North East Joint Health Scrutiny Commitee

Meeting on 21 June 2018 at 10am in the Council Chamber, Civic Centre, Hartlepool

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Agenda

1. **Apologies for absence**

2. **Appointment of Chair and Vice Chair**

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

4. **Minutes of the meeting held on 15 February 2018**

5. **Terms of Reference for the North East Joint Health Scrutiny Committee –** ***Chair of the North East Joint Health Scrutiny Committee***

6. **Work Plan for the 2018/19 Municipal Year –** ***Chair of the North East Joint Health Scrutiny Committee***

7. **Durham County Council - Adults Wellbeing And Health Overview And Scrutiny Committee - Member Feedback / Recommendations On NHS England's Proposed Review Of Specialised Vascular Services Across The North East –** ***Durham County Council Representative***

8. **Specialist Services Update (Neonatal Intensive Care) - Update Letter from the Chair –** ***Chair of the North East Joint Health Scrutiny Committee***

9. **Chairman's urgent items**

10. **Any other business**

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

To be confirmed

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

NORTH EAST JOINT HEALTH SCRUTINY COMMITTEE

MINUTES

15 FEBRUARY 2018

The meeting commenced at 10.00 a.m. in the Civic Centre, Hartlepool

Present:

Chair: Councillor Ray Martin-Wells, Hartlepool Borough Council

Darlington Borough Council: Councillor Newall
Newcastle City Council: Councillor Taylor
Stockton Borough Council: Councillor Povey (as substitute for Councillor Grainge)

Also Present: Mark Cotton, North East Ambulance Service NHS Foundation Trust (NEAS)
Mike Maguire, Chair, DDT Local Professional Network (Pharmacy)
Cara Charlton, Specialist Commissioning Team, NHS England
Liz Rodgerson, Specialist Commissioning Team, NHS England
Julie Turner, Specialist Commissioning Team, NHS England
Sundeep Harigopal, Newcastle Hospitals, NHS Trust
Michael Houghton, North Durham Clinical Commissioning Group
Carol Langrick, County Durham and Darlington NHS Foundation Trust
Philip Davey, County Durham and Darlington NHS Foundation Trust
Andrew Brown, CHS Healthcare
Sean Fenwick, CHS Healthcare
Paul Dunlop, CHS Healthcare

Officers: Durham County Council: Stephen Gwillym
Northumberland County Council: Paul Allen
Stockton Borough Council: Peter Mennear
Middlesbrough Borough Council: Caroline Breheny
South Tyneside Council: Paul Baldesera
Gateshead Borough Council: Angela Frisby
Newcastle City Council: Karen Christon
Joan Stevens, Statutory Scrutiny Officer (HBC)
David Cosgrove, Principal Democratic Services Officer (HBC)

56. Apologies for Absence

Durham County Council: Councillor Robinson.
Gateshead Borough Council: Councillor Green.
Stockton Borough Council: Councillor Grainge.

57. Declarations of Interest

Councillor Taylor Newcastle City Council declared a personal interest as an NHS employee.

58. Minutes of the meeting held on 27 September 2017

In relation to Minute 53 'NEAS – Performance Update' the Stockton BC representative raised the following questions for the NEAS representative: -

Had there been a change in the way stroke patients were treated when NEAS had indicated that they did not need a response including a paramedic;
How many mental health professionals were employed at the Trust;
Had the psychological services reduced;
How many staff had completed the friends and family survey;
How many managers were employed;
How many vacancies did the Trust currently have;
Did staff and managers receive performance bonuses.

The NEAS representative stated that there were no changes to the way stroke patients were treated. In stroke cases the patient needed a scan to assess the extent of the stroke and that could only be done in hospital. Essentially they needed transport to a hospital quickly but not a paramedic. In relation to the questions on mental health professionals and psychological services the NEAS representative stated he would have to provide a written response to the Committee.

The last friends and family survey had over 700 responses and the annual NHS survey was due which would target around 1000 staff. In terms of management, the Trust had recently undertaken a restructure which had been cost neutral. In terms of other staffing, the Trust had recently met its target for paramedics only to be given additional funding from government for additional staffing numbers. The trust was on target to meet the target numbers of paramedics later in the year when their training was completed. In terms of salaries, all staff were on the Agenda for Change pay structure with all directors' remuneration available on the NEAS website.

The minutes of the previous meeting were confirmed.

59. Specialist Services Update - Neonatal Intensive Care

Initial proposals for the Neonatal Intensive Care had been discussed in detail by the North East Joint Health Scrutiny Committee on the 17th December 2015. A number of progress reports have since been received by the Committee. There was a further presentation at this meeting by Dr Sundeep Harigopal, Lead for the Northern Neonatal Network, outlining the background and evidence base for the proposals to reconfigure

Neonatal Intensive Care services in the North East.

The presentation highlighted the following base issues primarily that there were too many Neonatal ICUs for the population and a perceived need to concentrate care in fewer units for better outcomes. This issue had been initially raised in 2012 when there had been support for the proposals from the clinicians involved and the Royal College of Paediatrics and Child Health. The key proposals for the service being that:

- The RVI in Newcastle provide the Quaternary Centre;
- Sunderland provide the NICU for babies born under 26 weeks gestation for the whole region;
- James Cook Hospital in Middlesbrough expand its services to become a viable tertiary neonatal unit; and
- North Tees Hospital NICU would only care for babies over 30 weeks gestation – only Intensive Care and the High Dependency Care would be affected at North Tees.

At a meeting of the NEJHSC in December 2015 (minute number 24 refers) it had been agreed that North Tees would not look after babies less than 27 weeks and that the care of babies born between 27 and 30 weeks would be addressed.

The presentation went on to outline the evidence base behind the clinical recommendations outlined showing the low number of births below 30 weeks – only 62 babies over three years. The numbers of babies that would be affected from the North Tees area that would move to be cared for in Middlesbrough would be 20. The real impact would be 10 babies a year with 10 other cases that would have been cared for in North Tees due to lack of capacity in one of the other three regional NICUs.

In concluding Dr Harigopal stated that there was now an independent review recommending urgent change, there was regional clinical consensus, systems were in place to support the proposals, there was evidence to support the better outcomes in higher volume units and the numbers of babies affected in the North Tees area would only be around 10 each year.

The Chair stated that one of the concerns the Committee had when the proposals were initially put to them was that the recorded outcomes for babies under 30 weeks at Sunderland were poorer than those for North Tees hospital so Members had been somewhat puzzled at the direction of transfer. Some of the birth rate figures for the south of the region also conflicted with the numbers members had previously reported to them. The Chair objected to the intonation that this Committee had delayed these proposals; Members had concerns that needed to be addressed/responded to. Members did object to frequently being told changes were for ‘clinical reasons’ as a device to stop them objecting to proposals that would down grade services in their hospitals.

A Member commented that parents of premature babies would go wherever the best outcomes could be had for their child. Sunderland may have in the past been receiving the babies with the poorest potential outcomes but there had been no evidence base to support that. Members questioned if James Cook Hospital in Middlesbrough had the capacity to be developed to become a viable tertiary neonatal unit; Dr Harigopal confirmed this was the case.

The officer from Stockton BC stated that SBC Scrutiny members had indicated their own concerns at the proposals and were to look at them in more detail, at a local level. The health representatives indicated their willingness to work with Stockton BC in addressing any concerns they may have.

The Chair thanked the representatives for their attendance at the meeting and concluded that the case for change had been well put. On this basis, subject to support from Stockton Borough Council following their individual consideration on the proposals, the Committee had no objection to the proposals.

Decision

i) That the proposals as reported be noted,

ii) Subject to support from Stockton Borough Council, following their individual consideration on the proposals, the Committee had no objection to the proposals, as detailed below:

- The RVI in Newcastle provide the Quaternary Centre;
- Sunderland provide the NICU for babies born under 30 weeks gestation for the whole region;
- James Cook Hospital in Middlesbrough expand its services to become a viable tertiary neonatal unit; and
- North Tees Hospital NICU only care for babies over 30 weeks gestation – only Intensive Care and the High Dependency Care would be affected at North Tees.

60. Specialist Services Update - Vascular Services Review

Representatives from the North East and North Cumbria Specialist Commissioning Unit gave an update on the progress of the North East Vascular Service Review following implementation of the recommendations from the Vascular Society of Great Britain and Ireland in 2016. The presentation restated the clinical case for the recommendations which would be based on three main centres in Newcastle, Sunderland and Middlesbrough. There would be no changes to out-patients services or support for diabetes, stroke, plastics, orthopaedics and gynaecology. Based on patient data from 2016/17 it had been estimated that the changes would affect around 12 patients a week with the main impact being on patients from Durham. Appropriate communication and engagement had

commenced and the proposed timeline for the changes would be completed later in the year.

Members questioned why the change of services were directed from Durham to Sunderland when the number of cases seemed to indicate the direction should be reversed. The representatives commented that there were a range of services at Sunderland that provided significant support to the vascular services, for example, Interventional Radiologists.

The Chair understood that the Commissioning Unit representatives were looking for the support of the NEJHSC but without appropriate representation from Durham CC that would not be possible. Durham CC may wish to review these proposals themselves due to the impact on their residents. The Chair also commented that the Committee would wish to see the results of the consultation and the business case for the proposed service changes.

The Officer representative from Durham CC commented that there had been an initial conversation with the County Council but that Members had requested clinicians to attend to discuss the issues further particularly as there were some differing opinions between NHS Trusts on the proposals.

The Chair concluded the debate indicating that at this point the Joint Committee would wish to see the evidence from the business case and the consultations. Durham CC would also need to give their consideration to the matter before it was reported back to this Joint Committee.

Decision

That the discussions be noted and the proposals reconsidered by the Joint Committee after consideration by Durham County Council's health scrutiny committee and provision of the consultation responses and business case to this Committee.

61. Community Pharmacies / Use of Pharmacies for Minor Ailments and Other Services

The representative from the North East Pharmacies Local Professional Network gave a presentation on Community Pharmacies and the use of pharmacies for minor ailments and other services. There were 618 pharmacies across the region with over 1.6m recorded visits to pharmacies across the whole of the UK each year. While there was the inverse health care law – those in affluent areas have the best access to the best health care services – community pharmacies tended to buck that trend with access to a community pharmacy within a 20 minute walk being available to 99.8% of people in deprived areas against the national figure of 89.2%.

The presentation outlined the community pharmacy referral service which was now part of the 111 NHS service. This had commenced towards the end of 2017 and some 400 pharmacies across the North East were signed up to service. There had been some 419 referrals to the service over

Christmas period with some 3250 referrals in total to date. Of these referrals only 5% of patients were then referred into clinical services.

There were a number of pharmacies offering a Minor Ailment service, though none presently in the Tees area. In Gateshead, Newcastle and North Tyneside this was a commissioned service.

The region still suffered some very stark health inequalities and locally there is a ten year change in life expectancy from one end of Marton Road in Middlesbrough to the other. The same applied to Ormesby Back.

The presentation outlined the Tees Healthy Living Pharmacies services which were now being seen as a gold standard for rest of UK. The presentation concluded with a video produced by the British Heart Foundation on how good pharmacy services could have an effect on heart patients care.

Members commented that many patients aware that paracetamol would not normally be prescribed by their GP were buying it in supermarkets and then taking too much at home. The Pharmacies Local Professional Network representative indicated that this was a concern shared by many pharmacists when it was sold without the correct advice.

A Member noted that not all pharmacies were taking part in the 111 service. The representative commented that the same could be said of GP Practices. There were some concerns being expressed around staffing but the 400 that had signed up showed it could be successful. The referrals from 111 could include minor ailments advice or consultation appointments.

Attention was also drawn to the value of the Pharmacy First service and it was noted that it is not commissioned in the Tees Valley. Members were interested to know why this was the case and agree that it be explored through this Committee in the coming year.

Decision

i) That the presentation and comments be noted.

ii) That the use of the Pharmacy First Service be explored through the North East Joint Health Scrutiny Committee.

62. NEAS NHS Foundation Trust – Quality Account 2017/18

The North East Ambulance Service NHS Foundation Trust (NEAS) representative gave a presentation on the Trust's Ambulances Response Standards. The representative commented that for some time paramedics and clinicians were somewhat frustrated that the measures were simply based on a 'clock stopping' approach and after representations to the Secretary of State, new measures had been introduced in October 2017. The new categories are now: -

Category 1 – time critical life threatening events – an average response time of 7 minutes with a 90% response time of 15 minutes.
Category 2 – potentially serious conditions - an average response time of 18 minutes with a 90% response time of 40 minutes.
Category 3 – urgent problems not immediately life threatening - 90% response time of 120 minutes
Category 4 – non-urgent; needs telephone or face to face assessment – 90% response time of 180 minutes.
Specialist response calls in hazardous areas or specialist rescue or mass casualty calls have no response measures.

These new national response targets to apply to every single 999 patient for the first time and should lead to faster treatment for those needing it to save 250 lives a year. There would be an end to "hidden waits" for millions of patients and there would be new standards to drive improved care for stroke and heart attack patients. The standards were those against which the service would be commissioned

The new targets did, however, require the Trust to reconfigure its fleet and staff. Previously a single responder could 'clock stop' the old Red 2 calls but now the measure was met when the conveying response arrived. Assessment now had to be made as to what was the most appropriate response to send to each call. With both category 3 and 4 calls having the 90% monitor more ambulances were going to be needed with crews. The changes to the structure of crews and shifts would be shared with the Joint Committee at a future meeting.

In terms of the Quality Account, the NEAS representative indicted that the proposed quality measures would be based around -

1. Early recognition of sepsis – as at the end of December 81.6% of staff had been trained and it was expected that the target of 95% would be met before the end of March. In relation to the compliance with the sepsis care bundle, the target of 40% had been exceeded and stood at 61%. Work was ongoing on developing further tools on sepsis recognition.

2. Cardiac arrest – the trust had implemented the Resuscitation Academy's ten steps and significant investment in new technology had been made with new defibrillation equipment in all ambulances. In the year to November 2016 there had been 304 successful Return of Spontaneous Circulation (ROSC). In the year nine months to August 2017 this had improved to 394, an average of 10 additional successful Return of Spontaneous Circulation each month.

3. Long waits – all ambulance trusts had suffered a deterioration in response times resulting from increasing demand, staffing pressures, increased travel times and waits resulting from increased pressure across the health system. There had been enhancement of real time performance feedback for call handlers and the procedures for reviewing the processes

for managing patients who had fallen and experienced long delays.

4. Safeguarding referrals – the trust had been working on improving the quality of its safeguarding referrals and was partially on track to achieving its aims and would be looking towards enhancing the audit process, improving training and developing a pool of safeguarding champions.

The priorities for 2018/19 would include a continuation of the work on sepsis, cardiac arrest and delays with a focus on patients who fall receiving some initial support. Other potential areas for monitoring including improving mental health pathways, improving end of life care and issues around frailty i.e. falls, dementia and emergency care plans.

A Members suggested that mental health issues should replace safeguarding going forward. There was also significant concern at the situation around long waits among the public that needed to be addressed.

The Chair commented that while the response to the new categories required the 'conveying' responder, single responders in cars were often very quick to get to patients and could start treating any casualty before the ambulance arrived. The NEAS representative commented that the response would be based on what the patient needed. A first responder may be able to start CPR or similar treatment but the measure would require the attendance of the most appropriate vehicle to convey the patient.

The Chair acknowledged the issue and commented that it would be wrong to be unfair to NEAS on the statistics when they were getting responders there within the timescales. The Chair indicated that he would wish to see single responders maintained by NEAS and would wish to know if any policy decision was taken on removing them in the future.

The NEAS representative commented that there was no intention to stop sending a particular response. Managers and commissioners knew what the demand was and what was needed to address patient needs. If there was a gap then NEAS would look to what was needed to fill that. The service was getting 42 more paramedics but at this time there was no certainty that would be enough. More may be needed or how and when they worked may need to change to meet the demands the service now faced. The NEAS representative referred to the Carter Review of Community Hospital Services in Liverpool and the efficiencies that had come out of that review. The review had now moved on to Ambulance services and that may bring forward new ideas on service provision. There were, however, different service models across the country, for example, in the Midlands every two man crew included one paramedic; we did not have that in this region. If that was something that was needed there would be significant costs associated with that.

The Chair thanked the NEAS representative for the presentation and responses to Members questions. The Chair indicated that, with the Joint

Committee's support, he would submit a formal response to the Quality Account Consultation. Members supported the suggestion.

Decision

1. That the presentation and comments be noted.
2. That the HBC Statutory Scrutiny Officer be delegated, following consultation with the Chair, to formulate a response to the North East Ambulance Service NHS Foundation Trust Quality Accounts 2017/18.

63. Expressions of Interest for Chair/Vice Chair – 2018/19

It was reported that the current Chair and Vice-Chair's term of office was due to come to an end in June 2018. Therefore, expressions of interest for the position of Chair and Vice-Chair for the 2018/19 Municipal Year were sought. Formal appointment of both positions will be at the June meeting of the Committee.

The Chair commented that he would be happy to pass the position onto any Member that wished to take the role. If there were no expressions of interest the Chair indicated that he would not wish to see the position remain vacant and would, should the Joint Committee agree, continue in the role.

Decision

That the member authorities of the North East Joint Health Scrutiny Committee consider the issue of nominations to the position of Chair and the two vice-chair positions of the Committee.

64. Chairman's urgent items / Any other business

None.

The meeting concluded at 12.25 p.m.

CHAIR

NORTH EAST JOINT HEALTH SCRUTINY COMMITTEE

21 June 2018

Report of: Chair of the North East Joint Health Scrutiny Committee

Subject: TERMS OF REFERENCE

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1. PURPOSE OF REPORT

1.1 To present the Terms of Reference for the North East Joint Health Scrutiny Committee.

2. BACKGROUND INFORMATION

2.1 At the first meeting of each Municipal year, the Terms of reference for the Committee are presented for approval by the Committee. A copy of the Terms of Reference is attached at **Appendix A**.

3. RECOMMENDATIONS

3.1 That the Terms of Reference be noted and approved for the coming year.

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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

21 June 2018

Report of: Chair of the North East Joint Health Scrutiny Committee

Subject: WORK PLAN FOR THE 2018/19 MUNICIPAL YEAR

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1. PURPOSE OF REPORT

1.1 To present, and seek approval for, the Work Plan for the North East Joint Health Scrutiny Committee during 2018/19.

2. BACKGROUND INFORMATION

2.1 Details of the proposed Work Plan are outlined below.

Items for the 2018/19 Municipal Year	
Items	**Meeting Date**
Appointment of Chair and Vice Chair Terms of Reference for the North East Joint Health Scrutiny Committee Specialist Services Update (Vascular Services) - Update from Durham County Council Specialist Services Update (Neonatal Intensive Care) - Letter from the Chair	21 June 2018
Regular performance update from NEAS Independent Complaints Advocacy Service REPOD: Resettlement Programme for Overseas Doctors and Health Care Professionals (or Nov)	September 2018 (date TBC)

Translation and Interpretation Services	
Expansion of the use of the Pharmacy First Service (agreed at the meeting in March) Direct Access to Adult Hearing Services - Five health commissioners across Durham and Teesside are working together to re- procure the Direct Access to Adult Hearing Services for Age Related Hearing Loss (age 55+) Audiology Services. Engagement 14th May 2018 - Friday 6th July 2018 online questionnaire (https://www.surveymonkey.co.uk/r/Audiologysurvey2018).	November 2018 (date TBC)
NEAS Quality Accounts Breast Screening and Cancer Mortality	February 2019 (date TBC)

3. RECOMMENDATIONS

3.1 That the work plan for the 2018/19 be noted and approved.

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

NORTH EAST JOINT HEALTH SCRUTINY COMMITTEE

21 June 2018

Report of: Durham County Council Representative

Subject: DURHAM COUNTY COUNCIL - ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE – MEMBER FEEDBACK / RECOMMENDATIONS ON NHS ENGLAND'S PROPOSED REVIEW OF SPECIALISED VASCULAR SERVICES ACROSS THE NORTH EAST

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1. PURPOSE OF REPORT

1.1 To introduce feedback and recommendations from Durham County Council's Adults Wellbeing and Health Overview and Scrutiny Committee, held on the 1st June 2018, following consideration of NHS England's proposed review of specialised vascular services across the North East.

2. BACKGROUND INFORMATION

2.1 The North East Joint Health Scrutiny Committee on the 15 February 2018 received and update from the North East and North Cumbria Specialist Commissioning Unit outlining progress in relation to the North East Vascular Service Review, following implementation of the recommendations from the Vascular Society of Great Britain and Ireland in 2016.

2.2 The Committee agreed that 'discussions would be noted and the proposals reconsidered after consideration by Durham County Council's health scrutiny committee, and provision of the consultation responses and business case to this Committee' (minute number 60 refers).

2.3 At a meeting of the Durham County Council's Adults Wellbeing and Health Overview and Scrutiny Committee held on Friday 1 June 2018, consideration was given to a report and presentation regarding proposals by NHS England to reconfigure specialised and some non-specialised vascular services in North East England.

2.4 Representatives of NHS England's specialised commissioning team, County Durham and Darlington Foundation Trust, City Hospitals Sunderland NHS Foundation Trust, North East Commissioning support and both of the County Durham Clinical Commissioning Groups attended to speak about the proposals

including the rationale for change, the independent evaluation of options undertaken by the Vascular Society of Great Britain and the recommended option of the third centre providing specialised vascular services at Sunderland Royal Hospital rather than at University Hospital North Durham.

3. RECOMMENDATIONS

3.1 Members considered carefully the proposals and have agreed to recommend to the North East Regional Joint Health Overview and Scrutiny Committee that:-

1) The clinical case for the reduction from 4 to 3 specialised vascular services centres in the North East is accepted by Durham County Council's Adults Wellbeing and Health Overview and Scrutiny Committee;

2) The rationale for the selection of Sunderland Royal Hospital as the third regional specialised vascular services centre is disputed from a geographical perspective as this would leave almost half of County Durham more than an hour's travel away from specialised vascular services;

3) The County Council's Adults Wellbeing and Health Overview and Scrutiny Committee believes that the proposals constitute a substantial development and significant variation in health services and that statutory consultation is required under Section 244 of the NHS Act 2006, particularly in respect of the decision of the location of the third regional centre for specialised vascular services between University Hospital North Durham and Sunderland Royal Hospital; and

4) The proposed communication and engagement activity in respect of the proposed review needs to be widened to ensure that the whole population of County Durham have the opportunity to provide their views on the proposals given the significant impact upon Durham of the preferred option.

Contact Officer:- Stephen Gwillym
Principal Overview and Scrutiny Officer,
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Tel No. 03000 268140

NORTH EAST JOINT HEALTH SCRUTINY COMMITTEE

21 June 2018

Report of: Chair of the North East Joint Health Scrutiny Committee

Subject: SPECIALIST SERVICES UPDATE (NEONATAL INTENSIVE CARE) - UPDATE LETTER FROM THE CHAIR

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1. PURPOSE OF REPORT

1.1 To introduce feedback and recommendations from Durham County Council's Adults Wellbeing and Health Overview and Scrutiny Committee, held on the 1st June 2018, following consideration of NHS England's proposed review of specialised vascular services across the North East.

2. BACKGROUND INFORMATION

2.1 Initial proposals for the Neonatal Intensive Care had been discussed in detail by the North East Joint Health Scrutiny Committee on the 17th December 2015. Following a number of progress reports, a further presentation was considered by the Committee on the 15 February 2018 (minute number 49 refers).

2.2 North East Joint Health Scrutiny Committee agreed that 'subject to support from Stockton Borough Council, following their individual consideration on the proposals, the Committee had no objection to the proposals for changes to the provision of neo-natal services, as detailed in the presentation

2.3 Following the meeting of the 15th February 2018, the Chair of the North East Health Scrutiny Committee received confirmation from Stockton Borough Council that the matter had been considered, on the 13th March 2018, by its Adult Social Care and Health Select Committee. Stockton's Select Committee had agreed that they had been provided with sufficient assurance in relation to the proposals and had agreed that no further action required by than at that time. In addition to this, the Chairman had received confirmation from the North Tees and Hartlepool NHS Foundation Trust that they agree that the proposals were the right thing to do in terms of the provision of services for this group of babies from the University Hospital of North Tees. Over and above these proposals, the Trust remained committed to the provision of a vibrant Special Care Baby Unit (SCBU) / model, ensuring the sustainability of remaining services from the University Hospital of North Tees as they go forward.

2.4 On the basis of the above, and in accordance with decision of the 15th February 2018, the Chairman of the North East Joint Health Scrutiny Committee confirmed, in writing to NHS England, that the Committee has no objection to the proposals for changes to the provision of neo-natal services, as detailed below:

- The RVI in Newcastle provide the Quaternary Centre;
- Sunderland provide the NICU for babies born over 26 weeks gestation for the whole region;
- James Cook Hospital in Middlesbrough expand its services to become a viable tertiary neonatal unit; and
- North Tees Hospital NICU only care for babies over 30 weeks gestation – only Intensive Care and the High Dependency Care would be affected at North Tees.'

2.5 A copy of the letter sent to NHS England by the Chair of the North East Joint Health Scrutiny Committee (**Appendix A**)

3. RECOMMENDATIONS

3.1 That the letter be noted.

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

Councillor Ray Martin-Wells
Chair, North East Regional Health Scrutiny Committee
Civic Centre
Hartlepool
TS24 8AY

HARTLEPOOL
BOROUGH COUNCIL

Penelope Gray
Assistant Director of Specialised Commissioning
– North East and Cumbria
NHS England

Sent via email to: penelope.gray@nhs.net

29 May 2018

Dear Penelope,

NEONATAL INTENSIVE CARE SERVICES

Further to my letter of the 22 May 2018, please note that an error has been identified. On this basis, please disregard my original letter and note the below amendment.

On the 15th February 2018, the North East Joint Health Scrutiny Committee agreed that 'subject to support from Stockton Borough Council, following their individual consideration on the proposals, the Committee had no objection to the proposals for changes to the provision of neo-natal services, as detailed below:

- The RVI in Newcastle provide the Quaternary Centre;
- Sunderland provide the NICU for babies born ~~under 20~~ over 26 weeks gestation for the whole region;
- James Cook Hospital in Middlesbrough expand its services to become a viable tertiary neonatal unit; and
- North Tees Hospital NICU only care for babies over 30 weeks gestation – only Intensive Care and the High Dependency Care would be affected at North Tees.'

As Chair of the North East Health Scrutiny Committee, I have now received confirmation that, on the 13th March 2018, Stockton's Adult Social Care and Health Select Committee agreed that they had been provided with sufficient assurance in relation to the proposals and that no further action required by than at this time. In addition to this, I have received confirmation from the North Tees and Hartlepool NHS Foundation Trust that they agree the proposals are the right thing to do in terms of the provision of services for this group of babies from the University Hospital of North Tees. Over and above these proposals, the Trust remains committed to the provision of a vibrant Special Care Baby Unit (SCBU) / model, ensuring the sustainability of remaining services from the University Hospital of North Tees as they go forward. A copy of the letter received from the Trust is attached for your information.

On the basis of the above, and in line with the decision of the North east Joint Health Scrutiny Committee at its meeting on the 15th February 2018, I would like to confirm that the Committee has no objection to the proposals for changes to the provision of neo-natal services, as detailed above. Should, however, the proposals be changed or amended in any way during the course of their implementation, the Committee will expect to be updated accordingly.

Yours faithfully

COUNCILLOR RAY MARTIN-WELLS
CHAIR OF THE NORTH EAST JOINT HEALTH SCRUTINY COMMITTEE

Copy to:

Councillor Christopher Akers-Belcher, Leader, Hartlepool Borough Council
Julie Gillon, Chief Executive, North Tees and Hartlepool NHS Foundation Trust