AGENDA ITEM 6

HOSC/08/11

Committee Health Overview and Scrutiny

Date 2 March 2011

Report by Graham Redgwell, Governance Officer
Contact details: Graham.redgwell@essex.gov.uk; Tel: 01245 430360

ESSEX HEALTH OVERVIEW AND SCRUTINY COMMITTEE
PRIVATE OFFSITE MEETING HELD ON WEDNESDAY 2 FEBRUARY 2011
AT RIVENHALL HOTEL, RIVENHALL END, ESSEX CM8 3HB

Attendees: Representatives from the Essex, Southend and Thurrock Health Overview and Scrutiny Committees, Essex based health and social care organisations, and supporting officers.

The following issues were raised and discussed and observations made:

Acute hospital trusts

(i) Despite trying to reduce the number and length of stay of acute beds, and increasing the number of intermediate care beds, there still remained considerable activity and demand for acute beds.

(ii) Issues about maintaining control over the numbers using A&E. No definitive science on the rise of A&E numbers but presumed that the demand was driven by an ageing population and that there was limited out-of-hours GP and community services. Were primary care service demands being fully met out of hours and at week-ends?;

(iii) Issues around demand management on elective surgery and community services and the critical mass for a service required at a hospital site. Looking at more efficient use of beds and more community based work;

(iv) Discussed attitudes to risk management particularly in relation to End of Life planning. Individual perception often could prefer 'safe' referral to hospital.

(v) Challenging financial outlook irrespective of strength of past financial performance. There were challenges and opportunities under QIPP for collaborative working and joint commissioning to tie-in with the vision in ECCs Target Operating Model;

(vi) Personalised budgets were already being implemented as part of ECC social care strategy and there was discussion on integrating it into non-ECC provider services;

(vii) Suggestion that certain service providers/additional services could be established in GP surgeries;

Public health

(i) Questioned the future role of borough and district council involvement in public health?

(ii) Limited contacts between hospital trusts and public health staff.

(iii) Suggested that there needed to be greater Public Health involvement in commissioning decisions. Public health was not just a medical model.

Mental health

(i) Increase in number of depressive illnesses; mental health patients often had a complex range of issues and not just health related;

(ii) Questioned whether the issues of vulnerable people in the mental health sector had a lower public profile than in the acute sector;

(iii) Acknowledged that, to date, the demand model was different for commissioning acute services as opposed to mental health services with the former seen to have had the largest increase. It was a concern that there could be a future concentration of resources into areas seen as pressured (i.e. the acute sector) and not into mental health for example.

General

(i) Agreed a general principle of any re-organisation should be to remove an administrative and/or management barrier and questioned whether GP commissioning would wholly achieve this;

(ii) Whilst it was recognised that some GPs were proactive it was suggested that they were not necessarily organised into economically viable consortia or of consistent competence;

(iii) Due to budgetary constraints both in commissioning and provider functions there was concern that short term fixes may be implemented that, over time, would be shown to have adverse long term implications;

(iv) Different models of support and engagement were required in different community areas.

Joint working - What will be the nature of commissioning in a few years time?

(i) There was more reason to collaborate rather than compete.

(ii) Are acute trusts working together identifying areas in which they could work together? Any collective procurement? There was already specialist national and regional procurement and that current focus instead was on sharing back office functions (e.g. call centres). It was suggested that there could be more working together on front office functions as well;

(iii) It was noted that mental health services had joint acute and community services set-up which was different from PCTs';

(iv) Joint commissioning of mental health services: It was questioned whether greater consideration could be given to multi-disciplinary commissioning to include health and social care as well clinical. It was acknowledged that different lines of accountability and responsibility would need to be maintained by the different providers.

Regulatory structure and oversight at regional level

(i) Discussion on roles of Monitor, commissioners, patients etc;

(ii) The regulatory role of the Strategic Health Authority was questioned and what would be the structure of any future replacement at regional level;

(iii) A regional role for development of specialist services was likely but who would oversee that?

(iv) National Commissioning Board would have strong powers.

Governors of Foundation Trusts

(i) Discussed future role of HOSCs and Governors once current role of Monitor had gone;

(ii) Did the changing role of Monitor mean an increased responsibility and accountability role for Governors?

(iii) Discussed the types and motivations of Governors that were appointed. They were a diverse body of knowledge/experience ranging through single issue Governors, staff and patient representatives and specialist appointees;

(iv) Governors had an increasingly important scrutiny role. Who are Governors representing and should there be closer working between them and the HOSCs? Strengthened accountability to members, staff and users?

(v) The importance of good training was emphasised as well as their receiving good independent information.

Health and Wellbeing Boards

(i) Acute trusts would be involved in the Health and Wellbeing Boards (HWB);

(ii) Shadow Essex HWB would be operating from April 2011. Separate HWBs for Southend and Thurrock;

(iii) HWB should not be seen as having a scrutiny function (how would bodies be held to account as they could be scrutinising themselves) but instead was expected to oversee commissioning;

(iv) Jenny Owen would be invited to attend the next Essex HOSC meeting to update on the HWB in Essex;

(v) ECC was reviewing its internal scrutiny structure.