**

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

4. **Minutes of the meeting held on 2 June 2016**

5. **Work Plan for the 2016/17 Municipal Year (for information) – *Scrutiny Manager***

6. **North East and Cumbria Learning Disabilities Fast Track Transformation Plan:-**

   (a) Written update from the North of England Commissioning Support Unit *(to follow)*
   (b) Appointments to the North East and Cumbria Learning Disability Transformation Board – *Scrutiny Manager*
   (c) Proposed redesign of Learning Disability Services in the Northwest – (for Information) - *Scrutiny Manager*

7. **Sustainability and Transformation Plans (STPs) – STP Lead for County Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby and STP Lead for Northumberland, Tyne and Wear**

8. **Specialised Commissioning Update including Congenital Heart Disease, neonatal intensive care, paediatric high dependency care (winter pressure) and vascular surgery – NHS England North**

9. **Chairman's urgent items**

10. **Any other business**

11. **Date and time of next meetings**

    Thursday 2 March 2017 at 10am, Hartlepool Civic Centre

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

NORTH EAST JOINT HEALTH SCRUTINY COMMITTEE

MINUTES

2 June 2016

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

Present:

Hartlepool Borough Council
Councillor Ray Martin-Wells

Durham County Council:
Councillor Robinson

Northumberland County Council:
Councillors Wallace and Nisbet

Redcar and Cleveland:
Councillor Kay

Stockton Borough Council:
Councillors Javed and Hall

Sunderland City Council:
Councillor Dixon

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

Also Present: Liz Rogerson, Mary Hardie and Peter Dixon, NHS England
Julie Gillon and Jane Barker, North Tees and Hartlepool NHS Foundation Trust

Officers: Stephen Gwillym, Durham County Council
Peter Mennear, Stockton Borough Coucil
Karen Christon, Newcastle City Council
Nigel Cummings, Sunderland City Council
Paul Allen, Northumberland County Council
Elise Pout, Middlesbrough Borough Council
Alison Pearson, Redcar and Cleveland Borough Council
Joan Stevens, Scrutiny Manager (HBC)
Denise Wimpenny, Principal Democratic Services (HBC)

1. Welcome/Appointment of Chair and Vice-Chair 2016/17

The Scrutiny Manager, (HBC) welcomed all attendees and sought nominations for the appointment of Chair and Vice-Chair. It was agreed that Councillor Ray Martin-Wells be appointed as Chair of this Committee and Councillor Robinson be appointed as Vice-Chair.

Councillor Martin-Wells took the Chair

2. Apologies for Absence

Apologies for absence were submitted on behalf of Councillor Green, Gateshead Borough Council, Councillor Turner, Newcastle City Council and Councillor Dryden, Middlesbrough Borough Council.

3. Declarations of Interest

Councillor Mendelson, Newcastle City Council declared a personal interest as an employee of the Foundation Trust.

4. Minutes of the Meeting held on 6 January 2016

Confirmed.

5. Terms of Reference and Protocols for the North East Joint Health Scrutiny Committee *(Chair of the North East Joint Health Scrutiny Committee)*

The Committee's agreement to re-confirmation of the terms of reference and protocols for the North East Joint Health Scrutiny Committee was sought.

Recommendation

That the Terms of Reference and Protocols for this Committee be re-affirmed.

6. Regional Back Pain Programme – North of England Commissioning Support Unit (NECS) *(Joan Stevens, Scrutiny Manager*

The Scrutiny Manager (HBC) expressed apologies on behalf of the North of England Commissioning Support Unit that a representative was unable to attend today's meeting. In terms of taking this issue forward, Members consideration of the report was sought and the Scrutiny Manager highlighted that any questions in relation to the report content would be

taken forward and reported back.

Recommendation

The contents of the report was noted.

7. Neonatal Intensive Care Transport/Update on Congenital Heart Disease/Vascular Surgery *(NHS England North)*

The Scrutiny Manager welcomed representatives from NHS England North who had been invited to the meeting to provide an update on the Neonatal Intensive Care Transport, Congenital Heart Disease and Vascular Surgery.

The representatives from NHS England North provided a detailed and comprehensive presentation which focussed on the following:-

Neonatal Configuration

- Recommendations included a reduction of intensive care units from 4 to 3
- Decisions from Overview and Scrutiny Committee meeting in December 2015
- Consultation being taken forward as part of the Better Health Programme
- Tees Clinicians recommended and Network endorsed North Tees should care for babies 27plus weeks (subject to agreement between Tees Trusts)

Neonatal Transport

- NHS England had agreed to fund a Neonatal Transport Service
- Timescales for implementation of the Neonatal Transport Service – jobs advertised 1st week in June – appointments August
- Service to be phased in from September 2016

Congenital Heart Disease

- 9 in 1,000 babies born in UK are affected
- July 2013 – new CHD Review agreed
- Trust submissions assessed by Local Panel and reported to National Panel
- Final national decision not expected before June 2016

Vascular Surgery

- Case for Change in 2014 recommended the most appropriate model for the North East is to have a maximum of 3 centres

- Third centre would be either Sunderland or Durham – both requested an independent review
- Two vascular surgeons recommended that the third unit should be Sunderland
- NHS England have received the Independent Review's recommendation but have not made a decision
- When NHS England is in a position to make a decision the OSC will be consulted to decide if a consultation is required
- Better Health included where relevant

A query was raised as to how widely the job vacancies would be advertised and for what period. A view was expressed that the advert should be as widespread as possible and for a reasonable period. The representative agreed to clarify the timescales with the Trust and report back following the meeting.

In relation to the neonatal transport proposals, concerns were raised regarding the impact of centralising services given the current pressures faced by the Ambulance Service in terms of response times. It was noted that service users could be travelling from as far north as Berwick and as far south as Northallerton. Given these challenges, the Committee requested that the RVI provide a protocol/implementation plan to enable the Committee to monitor progress of implementation in 12 months time.

Disappointment was expressed in relation to the recommendation that the third vascular centre should be Sunderland given that Sunderland's figures in terms of activity were lower than Durham. It was suggested that the clinicians from the units in Sunderland and Durham be invited to a future meeting of the Committee to provide a local/expert perspective on the proposals. The representatives responded to a number of issues raised by Members in relation to the information provided in the report.

During further discussions in relation to the vascular surgery proposals, the Committee viewed the proposed changes to the service as a substantial variation and, as such, required that it be consulted fully in accordance with the requirements of the Health and Social Care Act. The Committee requested that a further report be brought back to Committee at a time when data had been fully validated outlining:-

- Details of the outcome of the Independent Review (inc remit/terms of reference of the group, etc)
- Evidence to support the proposals (including validated data)
- Details of the proposed consultation process/timetable as required for a substantial variation of service

Recommendation

(i) That the contents of the presentation and comments of Members be noted.
(ii) That the proposals in relation to Congenital Heart Disease be noted.

(iii) That clarification on the timescales in relation to the job vacancies be provided following the meeting.

(iv) In relation to Neonatal Services, that the RVI provide a protocol/implementation plan to enable the Committee to monitor progress of its implementation in 12 months time.

(v) In relation to the Vascular Surgery proposals, that a further report be brought back to the Committee at a time when data had been fully validated outlining:-

- Details of the outcome of the Independent Review (inc remit/terms of reference of the group, etc)
- Evidence to support the proposals (including validated data)
- Details of the proposed consultation process/timetable as required for a substantial variation of service

(iv) That Clinicians from the Vascular Surgery units in Sunderland and Durham be invited to provide a local/expert perspective on the proposals.

8. Any other Business which the Chairman considers Urgent

The Chairman ruled that the following item of business should be considered by the Committee as a matter of urgency in accordance with the provisions of Section 100(B) (4)(b) of the Local Government Act 1972 in order that the matter could be dealt with without delay.

9. Any Other Business – Proposed Better Health Programme Joint Overview and Scrutiny Committee

(Principal Overview and Officer, Durham County Council)

The Principal Overview and Scrutiny Officer from Durham County Council reported that the Better Health Programme, formerly the Acute Quality Legacy Project and Securing Quality in Health Services was a sub-regional project across County Durham, Darlington and Tees Valley which sought to examine how the local NHS could provide the best possible services over the next five years and beyond for that locality. The Better Health Programme was about meeting patient needs now and in the future to appropriate clinical standards across a number of disciplines including accident and emergency, critical care, paediatrics, maternity and neonatology and interventional radiology. Commissioners had stated their desire to work with stakeholder organisations and public representatives during the programme and an indicative timeline for 2016 has been shared with stakeholders indicating public consultation to commence around November 2016.

Proposals had been developed to establish a Joint Health Scrutiny Committee under the provision of the Health and Social Care Act 2012 involving all local authorities affected by the Better Health Programme and any associated service review proposals. Six local authorities had therefore met to consider establishment of a Joint Health Scrutiny Committee under

the requirements of the Act nominating 3 representatives and each drafting terms of reference and protocols for that Committee. Following liaison with neighbouring local authorities in the region to inform them of the Better Health Programme Overview and Scrutiny Committee a request had been received from North Yorkshire County Council formally requesting that they be considered for membership. To date, nominations had been received from five of the six local authorities. A provisional date of Thursday 7 July at 2.00 pm had been agreed for the first meeting which Hartlepool had agreed to host. Subject to the agreement of this Committee, Councillor Robinson from Durham County Council had agreed to Chair the meeting.

In response to a query from a Member, the Principal Scrutiny Officer (DCC), outlined the legal requirements of the 2012 Health and Social Care Act to establish a Joint Health Overview and Scrutiny Committee to deal with issues of this type.

A Member sought clarification on the role and purpose of the Joint Committee. Members were advised that the Committee would consider the key principles in terms of why the Better Health Programme had been set up, the risks associated with non-compliance with the relevant standards and the impact for local authorities covered by the programme. Initial meetings would focus upon fact finding and would also consider a series of proposals that required statutory consultation. It was highlighted that the need to establish a joint committee would not preclude any individual health scrutiny committees from considering this issue independently.

Decision

That the information given be noted.

10. Date and Time of Next Meeting

The Chair reported that the next meetings would be held on Thursday 27 October 2016 at 10.00 am and Thursday 2 March 2017 at 10.00 am at the Civic Centre, Hartlepool

The meeting closed at 10.50 am.

CHAIR

North East Joint Health Scrutiny Committee **Items for the 2016/17 Municipal Year**	
Items	**Meeting Date**
Appointment of Chair and Vice Chair Terms of Reference for the North East Joint Health Scrutiny Committee Vascular Services Congenital Heart Review – Update Neo-natal Transport - Update Regional Back Pain Programme	2 June 2016
Learning Disabilities Transformation Project Member appointments to the North East and Cumbria Learning Disability Transformation Board Vascular Services Neonatal Implementation Plan Sustainability and Transformation Plans	27 October 2016
NEAS monitoring of performance including paramedic training and update on outcome of Inspection NE Urgent + emergency care vanguard project Congenital Heart Disease	Additional meeting – November - date TBC
NEAS Quality Accounts Update from NHS England / Senate Use of pharmacies for minor ailments and other services	2 March 2017

NORTH EAST JOINT HEALTH SCRUTINY COMMITTEE

27 October 2016

Report of: Scrutiny Manager

Subject: NORTH EAST & CUMBRIA LEARNING DISABILITY TRANSFORMATION PROGRAMME

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1. PURPOSE OF REPORT

1.1 To present to the Committee a written update in relation to the North East and Cumbria Learning Disability Transformation Programme.

2. BACKGROUND INFORMATION

2.1 The North East Regional Health Scrutiny Committee, at its meeting on the 1 October 2015, was made aware of review of the transformation of the Learning and Disability service being undertaken across five fast track areas. The North East and Cumbria being one of the identified fact track areas.

2.2 The Committee went on to receive a report from the North of England Commissioning Support Unit, at its meeting on the 6 January 2016, outlining details of the transformation plan, its proposals and timescales. By way of a reminder, details of the views / comments expressed by the Committee are outlined in **Appendix A**.

2.3 In order to provide the Committee with a further update, representatives from the North of England Commissioning Support Unit were invited to attend today's meeting. The North of England Commissioning Support Unit was unfortunately unable to attend today's meeting, however, in recognition of the time that has elapsed since the original report, a written update is attached at **Appendix B** for Members information.

2.4 Arrangements are being put in place to facilitate the provision of a more detailed presentation at the next meeting of this Committee.

3. RECOMMENDATIONS

3.1 The Joint Committee note the update.

4. REASONS FOR RECOMMENDATIONS

4.1 To update the Committee.

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

Minute Extract – 6 January 2016

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.

1.1 The North East & Cumbria Learning Disability Transformation programme aims include:

- Less reliance on in-patient admissions, delivering a 51% reduction in admissions to inpatient learning disability services by 2020. (53% reduction in commissioned Specialist Learning Disability beds from 31.03.15 baseline);
- Developing community support and alternatives to inpatient admission;
- Prevention, early identification and early intervention;
- Avoidance of crisis and better management of crisis when it happens;
- Better more fulfilled lives.

1.2 The North East and Cumbria learning disabilities transformation programme is led by the Transforming Care Programme Board and supported by NECS.

1.3 The programme has been awarded a further £1.2 million of funding from NHS England for 2016-17. The funding will be focused on four key areas:

- Supporting the cost of additional community care packages
- Funding to support transitional discharge costs
- Investment in community infrastructure
- Investment in workforce development

1.4 The programme has set annual timescales objectives for bed closures and rehousing people in community settings. These trajectories are monitored monthly by NHS England and the Finance and Contracting T&F Group are in the process of allocating funding to assist with re-housing people to meet the annual targets.

1.5 The programme's workforce group is leading on staff training for people carers and staff working with people who have learning disabilities and autism, developing community based alternatives to inpatient services and helping people who are living in hospitals to move successfully into the community. Work is underway to ensure that the North East and Cumbria Learning Disability Transformation transforming care plans are reflected in the sustainability and transformation plans. A "Confirm and Challenge" group made up of people with learning disabilities, carers and families helps the board and programme team to help ensure that transformation progress is co-produced.

1.6 The transformation programme is supported by local groups in all areas across the region and specific task and finish groups who focus on areas such as workforce development, finance and contracting, advocacy, medicines optimisation and information sharing, etc. These groups are working to implement pooling of budgets, improvements in communication between service providers across the region to ensure appropriate support to people moving from one area to another, and working to standardise the approach to people needing support in the community, particularly early intervention to prevent crisis happening.

1.7 A regional community model of care has been developed and local implementation groups are working to consider how to adopt the model locally.

1.8 A Positive Behavioural Support community of practice has been established and funding is being sought for a regional approach to staff development in PBS approaches.

1.9 Funding has been provided to a number of local advocacy groups and organisations to support improvements and new ways of providing advocacy for people. The funded groups gave an update at a Task & Finish Group session on 21st September and are due to present on finalised workstreams in March 2017.

1.10 A website has been developed and was launched on 22nd September at the Confirm and Challenge Group: http://www.necchangingcare.org.uk . The website is being updated by the Communications Team following feedback from the group. People can also keep updated and share thoughts and information on twitter using #necchangingcare.

1.11 For further information please contact the programme team at: NECSU.changingcare@nhs.net.

1.12 The Project Team have produced a statement confirming the Transforming Care Board's intention to support the development of stable, low occupancy homes for people with learning disabilities. This has been approved by the TCP Board and circulated to all areas.

NORTH EAST JOINT HEALTH SCRUTINY COMMITTEE

27 October 2016

Report of: Scrutiny Manager

Subject: NORTH EAST & CUMBRIA LEARNING DISABILITY TRANSFORMATION PROGRAMME - MEMBER OBSERVERS

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1. PURPOSE OF REPORT

1.1 To seek nominations from the North East Joint Health Scrutiny Committee for Member observer representation at the North East and Cumbria Learning Disability Transformation Board.

2. BACKGROUND INFORMATION

2.1 The North East Regional Health Scrutiny Committee, at its meeting on the 6th January 2016, approved the identification of Members from its membership, to attend meetings of the North East and Cumbria Learning Disability Transformation Board as observers. Details as follows:

- 2 Members from the Council's within the Northumberland, Tyne and Wear NHS Foundation Trust area **(covering Durham, Darlington and Teesside)**.

- 2 Members from the Council's within the Tees, Esk and Wear Valley NHS Foundation Trust area **(covering Newcastle, Northumberland and Sunderland, Gateshead)**.

2.2 It has proven difficult to fill all four of these positions, with only two nominations received.

i) Northumberland, Tyne and Wear NHS Foundation Trust Area
Cllr Schofield – Newcastle City Council

ii) Tees, Esk and Wear Valley NHS Foundation Trust Area
Cllr Bailey – Stockton Borough Council

2.3 I am conscious that these individuals are no longer members of this Committee and as such I would like to renew a request for the nomination of up to two representatives from each of the areas covered by the Northumberland, Tyne and Wear NHS Foundation Trust and Tees, Esk and Wear Valley NHS Foundation Trust.

2.4 To assist Members, the Group meets twelve times a year in Durham.

3. RECOMMENDATIONS

3.1 That the Committee seeks nominations to fill the positions of observers on the North East and Cumbria Learning Disability Transformation Board.

4. REASONS FOR RECOMMENDATIONS

4.1 To progress take up of positions.

Contact Officer:- Joan Stevens – Scrutiny Support Officer
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OFFICIAL

Our Ref : LP TK OSC1 2016

North Region Specialised Commissioning Team
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Quarry House
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Leeds
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Email : lesley.patel@nhs.net
Tel : 0113 82 52788

To:

July 2016

Dear Chair of Health Oversight and Scrutiny

RE: Proposed Redesign of Learning Disability Services in the Northwest of England.

I am writing to you in reference to the commitment that NHS England has made in relation to the Merseycare Specialist Learning Disability Division, Whalley site, previously called Calderstones Partnership Foundation Trust, in that subject to consultation it will look to commission a new model for Learning Disability services moving away from institutionalised care by 2019.

You have a small number of patients in this organisation and over the next 3 years the provider and commissioners will be working to ensure that a safe transfer /discharge appropriate to your patient group is implemented, as recommended in 'Building the Right Support' (2015).

The full consultation document will be available on the NHS England website and will be emailed to you when the consultation starts. However, due to the small number of your patients affected; we are not aiming to visit the Overview and Scrutiny Committee at this time.

If you have any queries or feel a meeting would be helpful as part of the consultation process please do not hesitate to contact me.

Yours sincerely

Lesley Patel
Director of Nursing Specialised Commissioning (North)

Health and high quality care for all, now and for future generations

NORTH EAST JOINT HEALTH SCRUTINY COMMITTEE

27 October 2016

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Manager

Subject: SUSTAINABILITY AND TRANSFORMATION PLANS (STPS) - UPDATE

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1. PURPOSE OF REPORT

1.1 The purpose of this report is:-

(a) to provide members with background information in respect of the development of Sustainability and Transformation Plans (STPs); and
(b) introduce STPs leads for Durham, Darlington and Tees ;Hambleton, Richmondshire and Whitby; and Northumberland,Tyne and Wear, who will be in attendance at today's meeting to update the Committee on the progress, development and submission of the STPs to NHS England.

2. BACKGROUND

2.1 In December 2015, the NHS shared planning guidance 2016/17 – 2020/21 outlined a new approach to help ensure that health and care services were built around the needs of local populations. To do this, every health and care system in England, involving local organisations such as NHS providers, commissioners, and local authorities, were asked to produce a multi-year Sustainability and Transformation Plan (STP), showing how local services would evolve and become sustainable over the next five years – ultimately delivering the NHS Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

2.2 To deliver plans that are based on the needs of local populations, local health and care systems joined together in January 2016 to form 44 STP "footprints" across England. The health and care organisations within these geographic footprints are working together to develop STPs which aim to drive genuine and sustainable transformation in patient experience and health outcomes of the longer-term.

2.3 The footprints were required to be locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver the services, transformation and public health

programmes required, along with how they best fit with other footprints. A map showing the originally identified STPs is attached to this report. (**Appendix 1**).

2.4 STP leads have been agreed, with the STP leads for the North East Region being:-

- Durham, Darlington and Tees ;Hambleton, Richmondshire and Whitby
  Alan Foster – Chief Executive of North Tees and Hartlepool NHS Foundation Trust
- Northumberland, Tyne and Wear
  Mark Adams – Chief Officer, Newcastle and Gateshead CCG

2.5 These officers have agreed to convene the STP process and to oversee the development of local plans. They have been selected following local discussions about who is best placed to play this role, together with discussions with national bodies.

2.6 Over the last few months NHS system leaders have met to discuss how best to create these plans, reflecting on the work that has already been developed in a number of areas across the North East and Cumbria.

2.7 During such discussions professionals have considered carefully the geographical footprint which will best enable the NHS to plan services and, as a result, it was agreed that the North Durham area will move from the Durham, Darlington and Tees ;Hambleton, Richmondshire and Whitby STP into the Northumberland, Tyne and Wear STP for planning purposes.

2.8 This change in the way the STP boundaries have been planned will provide an opportunity to plan the best possible care for patients and partner organisations will work together on the next iteration of the STP draft document which will be submitted in October 2016.

2.9 STPs footprints are not statutory bodies, but rather collective discussion forums which aim to bring together health and care leaders to support the delivery of improved health and care based on the needs of local populations. They do not replace existing local bodies, or change local accountabilities.

3. RECOMMENDATIONS

3.1 That the Joint Committee considers and comments on the update in relation to the STP development process.

4. CONTACT OFFICER

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BACKGROUND PAPERS

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

NHS England Guidance – Sustainability and Transformation Plans - https://www.england.nhs.uk/2016/03/footprint-areas/

March 2016

Sustainability and Transformation Plan footprints

1. Overview

The NHS Shared Planning Guidance asked every local health and care system in England to come together to create their own ambitious local plan for accelerating the implementation of the Five Year Forward View (5YFV).

These blueprints, called Sustainability and Transformation Plans (STPs), will be place-based, multi-year plans built around the needs of local populations. STPs will help drive a genuine and sustainable transformation in health and care outcomes between 2016 and 2021. They will also help build and strengthen local relationships, enabling a shared understanding of where we are now, our ambition for 2021 and the concrete steps needed to get us there.

To deliver these plans NHS providers, Clinical Commissioning Groups (CCGs), Local Authorities, and other health and care services have come together to form 44 STP 'footprints'. These are geographic areas in which people and organisations will work together to develop robust plans to transform the way that health and care is planned and delivered for their populations.

These footprints are of a scale which should enable transformative change and the implementation of the Five Year Forward View vision of better health and wellbeing, improved quality of care, and stronger NHS finance and efficiency.

This document provides information on the 44 STP footprints in England.

In forming their footprints, local areas will have taken the following factors into account:

- Geography (including patient flow, travels links and how people use services);
- Scale (the ability to generate solutions which will deliver sustainable, transformed health and care which is clinically and financially sound);
- Fit with footprints of existing change programmes and relationships;
- The financial sustainability of organisations in an area; and
- Leadership capacity and capability to support change.

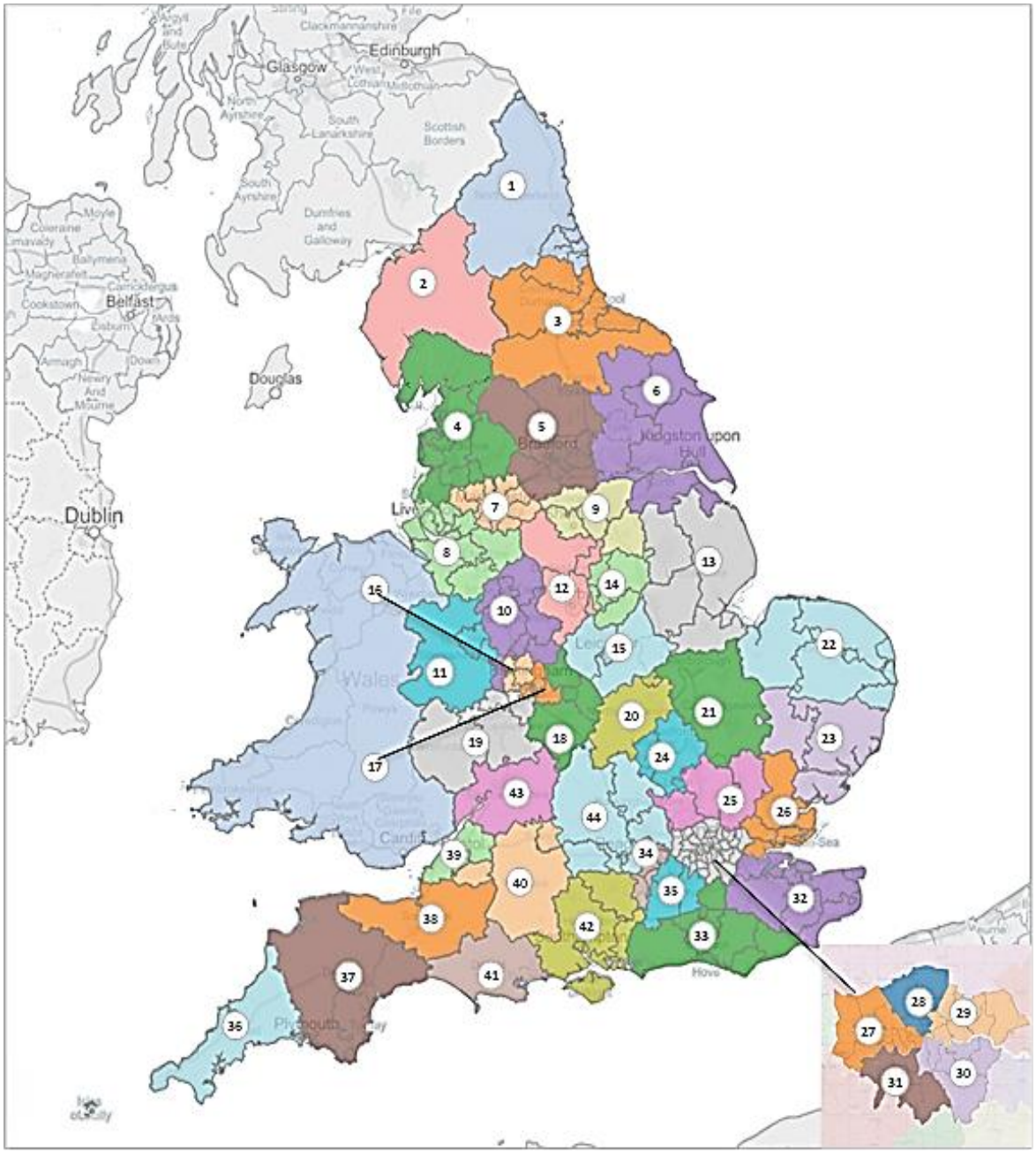
The boundaries used for STPs will not cover all planning eventualities. As with the current arrangements for planning and delivery, there are layers of plans which sit above and below STPs, with shared links and dependencies. It is also important to note that these boundaries may change over time as STPs are implemented, based on local circumstances.

2. Summary of footprints – national

NHS region	Total number of STP footprints	Average number of CCGs per footprint [1]	Average footprint population[2] (million)
England	**44**	**4.8**	**1.2**
North	9	7.4	1.7
Midlands and East	17	3.6	1.0
London	5	6.4	1.7
South	13	3.8	1.1

[1] One CCG (Cumbria) is split across two footprints.
[2] ONS 2014 population estimates used.

2.1 England – footprint map (index on next page)



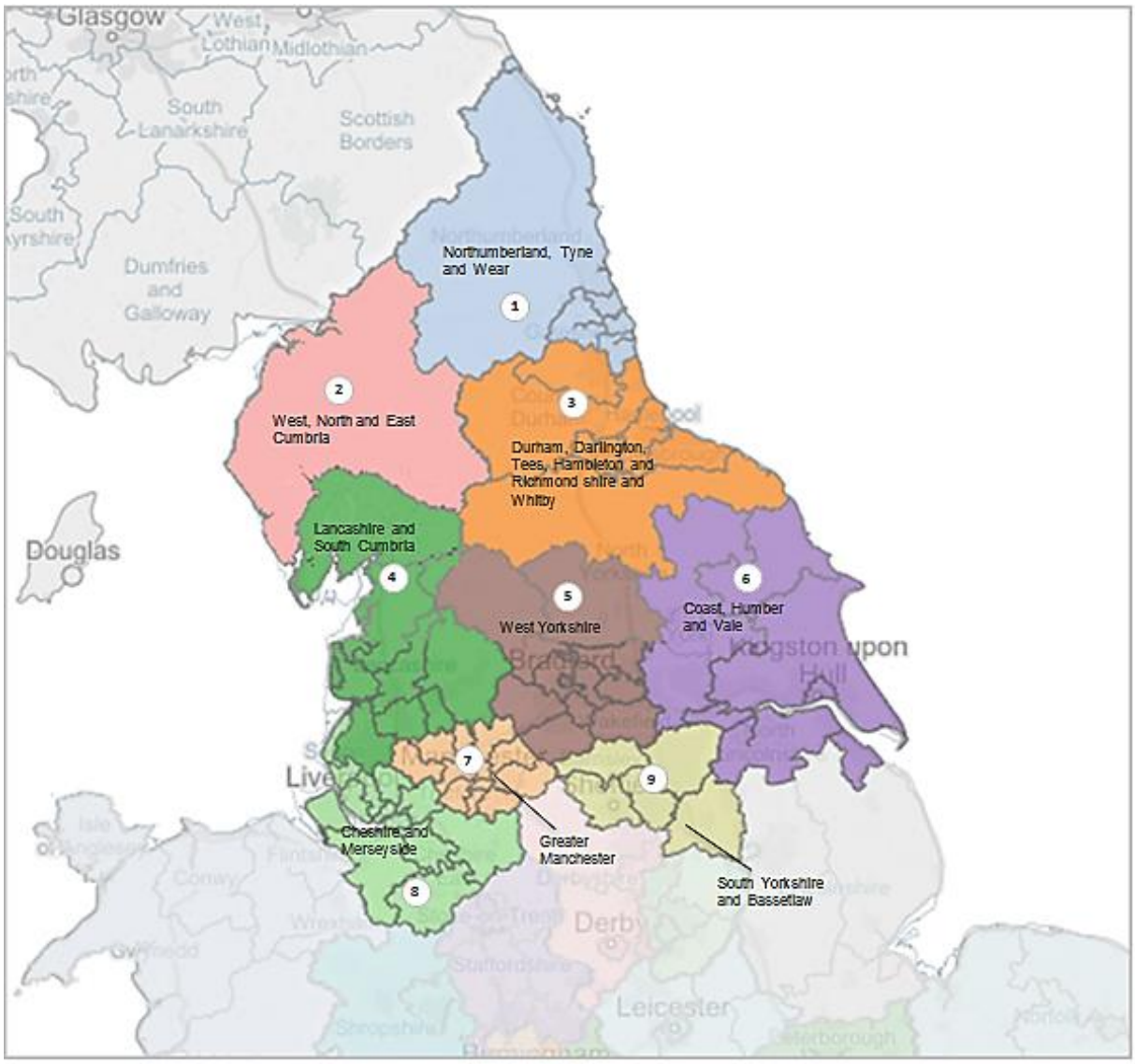
2.2 Index to national footprints map and key statistics

STP no	Footprint name	Footprint population (million)	Number of CCGs
1	Northumberland, Tyne and Wear	1.4	5
2	West, North and East Cumbria	0.3	1
3	Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby	1.3	6
4	Lancashire and South Cumbria	1.6	9
5	West Yorkshire	2.5	11
6	Coast, Humber and Vale	1.4	6
7	Greater Manchester	2.8	12
8	Cheshire and Merseyside	2.4	12
9	South Yorkshire and Bassetlaw	1.5	5
10	Staffordshire	1.1	6
11	Shropshire and Telford and Wrekin	0.5	2
12	Derbyshire	1.0	4
13	Lincolnshire	0.7	4
14	Nottinghamshire	1.0	6
15	Leicester, Leicestershire and Rutland	1.0	3
16	The Black Country	1.3	4
17	Birmingham and Solihull	1.1	3
18	Coventry and Warwickshire	0.9	3
19	Herefordshire and Worcestershire	0.8	4
20	Northamptonshire	0.7	2
21	Cambridgeshire and Peterborough	0.9	1
22	Norfolk and Waveney	1.0	5
23	Suffolk and North East Essex	0.9	3

24	Milton Keynes, Bedfordshire and Luton	0.9	3
25	Hertfordshire and West Essex	1.4	3
26	Mid and South Essex	1.2	5
27	North West London	2.0	8
28	North Central London	1.4	5
29	North East London	1.9	7
30	South East London	1.7	6
31	South West London	1.5	6
32	Kent and Medway	1.8	8
33	Sussex and East Surrey	1.8	8
34	Frimley Health	0.7	5
35	Surrey Heartlands	0.8	3
36	Cornwall and the Isles of Scilly	0.5	1
37	Devon	1.2	2
38	Somerset	0.5	1
39	Bristol, North Somerset and South Gloucestershire	0.9	3
40	Bath, Swindon and Wiltshire	0.9	3
41	Dorset	0.8	1
42	Hampshire and the Isle of Wight	1.8	7
43	Gloucestershire	0.6	1
44	Buckinghamshire, Oxfordshire and Berkshire West	1.7	7
	Total	**54.3**	**210***

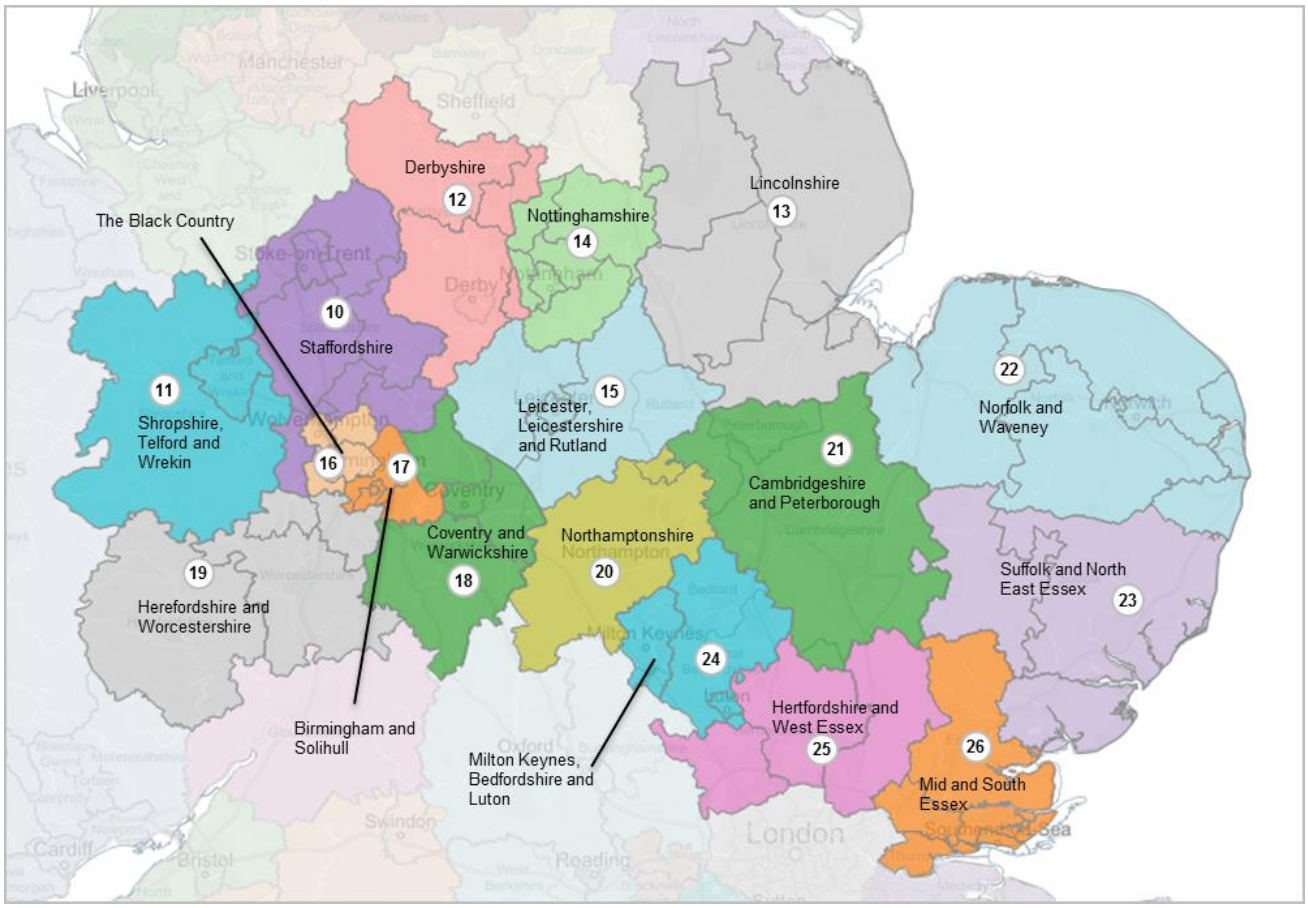
3. North region

Footprint map



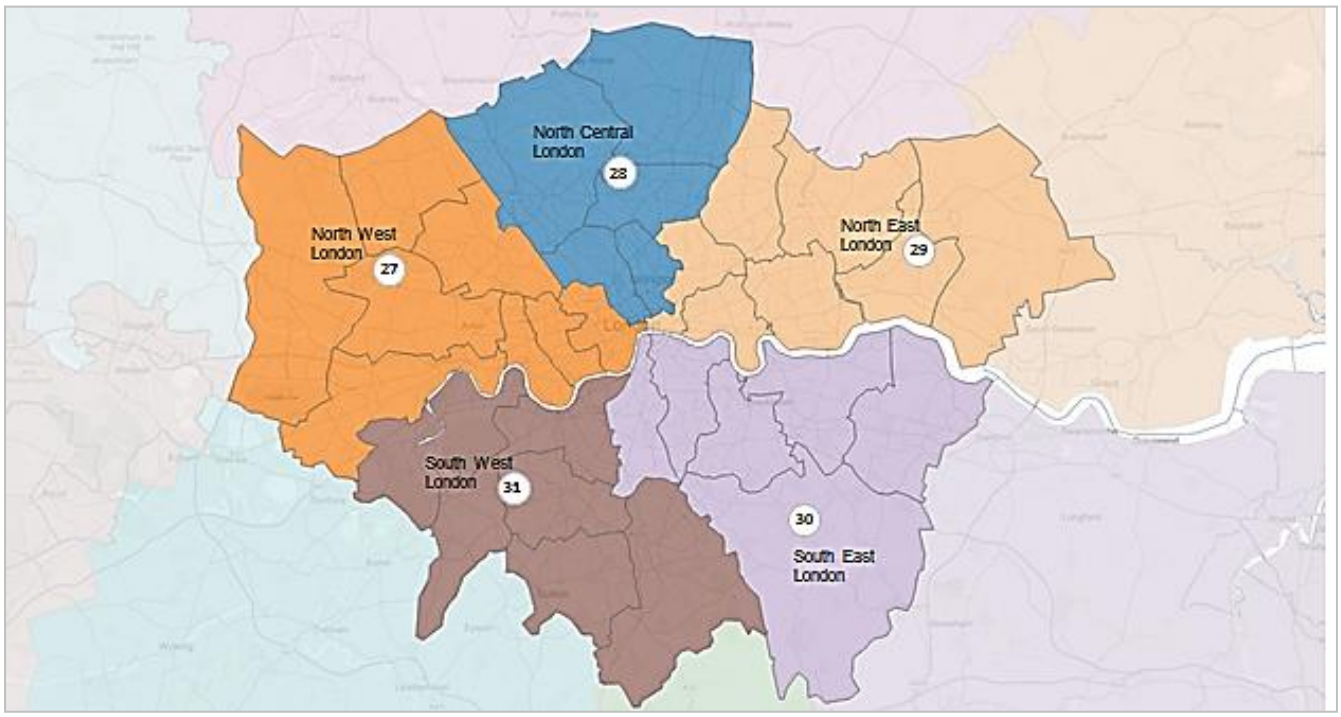
4. Midlands and East region

Footprint map



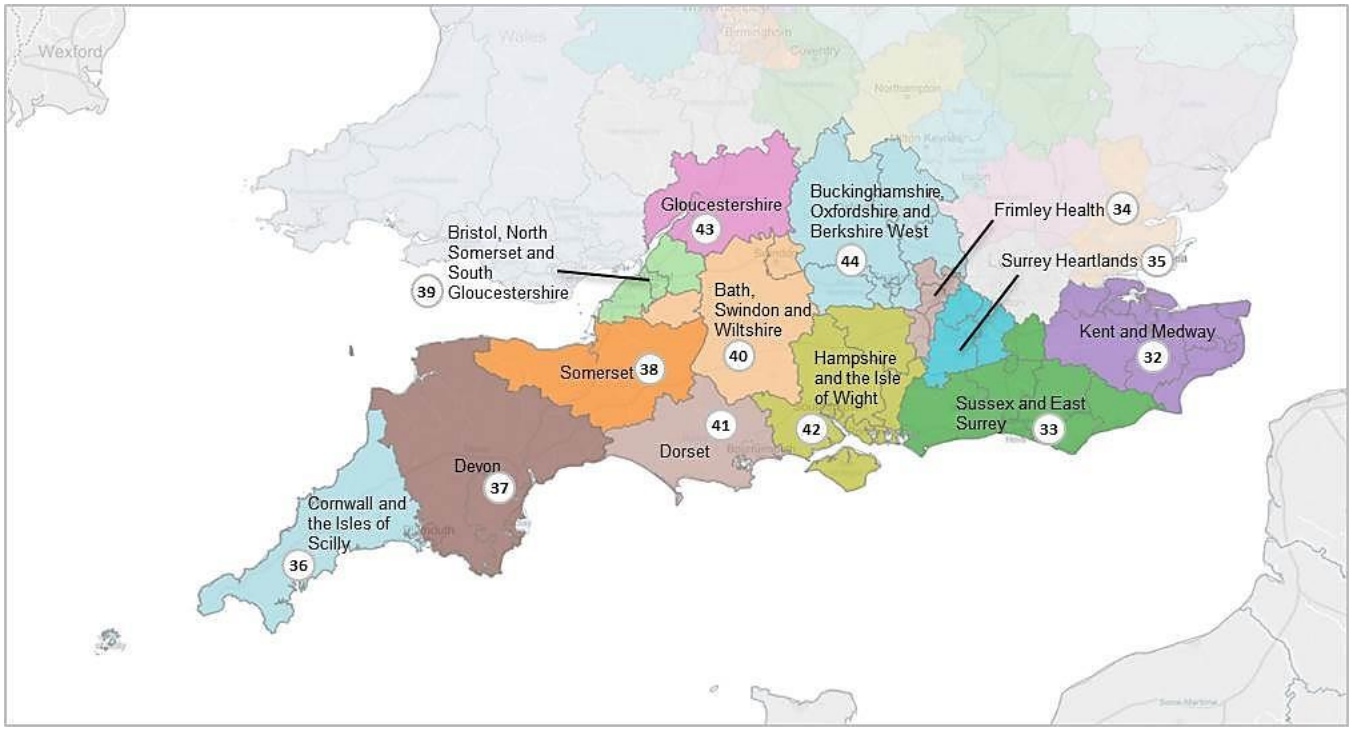
5. London region

Footprints map



6. South region

Footprint map



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North East Specialised Commissioning Hub

Summary report to

NE regional Joint Scrutiny Committee

Thursday 27 October 2016

This summary report sets out the current position of Specialised Commissioning work programmes which are of interest to the Committee, and attempts to answer the questions previously raised by the Committee.

Section	**Page**
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Neonatal Intesive Care (NICU)	8
Paediatric & High Dependency Care (PICU) – Winter Pressures	12
Vascular (Arterial) Surgery	13

Congenital heart disease (CHD)

Congenital heart disease (CHD) affects up to 9 in every 1,000 babies born in the UK. Many cases of congenital heart disease are diagnosed by an ultrasound scan in pregnancy. Treatment for congenital heart disease depends on the particular anomaly that the patient has. Complex disease may affect the person's ability to exercise and may shorten their life span. Most surgery and interventional procedures do not provide a cure, so people with congenital heart disease often need treatment throughout their life and therefore require specialist review during childhood and adulthood. People with complex heart problems can develop further problems over time and need further surgery or intervention. Less severe problems, such as a hole in the heart, may not need treatment, and are sometimes not detected until later in life when treatment may be a single straightforward procedure.

The exact cause of congenital heart disease is unknown, and may vary from case to case. However, causes can include:

- infections during pregnancy
- use of certain medications
- drug and alcohol abuse
- having a parent with a congenital heart defect.

Currently the numbers of NHS operations and other interventional procedures for CHD in England are:

- for children, provided by 10 hospitals performing 3,880 operations and 1,970 interventional catheter procedures
- for adults, provided by 24 hospitals performing 1010 operations and 1,430 interventional catheter procedures

The number of children born with CHD is expected to rise, as the birth rate rises. The number of operations and other interventional procedures has been increasing at three to four times the rate of population growth, and this is expected to continue.

There is a history of reviews of congenital heart disease services. The Safe and Sustainable review was launched by the Department of Health (DH) in 2008. At the end of that review, in July 2012, a joint committee of Primary Care Trusts (JCPCT) made a series of decisions on the future of children's congenital heart services in England including a decision to reduce the number of centres providing children's heart surgery from ten to seven. This resulted in two separate challenges – a judicial review (JR) of the decision, and referral to the Secretary of State by some of the relevant Health Overview & Scrutiny Committees. The Secretary of State in turn asked the Independent Reconfiguration Panel (IRP) to consider the JCPCT findings. The review's decisions were overturned and the process was halted, and responsibility handed to the newly created NHS England.

A recent review has shown that UK mortality rates are low, and compare favourably with current data from other international databases. About 80% of children with congenital heart disease will now survive into adulthood, with the result that for the first time, the number of adults living with

CHD is thought to exceed the number of children and young people, which has consequences for the planning of services.

In July 2013, after discussions with key stakeholders, NHS England established the New Congenital Heart Disease Review, designed to deliver improvements for patients by commissioning against a new set of service standards.

There are three categories of care within CHD :

- **Specialist Surgical Centres (level 1)**: Each network will have at least one (often more) Specialist Surgical Centre. All surgery and most cardiological interventions will be undertaken at these level 1 centres. These centres will provide the most highly specialised diagnostics and care.
- **Specialist Cardiology Centres (level 2)**: Not all networks will necessarily include level 2 centres, but because of the increasing number of adults living with CHD, Specialist Adult CHD (ACHD) Centres are expected be more common.
- **Local Cardiology Centres (level 3)**: Local children's cardiology centres will employ a paediatrician with expertise in cardiology (PEC) to provide ongoing monitoring and care, and run outpatient clinics alongside specialists from the Specialist Surgical Centre.

Within the North East and Cumbria, Newcastle-upon-Tyne Hospitals NHS Foundation Trust is a Level 1 service, and currently there are no Level 2 or Level 3 services. Newcastle is not fully compliant with the service standards, and is subject to a development Improvement plan, which is attached at appendix 1. The review recommended that :

- NHS England will work with Newcastle Hospitals NHS Foundation Trust to ensure progress is made towards meeting the standards and the strategic importance of the link of CHD surgery to the paediatric heart transplant centre is sustainable and resilient.
- CHD surgery at Central Manchester University Hospitals NHS Foundation Trust will transfer to Alder Hey Children's Hospital NHS Foundation Trust and Liverpool Heart and Chest Hospital NHS Foundation Trust.
- NHS England will support and monitor progress at University Hospitals Bristol NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust, University Hospitals Birmingham NHS Foundation Trust, Barts Health NHS Trust, Guy's and St Thomas' NHS Foundation Trust, and University Hospital Southampton NHS Foundation Trust to assist them in their plans to fully meet the standards.
- Birmingham Children's Hospital NHS Foundation Trust and Great Ormond Street Hospital for Children NHS Foundation Trust will continue to be commissioned, with ongoing monitoring, as they currently meet all or most of the standards.
- University Hospitals of Leicester NHS Trust and Royal Brompton & Harefield NHS Foundation Trust to safely transfer CHD surgical and interventional cardiology services to appropriate alternative hospitals.
- Hospital trusts not recognised as specialist centres have been instructed to make arrangements for such patients to be cared for at a specialist centre in future

Although the formal consultation is not complete, there is no reason to delay working with Newcastle Hospitals to implement the Development Improvement Plan and if necessary to include the plan within the 2017/18 contract documentation.

Appendix 1

Congenital Heart Disease

Service Development Action Plan

Newcastle-upon-Tyne Hospitals NHS Trust

Service Development improvement plan

Following the results of Newcastle Upon Tyne Hospitals NHS Foundation Trust's congenital heart services standards compliance assessment the following requirements have been identified.

Reference	Requirement	Deadline	Evidence Required	Action Owner (NUTH)	Notes	Related Standards
2.1	Newcastle Upon Tyne Hospitals must ensure they have a team of three surgeons each performing a minimum of 125 procedures per year averaged over a three-year period.	April 2017	Evidence that all surgeons have met these requirements during 2016/17.			B10(L1)Paediatric; B10(L1) Adult
2.2	Newcastle Upon Tyne Hospitals must ensure that their interventionists meet the minimum activity requirements of 100 procedures per year for their lead interventionist and 50 per year for all other interventionists averaged over a three-year period.	April 2017	Evidence that all interventional cardiologists have met these requirements during 2016/17		This only includes countable interventional procedures and as such excludes electrophysiology and pacing procedures. NICOR data does not match our definition of countable activity in all cases.	B17(L1) Paediatric; B17(L1) Adult

Reference	Requirement	Deadline	Evidence Required	Action Owner (NUTH)	Notes	Related Standards
4.1	Arrangements to meet the 2019 requirements for paediatric surgery, nephrology and paediatric gastroenterology to be co-located must be developed.	April 2017	Evidence of plans to co-locate these services by April 2019.			D6(L1) Paediatric; D8(L1) Paediatric
5.1	Newcastle Upon Tyne Hospitals must either provide further details of their network proposals to confirm that these both adult and children's services or develop plans to establish an appropriate network.	October 2016	Evidence that they have defined the necessary clinical governance arrangements (including scope, purpose, terms of reference and membership) and appointed a network clinical lead and patient/family representatives.			A11(L1) Paediatric A12(L1) Paediatric A11(L1) Adult A12(L1) Adult
5.1	Newcastle Upon Tyne Hospitals must continue to develop their network arrangements in line with commissioner requirements due to be confirmed during 16/17.	April 2017	Evidence of network development which meet the commissioner specifications.			Section A Adult and Paediatric

Neonatal Intensive Care (NIC)

Reconfiguration of Neonatal Intensive Care 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.

However, as also agreed with the Committee, the smallest and sickest babies will be transferred from Stockton Neonatal unit to Middlesbrough on the basis of clinical need.

Both Trusts have met and agreed that babies under 27weeks gestation should be transferred from Stockton to Middlesbrough. This proposal has been endorsed by the Neonatal Clinical Network.

An implementation plan has been agreed but a timeplan is still under discussion, particularly with respect to issues around the transfer of staff. The outline plan is attached as Appendix 2

Should the recommendations made by the independent reviews be agreed via Better Health, the four intensive/high dependency cots at Stockton would transfer to South Tees, and two to Newcastle. In addition the Clinical Network have made a proposal that 7 new cots need to be funded to make the network fully compliant with respect to staffing levels and occupancy rates. The proposal has not been costed, but has been presented to NHS England at an estimated cost of circa £3million.

The Intensive Care and High Dependency cot configuration proposed by the Clinical Network is as follows, although it should be stressed that this is dependent on the outcome of the Better Health consultation, and NHS England's consideration of the Clinical Network's proposal once costs are submitted.

Neonatal Retrieval

Recruitment to the recently funded Neonatal retrieval service has commenced via NHS Jobs, which was used because the jobs required a high level of specialised Neonatal nursing skills. The service will take approximately 12 months to become fully operational.

Appendix 2

Neonatal Intensive Care

Outline Implementation Plan for the transfer of Neonatal Intensive Care Cots from Stockton to Middlesbrough

Outline Implementation Plan for the transfer of Intensive Care Cots

from Stockton to Middlesbrough

		TASKS
TASK 1	**Confirm and Agree Trust Position**	
Sub-tasks		
	1.1	Agree Outline Model and Agree Scope of Plan for Neonates and Timelines Agree 1 / 4 phase approach as below
	1.2	Confirm and agree the model and phases **<u>Phase 1</u>** 1. All babies less than 27 weeks and those with HIE or very ill obtaining initial care at JCUH 2. Agree workforce model and issues 3. Highlight and manage transport issues 4. Obstetric and midwifery pathways in place 5. Agree communication plan to staff, patients and partners 6. Commence training need analysis and implementation plan, pick up ANP role 7. Review estates and equipment 8. Implications to other services 9. Agree all SOPs for above **<u>Phase 2</u>** 1. UHNT unit staff managing 27 weeks gestation babies and SCBU 2. Set up and commence roll out of training 3. Commence training and up-skilling of paediatric cover to prepare for paediatric consultants covering deliveries and eventual SCBU. Mentoring, experience for paediatricians at UHNT +/- JCUH and possibly ARNI places 4. Further develop ANNP role 5. Workforce issues and implement transition plan as necessary 6. Agree transferSOPs 7. Agree communication **<u>Phase 3</u>** 1. All intensive care on the JCUH site, SCBU at UNHT 2. Workforce model implemented 3. Communication model implemented 4. Pathways all agreed and implemented **<u>Phase 4</u>** Integrated service
	1.3	Scope/estimate potential timescales for service change • Phase 1 • Phase 2 • Phase 3 • Phase 4
	1.4	Agree Pace of Change to new models with Local commissioners and requirement of Trust during transition period
	1.5	Confirm working specification for the change period. (All other changes by negotiated contract variations)
	1.6	Confirm any interdependencies that have not been represented:- • Pathology • Radiology etc. • Pharmacy • Diabetics • Physio • SALT •

		TASKS
TASK 2	**Staffing and HR Implications -**	
Sub-tasks		Develop workforce plan – • To include current baselines – neonates and obstetrics • Agree new establishments • Agree training needs • To include – medicine, nursing, AHP, midwifery • Cost new modelsand business case • Implementation plan
	2.1	Briefing meeting with Staff and Unions on position, plus letter
	2.2	Develop Q&A briefing for staff and means to cascade
	2.3	Maintain up to date list of staff to inform: service transition potential/ service sustainability/ TUPE
	2.4	Establish further staff briefing/ change management sessions as required, including Union representation
	2.5	Agree appropriate timescales/ opportunities for engagement
	2.6	Agree position on travel if required
	2.7	Identify timescales for end of contract extension and formal consultation timescales and processes
	2.8	Identify Leadership roles required for new model development programme to achieve prior to transition
	2.9	Identify new roles required for new model, job descriptions and recruitment / development and training plan
TASK 3		
Sub-tasks		**Finance**
	3.1	Confirm current running costs of service and identify any deficit against contract income received
	3.2	Confirm additional resource required to implement change and business case • Staffing • Equipment • Build
	3.3	Agree contract and specification to be delivered.
	3.4	Identify any t redundancy/ retraining redeployment cost.
TASK 4	**Estates**	
Sub-tasks		
	4.1	Define current equipment inventory and deficits.
	4.2	Identify environmental issues related to increases in capacity
TASK 5		**Records Transfer, Information Systems and Information Governance**
Sub-tasks		
	5.1	Identify any issues related to Badger
	5.2	Discuss business suitability of any alternative systems proposed.
TASK 6		**Governance & Risk**
Sub-tasks		
	6.1	Establish governance arrangements for change , including Project Board and working groups.
	62	Agree governance rules for management of service during transition period.
	6.3	Establish Risk register and mitigations
TASK 7		**Communication & Engagement Strategy**
Sub-tasks		
	7.1	Establish communication strategy with stakeholders
	7.2	Agreement on handling of FOI and Media enquiries.

Paediatric Intensive & High Dependency Care

Winter Pressures

The pressure on Paediatric Intensive and High Dependency Care during winter is the most significant for Specialised Commissioning.

In previous years funding was non-recurrent, but is now recurrent which should allow the two Trusts (Newcastle and Middlesbrough) to make winter planning more robust.

NHS England is currently reviewing proposal from both Trusts; Newcastle for a second day team to bolster the PIC transport service; and Middlesbrough for two High Dependency beds. It is unlikely that both proposals can be funded, but discussions continue to achieve the best regional solution to mitigate as far as possible any potential winter pressures, such as Bronchiolitis or Bird Flu.

It will ensure that the transfer of children from DGHs is expedited to ensure the best possible outcomes, and that children can be transferred back to a hospital closer to home when clinically appropriate.

Vascular (Arterial) Surgery

Description of Specialised Vascular Services

NHS England commissions adult specialist vascular services, including all vascular surgery and vascular interventional radiology services, with the exception of the treatment of varicose veins.

Vascular disease relates to disorders of the arteries, veins and lymphatics. Conditions requiring specialised vascular care include: lower limb ischaemia; abdominal aortic aneurysm (AAA); stroke prevention (carotid artery intervention); venous access for haemodialysis; suprarenal and thoraco-abdominal aneurysms; thoracic aortic aneurysms; aortic dissections; mesenteric artery disease; renovascular disease; arterial/graft infections; vascular trauma; upper limb vascular occlusions; vascular malformations and carotid body tumours.

Patients with vascular disorders are cared for by specialist vascular teams, which include vascular surgeons, vascular interventional radiologists, vascular anaesthetists, vascular scientists, nurses, radiographers, physiotherapists and rehabilitation specialists.

It is anticipated that the number of centres delivering specialist vascular services will reduce over time as network and arterial centre configurations are established.

Arterial surgery is a specific element of specialised vascular services, and has been a focus of this review. All arterial surgery must be provided at a vascular centre, with the facilities outlined below.

- Leg amputations should only be undertaken in arterial centres
- Minimum of 6 vascular surgeons and 6 vascular interventional radiologists to ensure comprehensive out of hours emergency cover.
- Minimum of 10 AAA emergency and elective procedures per surgeon per year/minimum of 60 procedures per unit per year
- Minimum of 50 carotid endarterectomy procedures per unit per year
- Population of 800,000 per

Executive summary

There are 4 vascular surgery centres in the North East, Newcastle-upon-Tyne Hospitals NHS Foundation Trust (NuTH), City Hospitals Sunderland NHS Foundation Trust (CHS), County Durham and Darlington NHS Foundation Trust (CDDFT), and South Tees Hospitals NHS Foundation Trust (STH) but the size of these units suggest that there is only sufficient activity and vascular surgeons to support 3 centres at most and possibly only two, in compliance with the national service specification. The vascular network could not agree on the configuration of the service, although the likeliest reconfiguration is either two centres, Newcastle and Middlesbrough; or three centres, Newcastle and Middlesbrough and either Sunderland or Durham.

The key requirements for a fully compliant service as set out in the Service Specification include:

- Minimum population of 800,000
- Minimum of 6 vascular surgeons
- Minimum of 6 interventional radiologists
- Minimum of 60 AAA repairs per year (10 per surgeon)

In June 2014 the Northern England Strategic Clinical Network published "North East Vascular Services – Case for Change", which recommended that :

> *"This report confirms the need for change and is supported by substantial clinical evidence. To take this work forward a decision needs to be taken on the following options.*
>
> - *Option 1 – Following a consultation a decision is made on the thirdcentre being based either at Sunderland or Durham.*
> - *Option 2 – An Independent Review is carried out on the North East Vascular Services."*

Although the network agreed that the number of vascular centres should be reduced from four to three. Middlesbrough and Newcastle are designated as Major Trauma Centres, and so both must continue to provide specialised vascular surgery. If there were to be three centres in the North East, the third Centre would be a choicebetween Sunderland and Durham. Both Trusts insisted that the review should be carried out by independent reviewers. Two experienced vascular surgeons, one from Liverpool and one from Cambridge, were nominated by the Vascular Society.

The Terms of Reference for the review are set out in Appendix 1, and the full review is set out in full at Appendix 2, and concludes that :

"This independent review of Vascular Services in the North East of England was carried out by 2 nominated representative of the Executive of the Vascular Society of Great Britain and Ireland. After two days visiting the 4 centres in the region which currently provide on-site vascular services including arterial interventions, the following recommendations have been made to reconfigure services onto 3 Arterial Centres with networked Non-Arterial sites :

- Newcastle, networking with Gateshead
- Sunderland, networking with South Tyneside and Durham
- Middlesbrough, networking with Darlington in addition to current networked sites. "

Basis for Independent Reviewer's Recommendations

The Reviewer's recommendations were not based on past or present performance, rather on the potential of Durham and Sunderland to meet the required standards to achieve a safe and sustainable service.

The full review is attached as Appendix 2, but a summary of the reasons behind the

recommendations are set out below :

"Geography. Travel times between all the units in the region are below 1 hour which in many regions has been the travel time limit considered to be maximum for emergencies. The HES data shows that currently most ruptured AAA's in the region already go to Newcastle and Middlesbrough. The number travelling to Durham or Sunderland are single figures annually, and this number will decrease in future due to screening."

"Capacity. Both Sunderland and Durham would need to invest in new staff and facilities to meet the increased demand of a merged Arterial Centre…... but two areas that we felt were a particular challenge for Durham were IR (2 Consultant Interventionists Durham vs. 4 Sunderland) and ITU/HDU provision (10 beds Durham vs 18 Sunderland)."

"Current Network. Sunderland currently provide a strong visiting service to the non-arterial centre at South Tyneside… . a good demonstration of a commitment to outreach working, which is vital for successful vascular networks. The situation at Durham …. was not entirely clear … the need to complete changes to other services (moving elective services to Darlington and Bishop Auckland, adjusting ITU/HDU between Darlington and Durham) in order to create sufficient capacity for a merged Arterial Centre in Durham."

"Related Specialities. Whilst there is no absolute need to be co-located with other medical specialities… Both sites provided evidence of good cross-specialty working but we felt that there was demonstration of particularly strong on-site support in Sunderland from Cardiology (large PCI service), Renal and Stroke/Care of Elderly/Rehab services. It was our view that these strong links would be particularly conducive to supporting the significantly increased inpatient workload generated by a merged Arterial Centre in Sunderland."

Trust Objections

All acute Trusts in the North East and Cumbria were asked to comment on the Independent Review, and the answers received are detailed below :

Trust	Response to Recommendations
Newcastle-upon-Tyne Hospitals NHS Foundation Trust	No response
Northumbria Healthcare NHS Foundation Trust	No response
Gateshead Health NHS Foundation Trust	Broadly supportive; "From a partnership point of view, Gateshead has consistently fed back that while our working relationship with Durham is excellent, should any review suggest that our partnership need to be elsewhere, then provided we have the onsite cover which I have described then we are open to exploring other partnerships and in the case of the report clearly this is with Newcastle."

South Tyneside NHS Foundation Trust	Good networking arrangements with Sunderland for vascular and other services. "If CHS were no longer a vascular service the latter would no longer be possible to the detriment of our local population." Support for recommendation?
City Hospitals Sunderland NHS Foundation trust	Agree in full.
County Durham and Darlington NHS Foundation Trust	Not accepted because of "….concerns about the depth and breadth of the work undertaken, the rationale behind a number of the factors underpinning the decision, and appears somewhat superficial in nature, falling short of that needed for consultation purposes."
North Tees and Hartlepool NHS Foundation Trust	"I am able to confirm that as a trust we do support this report."
South Tees Hospitals NHS Foundation Trust	"I confirm that South Tees Hospitals NHS Foundation Trust is fully supportive of the report recommendations out of the Review of Specialised Vascular Services (Adults)"
North Cumbria University Hospitals NHS Trust	No response (separate Vascular Review)
Cumbria Partnership NHS Foundation Trust	Will make detailed comment during consultation.

Following several months of discussion between NHS England, the Vascular Clinical Advisory Group, County Durham and Darlington NHS Foundation Trust (CDDFT), and the Independent Reviewers, the most appropriate source of activity data remains unresolved, Hospital Episode System (HES) used in the review or National Vascular Registry (NVR) favoured by CDDFT.

The review used data derived from Hospital Episode System (HES) which is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England. This data is collected during a patient's time at hospital and is submitted to allow hospitals to be paid for the care they deliver. HES data is designed to enable secondary use, that is use for non-clinical purposes.

CDDFT favour the National Vascular Registry (NVR), which comprises data inputted by Consultant Vascular Surgeons. The National Vascular Registry (NVR) was established in 2013 to measure the quality and outcomes of care for patients who undergo major vascular surgery in NHS hospitals. The NVR is run by the Vascular Society and the Clinical Effectiveness Unit of the Royal College of Surgeons of England.

This point was put to the Independent reviewers appointed by the Vascular Society, who stated that "We had access to both HES and NVR data at the review and both supported our recommendation".

Similar problems were encountered by Professor Mike Horrocks during his analysis of activity data in his work with Getting It Right First Time (GIRFT), which is commissioned by the Department of Health to identify areas of unwanted variation in clinical practice and/or divergence from the best evidence within vascular surgery. This work will culminate in a report and set of national recommendations aimed at improving quality of care and also reducing expenditure on complications, litigation, procurement and unproven treatment. Prof. Horrocks visited the North East Network for a deep dive on 5th October 2006, and confirmed that problems with activity is common across the country. However, the recommendations set out in the review is not based on activity returns, rather which Trust is best placed to develop a fully compliant vascular surgery service which is safe and sustainable.

Conclusion

There is universal clinical agreement that the number of Vascular Centres should be reduced from four to three, with no preferences being expressed by any Trust other than CHS and CDDFT.

At the request of these two Trusts an Independent Review was instigated by NHS England, and whilst objections have been raised by CDDFT, the independence of the review has never been questioned.

Consultation

Previously, the committee requested NHS England to undertake a regional consultation on the recommendations.

NHS England has decided to commission an outside party to undertake a detailed consultation and deliver the following prior to 1 April 2017 to enable NHS to decide which configuration of Vascular Surgery is appropriate for the North East :

1. A detailed stakeholder mapping
2. Plan, coordinate and host key stakeholder events
3. Coordinate focus groups

4. Prepare supporting materials/activity; for example questionnaire design including development and analysis

5. Developing ToR for the group

6. Develop media protocols and management plans

7. Produce communication and engagement strategy

8. Produce Communication and engagement plans; especially hard to reach groups and groups with protected characteristics in order to fulfil equality act requirements

9. Develop public facing documents

10. Marketing collateral

11. Develop “You said we did” documents

12. Observation of information governance and confidentiality requirements throughout

13. Equality analysis of engagement activity