Durham Darlington and Teesside, Hambleton, Richmondshire and Whitby STP Joint Health Scrutiny Committee

Meeting on Wednesday 12 June 2019 at 2.00 pm in Committee Room 2 - County Hall, Durham

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Agenda

1. **Appointment of Chair**
2. **Appointment of Vice Chair**
3. **Apologies for absence**
4. **Substitute Members**
5. **To receive any Declarations of Interest by Members**
6. **Minutes (Pages 3 - 14)**

   To receive and approve the minutes of the meeting of the Durham Darlington and Teesside Hambleton Richmondshire and Whitby STP Joint Health Scrutiny Committee held on 27 November 2019 – Copy attached.

7. **Durham Darlington and Teesside, Hambleton, Richmondshire and Whitby STP - Terms of Reference and Protocol (Pages 15 - 20)**

   To receive and confirm the terms of reference and protocol for the Darlington and Teesside, Hambleton, Richmondshire and Whitby STP Joint Overview and Scrutiny Committee – Copy attached.

8. **Integrated Care System for the North East and North Cumbria (Pages 21 - 28)**

   Presentation by Alan Foster, Integrated Care System lead officer for the North East and North Cumbria – Copy attached.

9. **Chairman's urgent items**
10. **Any other business**
11. **Date and time of next meetings**
    - TBC

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Membership:

DARLINGTON BC
Councillor Wendy Newall
2 Vacancies

DURHAM COUNTY COUNCIL
Councillor John Robinson
Councillor Jean Chaplow
Councillor Richard Bell

HARTLEPOOL BC
3 Vacancies

MIDDLESBROUGH BC
Councillor Barrie Cooper
Councillor Alma Hellaoui
Councillor Jim Platt

NORTH YORKSHIRE COUNTY COUNCIL
Councillor Jim Clark
Councillor John Blackie
Councillor Heather Moorhouse

REDCAR AND CLEVELAND BC
Councillor Lynn Pallister
Councillor Deborah Dowson
Councillor Anne Watts

STOCKTON BC
Councillor Evaline Cunningham
Councillor Clare Gamble
Councillor Lynn Hall

Durham Darlington Teesside Hambleton Richmondshire and Whitby STP

Joint Health Scrutiny Committee

At a meeting of the **Durham Darlington Teesside Hambleton Richmondshire and Whitby STP Joint Health Scrutiny Committee** was held in the Council Chamber, Town Hall, Darlington on **Tuesday 27 November 2018 at 2.00p.m**.

Present:

Councillors W Newall and L Tostevin (Darlington Borough Council)
Councillors J Robinson, J Chaplow and R Bell (Durham County Council)
Councillors B Loynes and G Hall (Hartlepool Borough Council)
Councillors J Blackie and H Moorhouse (North Yorkshire County Council)
Councillors S Bailey and L Hall (Stockton-on-Tees Borough Council)

Scrutiny Officers

Peter Mennear (Stockton-on-Tees Borough Council)
Alison Pearson (Redcar and Cleveland Council)
Stephen Gwillym (Durham County Council)
Caroline Breheny (Middlesbrough Borough Council)
Joan Stevens (Hartlepool Council)

Other Officers

Christine Shields, Assistant Director of Commissioning, Performance and Transformation, Darlington Borough Council

NHS STP, Trust and CCG Representatives

Alan Foster, STP/ICS Lead
Sue Jacques, Chief Executive, County Durham and Darlington NHS Foundation Trust
Siobhan McArdle, Chief Executive, South Tees Hospitals NHS Foundation Trust
Deepak Dwarakanath, Medical Director, North Tees and Hartlepool NHS Foundation Trust
Stewart Findley, Chief Officer, North Durham, DDES, Darlington, Hartlepool and Stockton and South Tees CCGs
Mary Bewley, Head of Communications and Engagement, North of England Commissioning Support

Apologies

Councillor J Taylor (Darlington Borough Council)
Councillors B Brady, E Dryden and A Hellaoui (Middlesbrough Council)

Councillor J Clark (North Yorkshire County Council)
Councillors N Cooney, M Ovens and R Goddard (Redcar and Cleveland Borough Council)
Councillor L Grainge (Stockton-on-Tees Borough Council)
Daniel Harry, North Yorkshire County Council
Julie Gillon, Chief Executive, North Tees and Hartlepool NHS Foundation Trust

17. Substitute Members

None.

18. Declarations of Interest by Members

None.

19. Minutes

Agreed that the minutes of the meeting held on 25 September 2018 be confirmed and signed by the Chair as a correct record.

20. An integrated Care System for the North East and North Cumbria

(i) Developing Integrated Heath and Care Partnerships

Alan Foster, STP/Integrated Care System Lead gave a presentation regarding the development of an Integrated Care System (ICS) and associated Integrated Care Partnerships (ICP) across North Cumbria and the North East Region.

The Committee were advised that the North East and North Cumbria had declared their position as an aspirant Integrated Care System under a programme developed by NHS England and NHS Improvement. The North Cumbria and North East region currently consisted of 3 STP footprints which, under the ICS Programme, would develop a shared ambition to the best in England and Europe for health and care outcomes.

Mr Foster stated that the Cumbria and North East was a relatively high performing area for health and care albeit with some performance and finance challenges. It has a long established geography with a positive history of joint working across a highly interdependent system of clinical services where patient flows remain mostly within this area. Members have been advised in previous reports of service sustainability and configuration issues which have remained unresolved and fragmentation following the Health and Social Care Act 2012 that has made system wide decision making difficult.

The Committee noted that faster progress on improving health outcomes for the population was needed with more empowered patients supported by fully integrated health and social care. The system also needed to deliver a sustainable, equitable and affordable core offer of acute services as well as a strengthened collective decision making process for “at scale” improvement initiatives.

The presentation reaffirmed a unanimous commitment from NHS bodies to become an Integrated Care system with robust governance arrangements. The ICS would develop a vision and strategy supported by a suite of enabling workstreams. The ICS would create 4 Integrated Care Partnerships based upon existing population density/patient flows and hospital sites whilst preserving place based clinical leadership. These ICPs would be empowered to deliver sustainable acute services through managed clinical networks across multiple sites.

Mr Foster stressed that an ICS was not a statutory organisation in itself but rather an agreed partnership of individual organisations working to improve health and care based upon:-

- Developing a shared vision and high-level plan across NHS organisations;
- Reaching a formal agreement with NHSE/I to implement faster improvements in population health outcomes;
- Taking devolved responsibility for key NHS resources, and
- Collaborating across boundaries, e.g. clinical staff from different organisations working in networks 'horizontally' across hospitals but also integrating 'vertically' with GP and community services.

Integrated Care Partnerships were alliances of NHS Providers that work together with local commissioners to deliver care by agreeing to collaborate rather than compete. In this context providers could include hospitals, community services, mental health services and GPs as well as social care, independent and third sector providers.

Mr Foster also referenced plans by NHS England and NHS Improvement to develop seven joint regional teams led by directors tasked with developing more integrated local leadership. One of these teams would cover the North East and Yorkshire footprint. He stated that the ICS wanted to take more control over the resources it received and also take local decisions around staff recruitment, training and retention.

Members then considered the emerging outline of ICP geography with 4 ICPs being set up based around population density, patient flows and existing hospital sites. These would be for North Cumbria; North; Central and South.

In setting out the ICS approach to planning, Mr Foster indicated that a five year revenue budget settlement was anticipated for the NHS covering 2019-20 to 2023-24 which should provide a degree of certainty in developing the NHS Long Term plan. The new NHS approach to planning would include a review of standards, new financial architecture and more effective workforce and physical capacity planning. It will then be for the ICS to develop their own strategic plan which will deliver the NHS Long Term Plan and set out how the local NHS system will be run using available resources. In preparation for this all organisations (commissioners and providers) will be required to aggregate their plans into a single operating plan. This whole system plan for North Cumbria and the North East would in turn be signed off by all organisations by summer 2019.

Councillor Blackie stressed the dependency of rural communities in the area he represented upon those acute services provided at Darlington Memorial Hospital,

James Cook Hospital, Middlesbrough and the Friarage Hospital, Northallerton. In acknowledging the development of the ISC and ICPs he stated that assurances were needed that acute services will be provided across the whole region equitably.

Councillor Moorhouse, whilst acknowledging and agreeing the development of ICPs based around existing population density, highlighted the different population demographics across the North Cumbria and North East SC footprint and the importance of health and social care providers and commissioners developing services that meet specific needs of local communities. She gave the area of Hambleton, Richmondshire and Whitby as an example of a locality where there was a greater elderly population with highly complex health needs which would require a different approach to some more urbanised areas of the region. She stated that for such people it was more likely that care was provided in a more community based service model rather than at acute hospital centres.

Mr Foster referenced the excellent work being undertaken across the Hambleton, Richmondshire and Whitby CCG locality in respect of “frail elderly” and this being an example of the desire to provide care more locally. He advised the Committee that demand placed upon the health and social care system by frail elderly and the increase in such work was at the forefront of a specific workstream.

Councillor Bell referenced the proposal for a North East and Yorkshire regional development team and what that may mean for the 3 site acute centre model previously discussed by the Committee. He asked whether an emerging ICS would include North Yorkshire colleagues who sit on the STP Joint OSC at present. In response, Mr Foster indicated that Yorkshire was potentially to be covered by 3 ICS which added to the complexity of partnership working and the development of relationships across multiple provider and commissioning organisations. He stressed however that no “iron curtain” would descend upon patients seeking treatment within the region and that above all else patients would be put first. Councillor Bell welcomed that reassurance.

Cllr Robinson suggested that with the development of ICS and ICP structures there appeared to be a move back to the 1970’s structures within the NHS of Regional and Area health authorities. He asked whether County Durham was definitely to be included in the Central ICP? Mr Foster indicated that this was still being discussed and that a letter had been sent by the Leader and Chief Executive of Durham County Council seeking clarification on this issue.

Mr Foster stressed that the development of ICPs would not necessarily determine where patients would go for acute services but was rather about developing the opportunity for joint working amongst the NHS across organisational boundaries.

In response to a question from Councillor Loynes, Mr Foster stressed that the ICP boundaries on the map within the presentation were merely indicative of population density and all areas of the region would be covered by an ICP.

Councillor Tostevin expressed some doubt about the ability to develop and manage sustainable relationships under the ICS/ICP system as she felt this was much easier to achieve within a single organisational structure. Mr Foster acknowledged that the agenda for change was considerable and that to deliver

the changes necessary, partnerships needed to work. He stressed that whilst there was no suggestion that Local Government structures would change under the ICP development programme it was evident that relationships across the NHS were developing and delivering increased collaborative arrangements which was a particular strength within the region. Councillor Tostevin responded that she was also worried about the reality of the timeframes potentially being discussed for the establishment of ICS/ICPs given the huge amount of work currently being undertaken across the NHS and Local Government in terms of health and social care integration.

(ii) Clinical Strategy Development – South Integrated Care Partnership

Siobhan McArdle, Chief Executive, South Tees Hospitals NHS Foundation Trust gave a presentation regarding clinical strategy development and the work proposed under the South Integrated Care Partnership (ICP). Ms McArdle explained that a vision and scope had been developed for the South ICP. The vision was to "work collaboratively to maintain local access with a focus on delivering out of hospital care and ensuring the sustainability of safe clinical services to meet the needs of the population." The scope of the programme was "to develop a clinical strategy for the South Integrated Care Partnership with the aim of achieving and sustaining high quality hospital care across the area." The scope of this work included the following acute provider organisations:

- County Durham and Darlington NHS FT
- North Tees and Hartlepool NHS FT
- South Tees Hospitals NHS FT

The Programme would cover acute health services commissioned and provided for the people of Darlington, Tees, Durham, Dales and Easington, Hambleton, Richmondshire and Whitby. University Hospital North Durham will continue to provide the existing range of services.

Ms.McArdle reported that the clinical strategy for the South ICP would focus on how the following services would be delivered:-

- Urgent & Emergency Care
- Paediatric, Maternity (Gynaecology modelling interdependencies)
- Elective care:
- Spinal
- Breast
- Urology
- Frailty services
- Stroke services

It was intended that the clinical strategy would be brought back to the Committee in January 2019 for consideration.

Members were informed that the programme work builds on that undertaken as part of the Better Health Programme which had been reviewed to ensure a clear audit trail and evidence of previous stakeholder engagement. The starting point

for the ICP was a working list of ideas that will be appraised against 'must have' criteria for viability. Thereafter modelling workshops would take place to build up and discuss scenarios. Ms. McArdle stressed that clinical standards were a key driver to improving quality and patient outcomes and indicated that viable ideas would be subject to robust financial and activity modelling (value impact assessment) and further evaluation through stakeholder engagement. As part of this work, individual service clinical case for change will develop the draft case for change with credible scenarios being identified for formal consultation.

As part of this process, the Committee were informed that the following operating principles had been put forward by the programme leads:-

- The needs of people will have priority over organisational interests;
- We will work in clinical networks across hospital sites - sharing scarce resources to maintain local services;
- We will work collaboratively, urgently and with pace on system reform and transformation;
- Costs will only be reduced by improving co-ordinated care;
- Waste will be reduced, duplication avoided and activities stopped which have limited value or where benefit to our population is disproportionate to cost.

As previously reported, Ms. McArdle confirmed that clinicians were currently developing the clinical strategy. In doing so she stated that the programme would preserve each hospital into the future by using them differently and in a more joined up way to benefit all patients. It was suggested that some changes and improvements may be necessary to services currently provided from different hospital sites. All three NHS Trusts wanted to introduce new ways of working so that clinicians can work easily across multiple organisations and clinical sites. They were also committed to expanding the use of new roles and care models that would assist in managing demand and drive an improvement in health outcomes.

The presentation concluded with a proposed timeline which included the proposed clinical review of the Value Impact Assessments developed for the services in question during December 2018. At the same time a strategic Oversight Group would meet to review the draft clinical strategy. Following any comments made as part of that process the Group would meet again in January to approve the final draft clinical strategy. Thereafter the various scenarios developed and the proposed pre-engagement activity and emerging plans for formal consultation and engagement would need to be brought back to the DDTHRW STP Joint OSC for consideration and comment. Ms. McArdle suggested that this could be done towards the end of January 2019. The proposed timeline concluded with plans for a formal launch of service reconfiguration with staff, external stakeholder and public engagement scheduled for March 2019.

Members were advised that there were 6 key phases proposed in the programme timetable namely:-

Phase 1 – Clinical Strategy Development
Phase 2 – Pre-consultation engagement and develop business case

Phase 3 – Public Consultation
Phase 4 – Period of reflection
Phase 5 – Decision making process
Phase 6 – Final Business Case

Ms. McArdle concluded by emphasising that the programme was currently at Phase 1.

The Chairman then invited questions from members of the Committee.

Councillor Bell referred to previous discussions that had taken place in the development of a 3 acute hospital site model as part of the Better Health Programme and asked whether there had been “in principle” agreement to retain that model and were clinicians sited on and have an for a collaborative working model across multiple hospital sites?

Deepak Dwarakanath, Medical Director, North Tees and Hartlepool NHS Foundation Trust reported that clinicians across the South ICP were pushing for change to improve the quality of care available and delivered to patients. They also recognised that current workforce pressures being experienced across the clinical areas being reviewed would not allow for these services to be delivered across all sites. He referenced current problems being experienced in respect of gaps in workforce rotas, increased shifts for current staff and the reliance on locum clinicians.

Councillor Blackie placed on record his thanks to the NHS organisations across the area who had delivered life-saving treatment to himself and expressed the fervent wish that the NHS Services in the area were not stretched to the point that they “fell down”. In discussing possible future service models, Mr Dwrarkanath suggested that most services would remain available in the three major sites (Darlington Memorial Hospital; University Hospital of North Tees and James Cook Hospital) and that ambulatory services/care was a key element in facilitating this. He also stressed that any changes advocated by clinicians would aim to future proof services across the region and that this would include enhanced IT provision.

Councillor Blackie asked whether 24/7 Accident and Emergency and Maternity and Paediatrics services would be available from the three sites as there have been many concerns expressed about potential changes in acute services along with the development of specialist centres and the importance of having appropriate and effective patient transport systems that facilitate access to these services. Ms McArdle reiterated the comments of Mr Dwrarkanath and the input of clinicians and stressed that work was ongoing across the North Yorkshire and South Tees NHS FT area in this respect.

Councillor Hall welcomed the reference to working at pace and stressed the importance of North Tees and Hartlepool NHS FT and South Tees NHS FT working collaboratively to improve services. She stated that it had been this lack of pace which had frustrated members of this committee particularly in terms of the absence of information about what services are planned for future delivery. In responding, Ms McArdle agreed with and noted the concerns around the pace of

change, emphasising the importance of NHS Partners keeping local authorities engaged at the same pace.

Regarding transportation links and accessibility to services, Councillor Moorhouse referenced the Esk Valley Railway line which whilst being underused and poorly maintained was a potential asset that could be utilised to improve accessibility to services from North Yorkshire.

The Chair referred to the proposed Value Impact assessments that are being drafted in respect of Urgent & Emergency Care; Maternity Paediatrics; Stroke, Frailty, Breast, Spinal and Urology services and urged care in how the delivery and publication of these was to be managed to avoid adverse public reaction and also the risk of premature referrals to the Secretary of State for Health and Social Care.

Mr Dwrarkanath stated that the region's two main trauma centres would remain at Newcastle and Middlesbrough and that it was anticipated that no other A&E facilities would close. He also suggested that there would be no probable change with Maternity/Paediatrics services. He did recognise that the medical leaders/professionals had been poor at promoting and managing maternity services.

Councillor Bailey emphasised the importance and need for robust public consultations for any potential service changes and continued local authority involvement and engagement in that process.

Councillor Bell referred to the involvement and engagement of local authorities in public consultation and suggested that NHS partners would need to give consideration to the potential impact that local authority election purdah may have on any consultation timeframes.

Councillor Loynes asked what any future proposals would mean for University Hospital Hartlepool. She referenced the loss of several acute services from the hospital including A&E and the apparent running down of maternity services at the hospital with women discouraged from giving birth at UHH. In echoing the sentiments of Cllr Loynes, the Chair suggested that alongside the potential service development proposals for North Tees University Hospital, James Cook Hospital and Darlington Memorial Hospital, there needed to be comprehensive long term strategies for University Hospital Hartlepool, Bishop Auckland Hospital and the Friarage Hospital, Northallerton.

In response, Ms McArdle indicated that those latter three points of service delivery referenced by the Chair were vital to the future of the former. She also stressed that the value impact assessments being drafted would aim to retain as much local access to services as possible.

At the conclusion of the discussions the following action was agreed:

1. The report be noted; and
2. The Value Impact Assessments and associated engagement plans be brought back to a future meeting of the Committee in February 2019.

21. Darlington; Durham Dales Easington and Sedgefield; Hartlepool and Stockton; North Durham and South Tees CCGs Collaborative

Stewart Findley, Chief Officer, North Durham, DDES, Darlington, Hartlepool and Stockton and South Tees CCGs gave members a presentation setting out proposals for increased collaborative working arrangements across Darlington; Durham Dales Easington and Sedgefield; Hartlepool and Stockton; North Durham and South Tees CCGs**.**

He reminded members that the Health and Social Care Act 2012 established the statutory role of the Clinical Commissioning Group and sets out the statutory duties and requirements including those roles which are considered 'statutory' requirements, namely, that appointment of a Chair of the Governing Body, a Chief Officer, a Chief Finance Officer and an Executive Nurse.

Dr Findley indicated that many CCGs around the country are now either merging or creating joint committees and collaborative arrangements with a single agreed leader/Accountable Officer. The annual leadership assessment of CCGs by NHS England now also includes a focus on collaborative working. As a result, he indicated that the 5 CCGs in Durham and the Tees Valley (NHS Darlington CCG, NHS Durham Dales, Easington and Sedgefield CCG, NHS Hartlepool and Stockton-on-Tees CCG, North Durham CCG and NHS South Tees CCG) had agreed to develop joint leadership and management arrangements. They appointed a single Accountable Officer from 1st October 2018 supported by two Chief Officers and a highly skilled Director team. He confirmed that the new accountable officer was Dr. Neil O'Brien.

Members were also advised that NHS Hambleton, Richmondshire and Whitby CCG would also work closely with the 'collaborative' on areas of mutual interest, such as acute services commissioning.

Dr Findley explained the relationships between proposed Integrated Care Partnership footprints and existing CCG boundaries.

The Committee was informed that the CCGs had indentified a number of benefits to be derived from working more collaboratively including:-

- Working together to share expertise and capacity presents the opportunity to learn quickly, shorten delivery timescales and achieve stretching ambitions.

- Shared responsibility and delivery of the STP, working as key system leaders within a complex health and care system supporting the development of an Integrated Care System and Integrated Care Partnerships.

- Potential for greater overall clinical engagement and input.

- Support for both clinical and managerial succession planning across all CCGs.

- Greater potential for influence locally, regionally and nationally.

- An opportunity to re-focus, re-energise and align the team to support both the local and wider complex and significant transformation agenda by working at scale.

- Reputational benefits for CCGs as joint working brings shared benefits for delivery and improved performance.

- Management efficiencies in preparation for any running cost allowance reductions.

Members were advised that under the collaborative arrangement, place based commissioning would continue. This would be important as CCGs further develop integrated working with local authority and provider partners; develop and extend primary care and community services and ensure that services are responsive to local need and reduce the reliance on hospital based care. Dr Findley confirmed that each CCG would retain a strong local clinical voice and leadership whilst also retaining their individual statutory status.

Dr Findley reported that a robust governance framework would be developed which addressed statutory requirements at CCG level and also reflected an integrated approach across CCG and other partners as new relationships and ways of working were embedded. He stressed however that there would be no change to partnership working, existing governance and decision making, including the requirements for individual and joint consultation and engagement on service change proposals.

During the discussion which followed, Dr Findley reported that there were now requirements that 20% of CCG running costs needed to move into clinical improvement and/or transformation. This equated to around £4m across the collaborative.

Members noted that the collaborative proposals positioned the CCGs well to deal with finance and performance challenges and support transformation plans. Local place-based teams would be supported by more robust integrated and at sacle “support” functions which would free capacity for local engagement and shared working with partners.

Agreed that the report and information be noted.

22. Chairman’s Urgent Items

None.

23. Any other business

None.

24. Date and Time of next meeting

The next meeting date was to be confirmed but would be around the beginning of February 2019.

The meeting ended at 3.45 pm.

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Protocol for a Joint Health Scrutiny Committee

Durham Darlington Teesside Hambleton Richmondshire and Whitby STP

1. This protocol provides a framework under the Local Authority (Public Health, Health and Wellbeing Boards and Public Health) Regulations 2013 for considering and providing a formal consultation response in relation to the Durham Darlington and Teesside Hambleton Richmondshire and Whitby Sustainability and Transformation Plan and any associated proposals for substantial development and variation to health services contained therein or resulting therefrom. The proposals affect the Durham Dales, Easington and Sedgefield CCG area of County Durham, the Tees Valley region and the Hambleton, Richmondshire and Whitby CCG area of North Yorkshire. They are being proposed by the following:

   - Darlington Clinical Commissioning Group (CCG);
   - Durham Dales, Easington and Sedgefield CCG;
   - Hartlepool and Stockton-on-Tees CCG;
   - South Tees CCG;
   - Hambleton, Richmondshire and Whitby CCG

2. The terms of reference of the Joint Health Scrutiny Committee is set out at **Appendix A**.

3. A Joint Health Scrutiny Committee ("the Joint Committee") comprising Darlington BC; Durham County Council, Hartlepool BC, Middlesbrough BC, North Yorkshire County Council, Redcar and Cleveland BC; and Stockton-on-Tees BC ("the constituent authorities") has been established in accordance with the Regulations for the purposes of formal consultation by the relevant NHS Bodies in relation to the matters referred to at paragraphs 1. In particular in order to be able to:-

   (a) respond to the consultation

   (b) require the relevant NHS Bodies to provide information about the proposals;

   (c) require members/employees of the relevant NHS Bodies to attend before it to answer questions in connection with the consultation.

4. The Joint Committee formed for the purpose of the consultation outlined at paragraph 1 will, following approval of this protocol and terms of reference at its first meeting, circulate copies of the same to:-

   Local Authorities

   Darlington Borough Council (BC); Durham County Council, Hartlepool BC, Middlesbrough BC, North Yorkshire County Council, Redcar and Cleveland BC and Stockton-on-Tees BC;

   Clinical Commissioning Groups
   Darlington; Durham Dales, Easington and Sedgefield; Hartlepool and Stockton-on-Tees; South Tees and Hambleton, Richmondshire and Whitby.

NHS Foundation Trusts

County Durham and Darlington NHS Foundation Trust
North Tees and Hartlepool NHS Foundation Trust
South Tees Hospitals NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
North East Ambulance Foundation Trust

Membership

5. The Joint Committee will consist of equal representation, with three non-executive representatives to be appointed by each of the constituent authorities.

6. The term of office for representatives will be for the period from the date of their appointment by their constituent authorities until their relevant authority's next annual council meeting. If a representative ceases to be a Councillor, or wishes to resign from the Joint Committee, the relevant council shall inform the joint committee secretariat and the replacement representative shall serve for the remainder of the original representative's term of office.

7. To ensure that the operation of the Joint Committee is consistent with the Constitutions of all the constituent authorities, those authorities operating a substitution system shall be entitled to nominate substitutes.

8. The Joint Committee may ask individuals to assist it (in a non-voting capacity) and may ask independent professionals to advise it for the purposes of the consultation process.

9. The quorum for meetings of the Joint Committee shall be a minimum of one member representative from each of the constituent authorities.

Chair and Vice-Chair

10. The Chair and the Vice-Chair of the Joint Committee will be appointed annually at the first meeting of the Joint Committee following the constituent authorities' Annual Council Meetings. The Chair will not have a second or casting vote.

11. If the agreed Chair and Vice-Chair are absent from a meeting, the Joint Committee shall appoint a member to chair that meeting from the representatives present who are members of the same constituent Council as the Chair.

Terms of Reference

12. The Joint Committee will be the formal consultee under the Regulations and the Directions for the purposes of the consultation by the relevant NHS Bodies concerning those matters outlined at paragraphs 1. Terms of reference are set out at Appendix A.

Administration

13. Meetings shall be held at the times, dates and places determined by the Chair in consultation with each of the constituent authorities.

14. Agendas for meetings shall be determined by the secretariat in consultation with the Chair.

15. Notice of meetings of the Joint Committee will be sent to each member of the Joint Committee at least 5 clear working days before the date of the meeting and also to the Chair of the constituent authorities' relevant overview and scrutiny committees (for information). Notices of meetings will include the agenda and papers for meetings. Papers "to follow" should be avoided where possible.

16. Minutes of meetings will be supplied to each member of the Joint Committee and to the Chairs of the constituent authorities' relevant overview and scrutiny committees (for information) and shall be confirmed at the next meeting of the Joint Committee.

Final Report and Consultation Response

17. The relevant NHS body are required to notify the Joint Committee of the date by which its consultation response is required, and the date by which it intends to make a decision. The Guidance highlights that it is sensible for the Joint Committee to be able to consider the outcome of public consultation before its makes its consultation response.

17. The Joint Committee is independent of its constituent councils, executives and political groups and this independence should not be compromised by any member, officer or relevant NHS bodies. The Joint Committee will send copies of its final report and formal consultation response to the relevant NHS Bodies and the constituent authorities.

18. The primary objectives of the Joint Committee will be to reach consensus, but where there are any aspects of the consultation as regards which there is no consensus, the Joint Committee's final report and formal consultation response will include, in full, the views of all of the constituent authorities, with the specific reasons for those views, regarding those areas where there is no consensus, as well as the constituent authorities' views in relation to those matters where there is a consensus.

Following the Consultation

19. Any next steps following the initial consultation response will be taken with due reference to the 'Local Authority Health Scrutiny: Guidance to support Local Authorities and their partners to deliver effective health scrutiny' (Department of Health; June 2014).

Principles for joint health scrutiny

20. In scrutinising the proposals, the joint committee will aim to consider the proposal from the perspectives of all those affected or potentially affected by that proposal.

21. The constituent authorities and the relevant NHS Bodies 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 and/or disclosable pecuniary interests will be declared in all cases in accordance with the code of conduct and Localism Act 2011.

22. The Joint Committee's procedures will be open and transparent in accordance with the Local Government Act 1972 and the Access to Information Act 1985 and meetings will be held in public. Only information that is expressly defined in regulations to be confidential or exempt from publication will be able to be considered in private. Papers of the Joint Committee may be posted on the websites of the constituent authorities as determined by them.

23. Communication with the media in connection with the Joint Committee's views will be handled in conjunction with each of the constituent local authorities' press officers.

Appendix A

Joint Health Scrutiny Committee

Durham Darlington Teesside Hambleton Richmondshire and Whitby STP

Terms of Reference

1. To consider the draft Durham Darlington Teesside Hambleton Richmondshire and Whitby STP (hereafter called STP)

2. To consider proposals for substantial development and variation to health services as contained in and/ or developed from the STP and as proposed by the following:

   a) Darlington Clinical Commissioning Group (CCG);
   b) Durham Dales, Easington and Sedgefield CCG;
   c) Hartlepool and Stockton-on-Tees CCG;
   d) South Tees CCG;
   e) Hambleton Richmondshire and Whitby CCG.

3. To consider the following in advance of the formal public consultation:

   - The aims and objectives of the STP, the constituent workstreams therein including those proposals formerly developed as part of the Better Health Programme;
   - The plans and proposals for public and stakeholder consultation and engagement;
   - Any options for service change identified as part of the STP including those considerations made as part of any associated options appraisal process.

4. To consider the STP's substantive proposals during the period of formal public consultation, and produce a formal consultation response, in accordance with the protocol for the Joint Health Scrutiny Committee and the consultation timetable established by the relevant NHS Bodies.

5. In order to be able to formulate and provide views to the relevant NHS bodies on the matters outlined above, the Joint Committee may:-

   a) require the relevant NHS Bodies to provide information about the proposals the subject of the consultation with the constituent local authorities and the Joint Committee; and

   b) require an officer of the relevant NHS Bodies to attend meetings of the Joint Committee, in order to answer such questions as appear to them to be necessary for the discharge of their functions in connection with the consultation.

6. To ensure the formal consultation response of the Joint Committee includes, in full, the views of all of the constituent authorities, with the specific reasons for those views, regarding those areas where there is no consensus, as well as the constituent authorities' views in relation to those matters where there is a consensus.

7. To oversee the implementation of any proposed service changes agreed as part of the STP/Better Health Programme process.

8. The Joint Committee does not have the power of referral to the Secretary of State as this will be retained by individual local authorities.

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Join our Journey

North East and North Cumbria

Integrated Care System for the North East and North Cumbria

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ICS Lead

Join our Journey

North East and North Cumbria

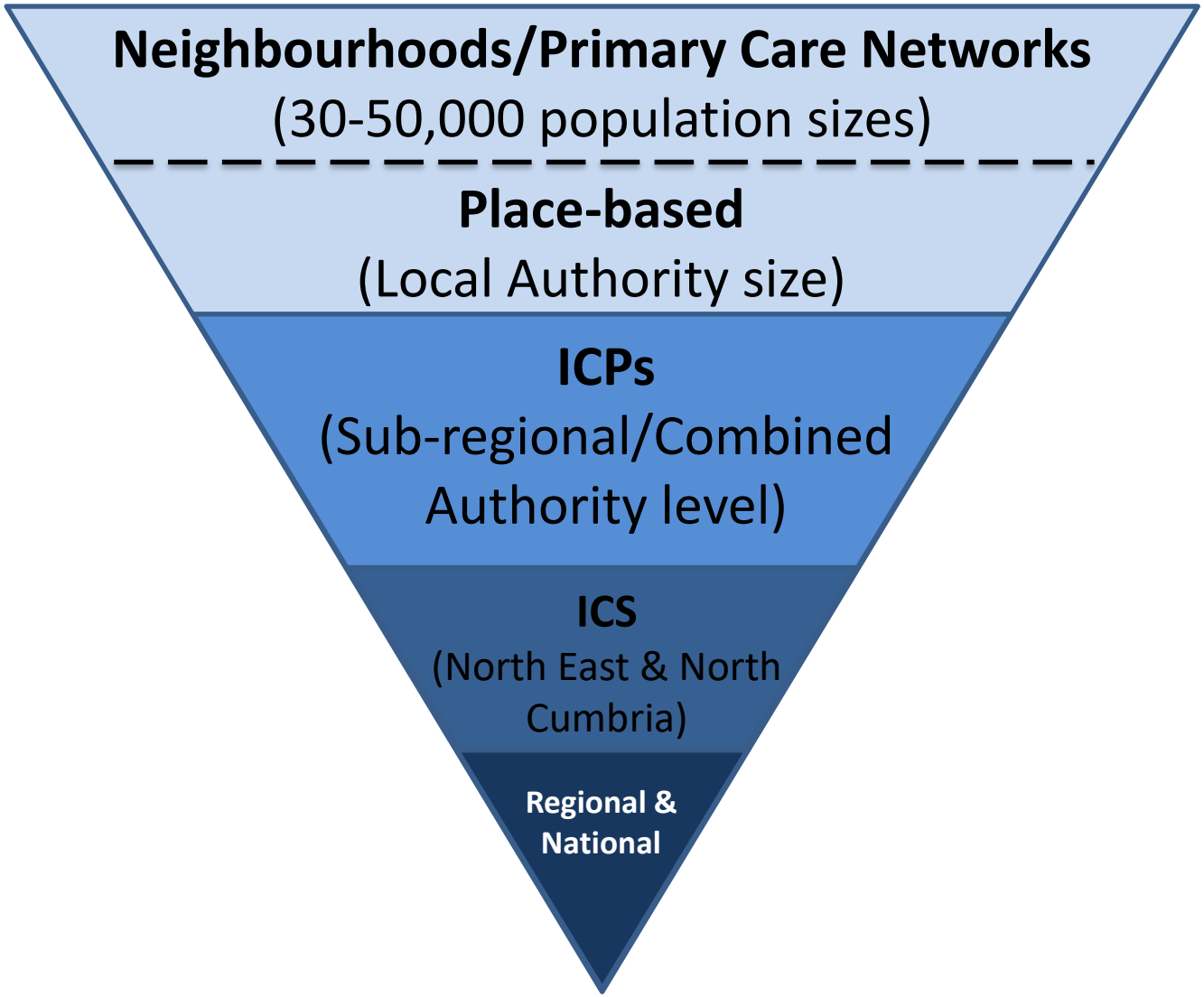
Background

- **NENC is a high performing region but with serious health inequalities**
- **We must move to population based Health, Care and Wellbeing with our Local Authority Partners**
- **A focus now on prevention to deliver improved outcomes**
- **This requires a integrated System based approach between trusted partners**
- **Subsidiarity is vital but some change requires making positive change across NHS and LA boundaries**
- **A wider Partnership must work collaboratively at scale to serve our 3.1m population**

Twin purpose of our ICS

“Do the right things at the right level with the right partners”

People

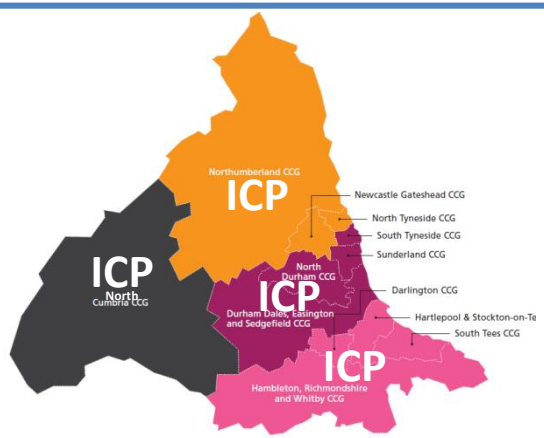


Places and neighbourhoods

Areas of focus

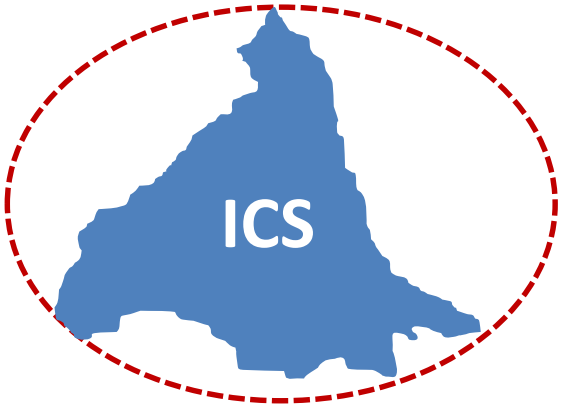
- Partnership working between NHS and local authorities via **Health & Wellbeing Boards**
- Ensuring the quality, safety and accountability of local health services
- Public and political engagement and consultation
- Primary Care Network development
- Health and Social Care Integration initiatives
- Joint-working with local voluntary sector

Integrated Care Partnerships



- Focus on acute services sustainability: clinical networking between neighbouring FTs and coordination of service development proposals
- One streamlined commissioning hub per ICP
- Work towards a single, shared approach to finances, and risk-sharing where appropriate.
- Make best use of the existing premises and facilities and jointly plan capital investments

Integrated Care System



- Strategic Commissioning (e.g. specialised; ambulance)
- Shared policy development (e.g. VBCC/IFRs)
- Overarching clinical strategy and clinical networks
- Six priority workstreams:
  - Population Health & Prevention
  - Opt. Health Services (inc clinical networks)
  - Workforce Development
  - Digital Transformation
  - Mental Health
  - Learning Disabilities

What are the key benefits to local people?

- **The NHS working alongside Councils, and drawing on the expertise of local charities and community groups, can help people to live healthier lives for longer.**
- **Local Health and Social Care services can provide better and more joined up care for patients when different organisations work towards common goals.**
- **Working systematically at scale allows us to make faster progress in tackling health inequalities and improving health outcomes (e.g. cardio-vascular disease).**
- **Investing in our workforce, doing more to recruit and retain our staff in NENC, and equipping them with the right skills for the future, will improve the effectiveness of our services and help local people into employment.**
- **Improved collaboration and clinical networking between neighbouring hospitals will allow us to sustain equitable access to high quality clinical care.**
- **Integrated systems can better analyse and share date about local people's health, intervening earlier and providing care that is tailored to individual needs.**

ICS Health and Care Strategy

1. Optimising Health Services

2. Workforce Development

4. Population Health & Prevention

6. Learning Disabilities

3. Digital Care

5. Mental Health

Financial strategy

Operational delivery

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