MINUTES OF A MEETING OF THE HEALTH/NHS OVERVIEW AND SCRUTINY COMMITTEE HELD ON 21 APRIL 2011 AT 9.30 AM AT COUNTY HALL, CHELMSFORD

County Councillors:

*	G Butland (Chairman)	*	R Gooding
*	Mrs J M Reeves (Vice-Chairman)	*	Mrs S Hillier
*	Mrs M A Miller (Vice-Chairman)		
*	J Baugh		E Johnson
	R Boyce	*	J Knapman
*	P Channer (substitute)	*	C Riley

District Councillors:

*	Councillor N Offen	-	Colchester Borough Council
	Councillor M Maddocks	-	Rochford District Council
	Councillor S Henderson	-	Tendring District Council

(* present)

Cabinet Member Ann Naylor, Deputy Cabinet Member Anne Brown, Councillors Bill Dick, Ray Howard and Janet Whitehouse, and John Carr from Essex and Southend LINk were also in attendance.

The following officers were present in support throughout the meeting:

Graham Hughes	-	Committee Officer
Graham Redgwell	-	Governance Officer

1. Apologies and Substitution Notices

Apologies for absence had been received from County Councillors R Boyce (for whom Councillor P Channer attended as substitute) and E Johnson and Rochford District Councillor M Maddocks.

2. Changes to Committee Membership

It was **agreed** that Councillor E Hart be appointed as a member of the Committee for the time being, to fill the vacancy arising from the removal from office of Councillor L Dangerfield.

Councillor Miller was asked to pass on the Committee's condolences to the family of Councillor Hutchon who had recently sadly passed away.

3. Declarations of Interest

The following standing declarations of interest were recorded:

Councillor John Baugh	Director Friends of Community Hospital Trust
Councillor Graham Butland	Personal interest as Chief Executive of the East Anglia Children's Hospice. Personal interest due to being in receipt of an NHS Pension.

Councillor Sandra Hillier	Personal interest as member of Basildon and Thurrock Hospital Trust
District Councillor Nigel Offen	Personal interest due to being in receipt of an NHS Pension

In addition, Councillor Penny Channer declared an interest as a Member of New Maldon Community Hospital and Primary Care Facilities Stakeholder Group

Whilst not a member of the Committee John Carr declared an interest being a member of the Transformation Board for West Essex.

Dr Gary Sweeney, presenter under Item 6, declared an interest in that he held a remunerated post as Joint Chief Executive of North East Essex Strategic Commissioning consortium (Colchester and Tendring area).

4. Minutes

The minutes of the meeting of the Health Overview and Scrutiny Committee held on 2 March 2011 were approved as a correct record and signed by the Chairman.

5. Questions from the Public

There were no questions from the public on this occasion.

6. The Emerging New Agenda

Jenny Owen, Executive Director – Adults, Health and Community Wellbeing; Mike Gogarty, Director of Public Health; Dr Gary Sweeney, Chairman of North Essex Local Medical Committee; Cabinet Member Ann Naylor; and Clare Hardy, Senior Manager, Executive Office, Adults Health and Community Wellbeing, joined the meeting and introduced items as indicated below and participated in the discussion arising.

Earlier in the month the Government had announced that there would be a pause for a further listening exercise on the Health and Social Care Bill ("the Bill"). Subsequent discussion in the meeting was on the assumption that the main proposals in the Bill would remain after the consultation.

The Chairman questioned whether ECC was taking the opportunity provided by the Government's pause for consultation, to rethink its own approach and make representations on any preferred alternative structures. However, the Department of Health had advised that organisations should continue to plan and think on the basis of substantially the same structure. Any decision to make representations to Government before the end of May would be shared with the Committee.

(a) <u>Health and Wellbeing Board (Jenny Owen)</u>

The Committee received a report (HOSC/10/11) updating Members on the status and current membership of the Shadow Health and Wellbeing Board (HWB) in Essex.

It had been intended to move the Pre-Shadow HWB into formal shadow form. In view of the pause announced by the Government, no decision to date had been made as to when the HWB would move to shadow form. ECC had always considered 2011-12 to be a developmental year with a phased implementation approach during the period, before a dry run of the HWB in 2012-2013.

(i) Membership

The current proposals in the Bill required the following post holders to be members of the HWB: Representatives of GP consortia and HealthWatch, at least one member of the upper tier local authority, Director Adult Social Care, Director Children's Services, and local Director of Public Health. Additionally, ECC had also concluded that there should be representatives from district councils, NHS Commissioning Board (for strategy discussions), PCT cluster Chief Executive, relevant Cabinet Member, ECC Chief Executive and the police.

ECC had also concluded that, separate to the HWB, a wider stakeholder group should be established, to include further public, stakeholder and voluntary sector representation, to provide a wider engagement mechanism.

The work of the pre-shadow board was supported by a task and finish development group. The development group was exploring issues around functions, governance and structures and reported to the pre shadow HWB. Once the development group and the HWB had agreed a set of proposals they would engage and seek views from a wider range of stakeholders.

The pre shadow HWB had evolved from an original officer working group. The chair of the HWB would switch to being an elected Member once it had formally transitioned into the Shadow HWB.

(ii) Purpose of the HWB

It was confirmed that the key roles of the HWB were to provide democratic accountability and strategic leadership to join up health, social care and public health based on an enhanced Joint Strategic Needs Assessment (JSNA). There was no similar body serving all of this broad remit at the moment. However, Members questioned the overall purpose of the HWB and how it would be monitored and whether there would be greater democratic input into commissioning decisions if there was no HWB.

Members also questioned the future arrangements for patient representation. However, it was anticipated that HealthWatch, a new proposed body, would be stronger than the current arrangements. ECC was putting together a proposal to be an Early Implementer for HealthWatch. An ECC sponsored

stakeholder event on the patient experience and related issues had already been held which had included attendance by representatives from Essex and Southend LINk.

Members suggested that mental health provision should also be included under the HWB remit and it was **agreed** that this would be reviewed.

(b) Public Health (Mike Gogarty)

The Committee received a report (HOSC/11/11) updating on the transfer of responsibility for public health to ECC and the future role of district/borough councils.

(i) Director of Public Health (DPH)

The proposals required the appointment of a DPH jointly by the upper tier local authority and Public Health England. The job description and person specification was likely to be centrally determined and be in line with the Faculty of Public Health expectations. Whilst public health service in the county did not need to be headed by a medically qualified person it was thought that the future post holder should be a fully accredited public health commissioner and a strong regional leader. Additional clinical experience could be a slight advantage.

(ii) Public health outcomes

Public Health England and, in turn, local authorities and other organizations charged with commissioning public health services, would be required to deliver on the public health outcomes agreed nationally. These outcomes could broadly be described as health protection and resilience, broader determinants of ill health (such as material deprivation), health improvement (lifestyle choices people make), prevention of ill health, and life expectancy.

The JSNA had been used to identify local needs although the probability was that there would be a particular expectation to deliver on national outcomes. At present it was unclear how the current public health budget residing with PCTs would be split between Public Health England and local authorities; Consequently, there was a genuine concern about the actual power of local authorities to be able to deliver on expected public health outcomes.

(iii) The proposed structure

Members questioned the best model in which to deliver public health and whether the current proposed model for future public health really would be an example of localism put into practice when it was actually placed with a top tier local authority. The Bill set out the responsibilities of the top tier local authority irrespective of whether delivery was at a more localised level. It was stressed that there was a need to engage better with stakeholders and that some aspects of public health had to be delivered at different levels. Discussions would continue on the respective roles of county and

district/borough councils. Members stressed that scrutiny had to be undertaken at local level.

Members discussed examples given of commissioning public health services at county level that were delivered locally.

(iv) Public perception and profile

The direct ability of a local authority based DPH to influence the local public health agenda would depend, in part, on the proportion of the proposed ring fencing of funds with Public Health England that was distributed to upper tier local authorities.

The perception of public health had traditionally been connected with 'drains and diseases' and it was agreed that it needed to have a higher profile to engage people and to emphasise that it also covered general wellbeing.

Members emphasized the importance of face to face communications and questioned whether any guarantee could be given that there would be a permanent public health representative in every town hall in the county. It was stressed that, in comparison with other county councils, Essex already had a greater presence. The issue in future would be whether to have strategic level representatives (such as currently at Colchester and Tendring) or more of an operational post (such as at Braintree) at local town halls. No guarantee could be given, at this time, on such representation as it would be dependent on optimum use of available resources. Members were concerned that this could be a major problem if such a presence could not be provided.

The importance of 'on the ground' initiatives was stressed and a successful recent leaflet drop undertaken with the Citizens Advice Bureau in Jaywick was cited as an example.

At Members suggestion it was **agreed** that there could be a role for local community police officers and other community volunteers to help offer public health advice in the community and that this could meet the 'Big Society' model encouraged by the current Government.

(c) GP Consortia (Dr Gary Sweeney)

The Committee received a report (HOSC/12/11) from North and South Essex Local Medical Committees Limited, updating Members on GP views, issues and plans for the changes proposed for GP commissioning. Dr Sweeney emphasized that the evidence submitted to the Committee, and his views expressed at the meeting, were primarily related to his experience as Joint Chief Executive of the North East Essex GP Commissioning Consortium (NEEGPC).

(i) Development of GP consortia

Updates on the development of GP commissioning in each of the five Essex PCT administrative areas were included in the written report to the Committee. The pace of change was not uniform across the county. In the south of the County there was a greater number of smaller GP practices which had made the development of consortia more challenging. GP consortia pathfinders so far confirmed in North Essex currently covered 66% of practices and 70% of the population and, in South Essex 38% of practices and 39% of the population.

(ii) Governance

In response to member questioning it was confirmed that GPs were looking to continue the public engagement and democratic processes currently run by the PCTs. Those GPs applying for pathfinder status had to outline their proposals for public engagement as part of their application.

GP commissioning groups would have a responsibility for large amounts of public money and Members drew the comparison with other public organizations who had independent Chairmen and specialist Chief Executives and Directors of Finance.

The first part of NEEGPC meetings were held in public, with papers published on their website. Board Member interests also were published on the website and details of the web site would be provided to HOSC Members.

Whilst there were elections held to determine membership of the NEEGPC it was acknowledged that the electorate was limited, with it just comprising GP practices in the area. Members suggested that there should be greater involvement by people democratically elected by a wider electorate. Members questioned the relationship between GP commissioning groups and the LMC. In the past the LMC had worked on issues between PCTs and GP practices and it was anticipated that such a conciliatory role could be utilized in future to work on issues between individual practices and a consortium. Members were concerned that a consortium could become too powerful and questioned where patient rights would be defended. The Royal College of Nursing had recorded similar concerns recently.

It was acknowledged that the NEEGPC members had accepted that it was necessary to significantly increase their public accountability. Members questioned the balance between the increased workload from this increased public accountability with continued GP responsibilities. It was stressed that robust governance processes would need to be in place to assist this balancing of responsibilities.

(iii) Commissioning

It was confirmed that precise criteria for services to go out to tender were determined nationally and would include quality of service standards.

Members speculated on the actual level of commissioning to be undertaken by the HWB bearing in mind the direct commissioning being undertaken by GP consortia and the risk of duplication. It was stressed that pre shadow HWB work streams were already looking to identify the leanest commissioning processes. It was noted that the HWB would have a broader remit than anything currently in operation as it would also have responsibility for children's services.

Members questioned the connection between commissioning of health services and social care and how the outcomes could be monitored. Attention was being given to co-terminosity of services on county boundaries particularly in the south west and boundaries with Thurrock and Southend. Social care teams had been created in Essex which were aligned with PCT boundaries and ECC would need to make a similar aligment in future with GP consortia administrative areas.

Members questioned the arrangements for commissioning out of hours services as it would be interdependent with the demand for, and the level of, Accident and Emergency Services (A&E). Good primary care services were important to avoid unnecessary patient visits to A&E. A small proportion of GPs would provide out- of-hours services. Members questioned whether there might be an inherent conflict of interest for GPs in possibly commissioning their own out of hours services. However, it was acknowledged that GPs would not be resourced appropriately if they could not grasp some aspects of primary care themselves. This had been looked at previously as part of Practice Based Commissioning.

Members questioned when the GP consortia would start to look strategically at future configurations of services that would be required in Essex. Dr Sweeney indicated that there were some services that should be repositioned away from being provided in acute hospital settings and moved instead into the community.

(iv) Scrutiny

Outcomes frameworks would be issued by the Government and GP consortia would be expected to show delivery against those outcomes. Members suggested that there needed to be locality based scrutinies to monitor local commissioning performance. It was noted that there would be a national Commissioning Board under the current proposals and it was acknowledged that it was possible that a localized sub national structure could be announced in any updated Bill. However, whilst such a sub national structure could undertake monitoring it was likely that detailed scrutiny would remain with the Health Overview and Scrutiny Committee.

GP commissioning leads had become members on the Clinical Executive committees of PCTs although they were wary that they did not want the GP commissioning consortia evolving into a body that still looked like a PCT. This particular point had been one of the concerns raised by the House of Commons Health Select Committee. GP consortia representatives had

already met LINk representatives and expected to be fully involved in the establishment of HealthWatch.

The NEEGPC had provided feedback to its local MP on the proposals for GP commissioning. It had yet to decide if any written representations would be made to the Secretary of State during the Government pause for reflection.

(v) Conclusion

It was suggested that, whilst many people supported greater involvement by GPs in the commissioning process, they were not in support of GPs being the sole commissioner of services. Dr Sweeney agreed that commissioning should be 'clinically led' and that planning was on this basis.

The Chairman thanked Dr Mike Gogarty, Cabinet Member Ann Naylor, Jenny Owen, and Dr Gary Sweeney for attending and the robust discussion that had ensued. The Chairman queried whether ECC should be more proactive in seeking to influence the Government review of the proposals, particularly as ECC's Chief Executive and the Chief Executive of Mid Essex PCT were members of the NHS Future Forum that was co-ordinating responses to the national review. However, it was acknowledged that they were representing local government and the PCTs in general rather than their specific organizations. In particular a more open debate would aid obtaining a clear view of what was needed in Essex.

Members asked that they be kept informed of changes to services on the edges of, or just cross border, from Essex based administrative areas which were used by Essex residents.

At this point the witnesses (listed above), left the meeting.

The Chairman suggested that there was an opportunity for the Committee to exert influence on the Government consultation, independently from the political leadership at ECC. After further discussion, Members agreed with this independent approach and agreed that the following broad views should be forwarded to the Secretary of State (by the Chairman of the Committee in consultation with the Governance Officer for and on behalf of the HOSC), in response to the Government consultation:

(i) Commissioning should not be left entirely to GPs.
(ii) There should be genuine local democratic involvement in commissioning groups;
(iii) Strong robust governance of commissioning groups was important and should be encouraged to provide good outcomes;
(iv) There should be further provision for, and an increased role for, local scrutiny.

[A copy of the response was sent subsequently to HOSC Members – Secretary]

It was pointed out that district and borough councils provided and/or co-ordinated the provision of social housing, which was a significant determinant of health and wellbeing outcomes and yet acknowledgement of this was largely excluded from the detail of the Bill at the moment.

7. **NHS South East Essex Strategic Plan Review**

The Committee received a report (HOSC/13/11) on the review of the NHS South East Essex Strategic Plan undertaken by the South Essex Area Forum under delegated authority from the HOSC. Councillor Ray Howard, as chairman of the Forum, outlined the report and key conclusions. A Summary of Actions and Issues Arising were listed at the end of the report.

It was highlighted that there had been a very limited response from relevant organizations invited to submit their views.

In discussion the following were raised and discussed by Members. Andrew Pike, Chief Executive, NHS South West Essex was able to provide the following updates:

(i) NHS South East Essex had worked with partners to develop treatment centres locally to provide either extended hours or out of hours provision in some cases so as to reduce the level of attendances at A&E. The establishment of an Urgent Care Centre (UCC) at Southend University Hospitals Trust had been delayed. Planning permission had been rejected by Southend Borough Council on two occasions due to concerns over the lack of car parking spaces. As a result there would need to be a redesign of the urgent care pathway with the UCC now re-prioritised as SUHT were looking to introduce GP, district nurse and other community based service liaison points near to A&E at the hospital;

(ii) A new step-up intermediate care facility had opened at SUHT which it was hoped would reduce the number of emergency admissions. NHS South East Essex was looking to increase further the number of intermediate care beds for medical step up in South Essex;

(iii) A six month pilot was in place to test the proposed new service access model for musculo skeletal community services. The intention had been that timely intervention through alternative intensive physiotherapy could have reduced overall spending but results to date had not supported this contention. It remained to be seen what was the optimal time for surgical intervention;

(iv) Cateract treatment had been in high demand and access to the service had been examined to ensure that patients received it only when the symptoms were interfering with their lifestyle. There had been a tendency for too many early referrals. Mr Pike suggested that the Committee may wish in future to scrutinise the service restriction policy

being developed (with GP involvement) that specified thresholds for surgical referrals;

(v) Members questioned the significant discrepancy in spending between domiciliary dental service and dementia spending. The former had received funding for dental health from the Department of Health as part of a national drive. However, the QIPP in May would provide a further update and would indicate an increased future focus on services for the care of the elderly and dementia. It was acknowledged that a national campaign may not always strictly align with local priorities.

Mr Pike was specifically thanked for his updates given at the meeting. Given these updates, it was **agreed** that a revisit of the Strategic Plan, to review progress against identified issues, be deferred until October 2011 (rather than July as suggested) whereupon a written update, in the first instance, would suffice. Amended accordingly the report from the Forum was adopted.

The report had been aided by excellent input from the PCT. Members complimented the easy reading nature and structure of the report and it was suggested that a similar report could usefully be produced for NHS West Essex.

8. **NHS South West Essex: Intermediate Care Beds Review**

The Committee received a report (HOSC/14/11) on a consultation exercise being undertaken by the PCT on the future of intermediate care beds within local hospitals. Andrew Pike, Chief Executive, and Tonia Parson, Associate Director of Out of Hospital Services, were both in attendance to introduce the item. Whilst continuing to admit the same number of patients, fewer intermediate care beds were required for South West Essex due to various improvements made to shorten the time patients needed to stay in hospital. Consequently it was proposed to reduce the number of intermediate care beds at Brentwood and Mayflower Community Hospitals. Clarification on consultation with Basildon Borough Council members would be sought.

Evidence showed that there had been a significant number of empty intermediate care beds in the current facilities for considerable periods of time. There had been attempts to increase the provision of such beds in community hospitals but these hospitals generally did not have overnight medical cover. Reducing the length of stay and getting people onto their feet increased the chances of being able to eventually discharge patients back to their homes.

It was confirmed that there was a commitment to retaining the three community hospitals in the administrative area but that getting bed capacity at the right level was key to utilise the space released for other treatments (e.g. stroke beds).

If the proposals were implemented the PCT would only pay for the beds that it needed, saving £1.36 million a year primarily from staff reductions achieved through natural wastage. Further emphasis would be given to encouraging

re-ablement initiatives with local authorities.

The Committee accepted the rationale for the proposals and was supportive of the changes outlined in the report.

9. **East of England Regional Health Chairs Forum**

The Committee received a report (HOSC/15/11) from the Governance Officer on the Regional Health Chairs Forum held in February 2011 and this was noted. It was **agreed** that the special report published by the Care Quality Commission on Supporting Life After Stroke would be included on the agenda for the next Essex HOSC meeting. The Cabinet Member reported that to date responses received from PCTS in Essex had indicated inequity in the way the process was managed. It was also **agreed** that she be invited to contribute towards the proposed agenda item.

10. **General Update Item**

The Committee received a report (HOSC16/11) from the Governance Officer updating the Committee on a range of health issues he had dealt with recently, and this was noted.

Details of proposals for the expansion of services to provide radiotherapy in Essex from the Essex Cancer Network had been circulated previously (the proposals did not affect West Essex, which fell within the area of another cancer network). Whilst the proposals indicated a service improvement and better outcomes by operating from large centres of excellence, there had been some opposition that the sites chosen were in the north and south of the county and that there would be no facility in the centre of the county. It was **agreed** that the views of the GP Commissioning Groups in Essex would be sought but that the Committee was minded to support Option 1 set out in the consultation document (basing facilities at Colchester and Southend General Hospitals).

11. **Date of Next Meeting**

The next meeting of the Committee would be held at 10am on Wednesday 1 June 2011.

There being no further business the Chairman closed the meeting at 12.08pm

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Chairman
1 June 2011.