North East Joint Health Scrutiny Commitee

Meeting on Wednesday 28 June 2017 at 10.00 am in the Council Chamber, Civic Centre, Hartlepool

Agenda

1. **Chairman's Welcome**

2. **Apologies for absence**

3. **Appointment of Vice Chair**

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

5. **Minutes of the meeting held on 2 March 2017**

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

7. **Better Health Programme – Verbal Update**

8. **Work Plan for the 2017/18 Municipal Year – Statutory Scrutiny Officer**

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

   (a) **Covering report – Statutory Scrutiny Officer**
   (b) **Update and Further Information - Presentation by the North of England Commissioning Support Unit (NECS)**

10. **Chairman's urgent items**

11. **Any other business**

12. **Date and time of future meetings: -**

    27 September, 2017 at 11.00 am, Hartlepool Civic Centre
    23 November 2017 at 10.00 am, Hartlepool Civic Centre
    15 February at 10.00 am, Hartlepool Civic Centre

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

NORTH EAST JOINT HEALTH SCRUTINY COMMITTEE

MINUTES

2nd March 2017

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

Present:

Chair: Councillor Martin-Wells, Hartlepool Borough Council
Councillor Robinson, Durham County Council
Councillor Weatherley, Gateshead Borough Council
Councillor Taylor, Newcastle County Council
Councillor Brady, South Tyneside Borough Council
Councillor Dixon, Sunderland County Council
Councillor Javed, Stockton on Tees Borough Council

Also Present: Mark Cotton, North East Ambulance Service
Peter Dixon, NHS England
Maureen Gordon, North East Ambulance Service
Rachel Lonsdale, Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH)
Angie Martin, Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH)
Robert Ornall, NHS England
Ben Parker, NHS England
Louise Robson, Newcastle Upon Tyne Hospital Trust

Officers: Stephen Gwillym, Durham County Council
Angela Frisby, Gateshead Borough Council
Karen Christon, Newcastle County Council
Paul Baldasera, South Tyneside Council
Peter Mennear, Stockton Borough Council
Nigel Cummings, Sunderland County Council
Joan Stevens, Scrutiny Manager (HBC)
Laura Stones, Scrutiny Officer (HBC)
Jo Stubbs, Democratic Services Officer (HBC)

31. Apologies for Absence

Apologies were submitted by Councillor Brooks (North Tyneside Borough Council) and Councillor Kay (Redcar and Cleveland Borough Council)

32. Declarations of Interest

Councillor Taylor declared a personal interest in item 6 (Proposals to Implement Standards for Congenital Heart Disease Services for Children and Adults in England) as an employee of Newcastle Hospital NHS Trust.

33. Minutes of the meeting held on 3rd November 2016

The minutes were approved

34. Expressions of interest for Chair/Vice-Chair – 2017/18

Expressions of interest were sought for the positions of Chair and Vice-Chair for the 2017/18 municipal year. It was agreed that Councillor Ray Martin-Wells continue as Chair of the Committee and Councillor Robinson continue as Vice-Chair (subject to his successful re-election in May). It was noted that the Committee constitution allowed for 2 Vice-Chairs. The Chair asked that anyone interested in taking on the second Vice-Chair role contact the Scrutiny Manager.

35. Proposals to Implement Standards for Congenital Heart Disease Services for Children and Adults in England

Representatives from NHS England and Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH) were in attendance to provide an update on the current consultation on the future commissioning of Congenital Heart Disease (CHD) services. In 2016 NHS England had published a set proposed national safety service standards which all hospitals carrying out CHD services would be expected to adhere to. Of 283 standards 3 were relevant to the proposals:

a) Surgeon working requirements – that there be teams of at least 3 surgeons now and 4 by April 2021. Surgeons must carry out at least 125 congenital heart operations a year averaged over a 3 year period.

b) Service interdependence or co-location – specialist children's cardiac services must be delivered where a wider range of other specialist children's services are within a 30 minute bedside call.

c) Interventional cardiology – that they work in teams of 3 presently and 4 by April 2017, carrying out a minimum of 100 procedures a year (lead cardiologist) or 50 for non-lead.

A number of proposals were listed within the consultation document

detailing which should and should not provide these services based on these criteria. Included in these was a proposal that Newcastle Upon Tyne Hospitals NHS Foundation Trust should continue to provide surgery and interventional cardiology for adults and children. This was despite the fact that they were unlikely to meet standards a) and b) within the required timescales. However it was felt that given their unique strategic position and their status as the only level 1 provider delivering heart transplantation services in a CHD setting a time-limited exception should be made in their case. However changes in terms of surgeon working requirements and co-location would need to be made at some point in the future. Representatives from NHS England highlighted that current outcomes for the Newcastle Trust were in the top 5 across the world and there were no concerns regarding their current service or delivery. Services were currently provided on 2 sites approximately 10 minutes drive away and decisions would be made as to whether services should be moved around the existing sites or a completely new building commissioned. Local consultation would be carried out in Newcastle and staff and patients would be fully involved.

The Chair queried how long Newcastle would be given to make the changes. The NHS Representative advised that no decisions of this nature would be made until the consultation was completed at the beginning of June but they would hope to formulate a time frame in the Autumn. The Chair requested an update to the Committee at that time.

A member asked whether any consideration had been given to James Cook Hospital being given Level 2 provider status. The NHS Representative indicated that they had not expressed an interest in becoming a Level 2 provider and therefore had not been selected. Should they express any interest in the future they could apply for assessment.

A member asked whether consultation would be carried out South of Newcastle. The NHS Representative confirmed they would be happy to carry out consultation events in the Teesside and North Yorkshire area and engage with patient groups and other interested parties.

A member queried whether current outcomes at Newcastle Trust were as good as they would want them to be. The NHS Representative reported good results at Newcastle and excellent standards. This process was about defining a set of standards for the future. In terms of the standards which were currently not being met it was felt that the minimum number of consultants would not be a problem but the number of patients per consultant could be more challenging. Co-location was also an obvious issue.

A member referred to public concern that these changes were cost driven and asked for assurance that these changes would lead to a period of stability. The NHS Representative advised that the proposals were based on clinical consensus and would hopefully lead to some stability depending on clinical procedure changes. All the centres providing these services had

been assessed based on the proposed standards with no limit on the number of sites.

A member asked for an assessment of the costs of the various co-location options. A representative from the Newcastle Hospital Trust acknowledged that it would be costly and complicated. All options from moving between sites to a new build would be considered however her preferred option would be the movement of Cardiothoracic to the Royal Victoria Infirmary with other elective based services going to the Freeman. A member acknowledged current problems around consultants visiting patients across the 2 sites and felt co-location would make a big difference.

The Chair referred to Newcastle Trust's world class status in this field and asked whether these changes were necessary as they were already delivering the best outcomes they could. Millions could be spent to make improvements to a service which did not require improvement. The NHS Representative believed that the new standard would make the service more stable and resilient and provide even better outcomes.

A member asked whether consideration had been given to the impact an increase in patients at Newcastle would have on other Level 1 centres. The NHS Representative indicated that there was an element of choice based on service quality and Newcastle saw patients from across the UK and worldwide. It should not be seen as a local centre.

The Scrutiny Manager asked all members present to formulate individual responses for inclusion in the Joint Committee response based on today's discussions. She asked that these responses be forwarded to her for central co-ordination. She also asked whether the Committee would wish to receive a further update before finalisation of the co-location plans.

Recommendation

1) That the information presented be noted

2) That views and comments expressed at the meeting be included within the Committee's response

3) That all Local Authorities provide a comment for inclusion in the Committee's response

4) That a further update be brought to Committee prior to finalisation of the co-location plans

36. North East Ambulance Service NHS Foundation Trust – Quality Account 2016/17

The Assistant Director, Communications and Engagement from NEAS provided the Committee with a detailed and comprehensive presentation

which included a review of performance for 2016/17, future service developments, demands on the service and the priorities for the service for 2015/16. He noted that by April approximately 550 paramedics would be employed by the service, the target being 600. Future priorities included improvement in early recognition of Sepsis, promotion of falls prevention and enhancement of end of life transport.

The Chair declared a personal interest in this item as a member of the Cleveland Fire Authority. He congratulated them on almost reaching their target number of paramedics and their efforts in improving care for patients at the end of their lives.

The Chair referred to an ongoing pilot scheme whereby fire appliances were being used for emergency calls. He asked what impact this had had on performance and queried whether funding would be made available to enable the fire authority to invest in more appropriate vehicles should the decision be taken to continue the service. The Assistant Director felt that the trial had been successful thus far with the final results due for evaluation upon completion. Any decision to continue the initiative would require discussions between the NEAS, Fire Authority and Trade Unions and cost would clearly be an issue. Performance targets had not been massively impacted but the initiative had been about getting the best care for patients rather than figures.

A member requested an update on misuse of the ambulance service and what measures were being taken to reduce unnecessary call outs. The Assistant Director referred to the use of the NHS pathway system during the initial call which was designed to effectively evaluate whether an ambulance and /or hospital admission were needed. However the symptoms being presented by the patient might be beyond the capabilities of the paramedic in attendance necessitating hospital admission whereas a different paramedic might be more skilled. The numbers of actual hoax calls made were miniscule in comparison.

Decision

1) That the presentation be noted

2) That a response be formulated based on views and comments expressed, for inclusion in the Third Party Declaration.

3) That final approval of the Third Party Declaration be delegated to the Chair and Vice-Chair, in conjunction with the Scrutiny Manager.

37. Verbal Update on the Better Health Programme

Councillor Robinson, as Chair of the Better Health Programme Joint Health Scrutiny Committee, and Stephen Gwillym from Durham County Council

gave a detailed and comprehensive update on the work of the Better Health Programme, including issues considered at the previous meetings. Future meetings would be scheduled after the elections.

Decision

That the update be noted.

38. Chairman's Urgent Items

None

39. Any other business

The Chair wished all those members standing for election the best of luck on 4th May.

40. Date and time of next meeting

To be arranged

The meeting concluded 12:10pm

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 Joint Health Scrutiny Committee **Items for the 2017/18 Municipal Year**	
Items	**Meeting Date**
Appointment of Chair and Vice Chair Terms of Reference for the North East Joint Health Scrutiny Committee Better Health Programme - Update North East and Cumbria Learning Disabilities Fast Track Transformation Plan	June 2017
Regular performance update from NEAS Congenital Heart Disease – update NHS England – update	September 2017
Community Pharmacies / Use of pharmacies for minor ailments and other services Big Conversation (Mortality) – Jayne Medcalfe Refugee project – Jayne Medcalfe	November 2017
NEAS Quality Accounts	February 2018

NORTH EAST JOINT HEALTH SCRUTINY COMMITTEE

28 June 2017

Report of: Statutory Scrutiny Officer

Subject: NORTH EAST & CUMBRIA LEARNING DISABILITY TRANSFORMATION PROGRAMME

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1. PURPOSE OF REPORT

1.1 To inform the Committee that representatives from the North of England Commissioning Support Unit will be in attendance at today's meeting to present to the Committee an 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 the Committee meeting held on 27 October 2016, unfortunately, representatives were unable to attend, however, in recognition of the time that has elapsed since the original report; a written update was submitted, which is attached at **Appendix B** for Members information.

3. RECOMMENDATIONS

3.1 The Joint Committee seek clarification where necessary and note the update.

4. REASONS FOR RECOMMENDATIONS

4.1 To update the Committee.

Contact Officer:- Joan Stevens – Statutory Scrutiny Officer
Chief Executive's Department
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.