MINUTES OF A MEETING OF THE HEALTH/NHS OVERVIEW AND SCRUTINY COMMITTEE HELD ON 1 JUNE 2011 AT 10 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)		E Johnson
*	J Baugh	*	J Knapman
*	R Boyce		L Mead
*	M Fisher	*	C Riley

District Councillors:

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

(* present)

Cabinet Member Ann Naylor, Deputy Cabinet Member Anne Brown, 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

35. Apologies and Substitution Notices

Apologies for absence had been received from County Councillors L Mead and E Johnson.

36. Changes to Committee Membership

New County Councillor membership for the Committee, which had been approved at Full Council on 10 May 2011, was **noted**. Councillors Margaret Fisher and Linda Mead were welcomed to the Committee. The Chairman advised that, due to becoming an Executive Member at Rochford District Council, District Councillor Malcolm Maddocks would be unable to continue as a member of the Essex HOSC. The Brentwood District Council area remained unrepresented on the HOSC. It was **agreed** that the Governance Officer should invite both Brentwood and Rochford District Councils to nominate a representative to serve on the Committee. It was also **agreed** that Councillor Offen should continue to serve as a District Councillor member.

37. 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

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

38. Minutes

The minutes of the meeting of the Health Overview and Scrutiny Committee held on 21 April 2011 were approved as a correct record and signed by the Chairman.

39. Questions from the Public

There were no questions from the public on this occasion.

40. Turnaround Plan for NHS South West Essex

The Committee received an update (HOSC/18/11) from Andrew Pike, Chief Executive of NHS South West Essex (SWE) on its financial turnaround plan, which was supplemented orally at the meeting.

(a) Background

The Committee had previously received a report on SWE's turnaround plan on 3 November 2010. This had showed that SWE's financial performance had significantly deteriorated over the previous two years with a breakeven position for 2010/11 reliant on full implementation of a £47 million cost reduction programme. The turnaround proposals had sought to return SWE service provision broadly back to the levels provided prior to the rapid expansion.

(b) Financial update

The report submitted to the meeting provided an update on the latest financial data for the end of the 2010/11 financial year, and outlined continuing programmes and performance updates (and forecasts) for the year ahead. In July 2010 the SWE Board had identified a turnaround savings plan target of £51million and SWE had saved approximately £41 million in the eight months since then. Consequently unaudited accounts for the 2010/11 financial year showed that SWE had reached financial break even, with a small surplus of £48k. SWE had also made a strategic decision to draw down its remaining deposit held with the Strategic Health Authority as the financial effect of other planned savings actions could take up to eighteen months to be seen. The total value of savings identified for 2011/12 was £45 million. SWE also had to make further savings to meet Ggovernment spending targets as well as the

need to generate a reserve. It was currently on target to meet all these objectives.

SWE was on course to achieve break-even on a monthly basis by August or September 2011.

(c) Waiting lists

SWE's turnaround plan in July 2010 had included an elective slowdown whereby waiting times were extended for routine cases for both inpatients and outpatients. Investment in these referral areas had previously seen unsustainable growth. It was acknowledged that, in order to achieve this elective slowdown, the issue of notifications of appointment dates to patients had been delayed. The elective slowdown had not achieved all the savings that had been targeted but had saved approximately £2 million and the elective slowdown was now being removed. As at the end of May 2011, the current waiting time for routine appointments was 13/14 weeks although this was now reducing quickly. However, it was acknowledged that up to a thousand patients waiting for appointments were now close to the eighteen week national guideline threshold. With immediate effect, upon referral from a GP, patients now would be given the first available appointment dates for inpatient or outpatient services.

There had been an increase in the numbers of complaints received as a result of the increased waiting times. Mr Pike acknowledged that some people had received a deteriorating service in the last four months of the year and offered a public apology and stressed that all patients should now be receiving an equitable service. It was anticipated that the level of complaints now would start to fall. However, it was acknowledged that waiting list management was dynamic and often did not reveal the whole picture as the data could exclude repeat visits for example.

(d) Referral gateway and Service Restriction Policy

Significant progress had been made in agreeing strict guidelines and criteria for referrals with GPs. It was hoped that this could lead to up to a ten per cent reduction in referral cases in the system and release funds for use elsewhere. A review of SWEs Service Restriction Policy had been delayed due to concerns raised by clinicians in Pain Management, Spinal and Orthopaedic departments although agreement had now been reached with them and the policy updated accordingly. There would be an ongoing review of the muscoskeletal service. It was now a contractual requirement for all SWE providers and associate providers to follow all evidence based best practice to avoid too early referrals, particularly for surgery, so as to alleviate pressure points. This could mean redirection to an alternative treatment rather than referral straight to surgery. It was stressed that there should be no noticeable inconvenience for patients.

Recently agreed updated hospital contracts also now stipulated an effective cap for the number of follow-up appointments based on an average indicator

and upon which the levy paid to the hospital would be based. This had brought an element of self restraint to the process which should provide future cost savings.

(e) Community services

SWE's original turnaround plan in July 2010 had included proposals to review significant elements of the community services provision. A £8 million efficiency saving on a £70 million operating cost base had been identified. Certain examples were given of community services that were provided in unsustainable delivery models and that efforts were being made to take out duplication and waste and encourage alternative provision in the community. Community dental services were given as an example of a service with low usage rates and, by remodelling the delivery model, the same number of patients could be seen in a more cost effective manner whilst also, at the same time, tightening up the qualifiying criteria.

The initial response from GPs in the SWE administrative area suggested that they did not wish to participate in the scheme to provide prostate cancer follow ups in the community. Members were concerned as it was felt that it could be a relatively straightforward care pathway, often just involving a blood test. Mr Pike agreed to follow-up on this and to write to the HOSC Chairman with further information and update.

Overall spending on childrens safeguarding had increased despite the decommissioning of specific SWE services as there had been a pooling of resources to obtain economies of scale across the five PCTs in Essex.

Access to Fertility treatment had been restored. The temporary unavailability of the service had been controversial and the families affected had been consulted during the period.

(f) Dementia care

A team of dementia care workers were based in Accident and Emergency at Basildon University Hospital Foundation Trust (BUFT) to identify and support suitable arrivals and co-ordinate a community care package for them to avoid hospital admission. The team would now work more closely with nursing homes, introducing regular medication reviews and better specialist support, again to avoid unnecessary admissions to acute hospitals. In addition, there were potential savings in respect of reducing the length of stay in acute beds for dementia patients. SWE paid a set tariff to BUFT for each patient occupying an acute bed despite often there being no active medical care need other than treating the onset of dementia which could be treated more effectively elsewhere.

(g) London based services, procurement and property

SWE wanted to further rationalise GP referrals, by encouraging less referrals to London based services and, for example, increase the use of the Essex

Cardiac Centre at Basildon Hospital instead. It was acknowledged that managing tertiary referrals was complex. There were also some complex contracting processes currently used to reconcile data from invoices and contracts for London based tertiary services and these were being reviewed. On average, London based services could cost 20% more than local services.

There had also been a tightening up of all general contracting and procurement processes and systems which had provided financial cost savings.

A review of the property portfolio of SWE and NHS South East Essex (SEE) was also underway to identify those buildings that were superfluous and/or underused as a result of the new PCT cluster arrangements. Further efficiencies had also been agreed with SEPT.

(h) Staffing

Mr Pike considered that SWE had been relatively overstaffed compared to SEE. A two hundred person staff reduction at SWE had been largely achieved through voluntary redundancy and staff turnover. Further staff reduction savings were planned so that, including the earlier staff reduction, there would be an overall 50% reduction from 2009 staffing levels. Approximately half the overall job losses would be in administration and management across both the commissioning function and the community provider arm, although the numbers did include a small number of health care workers (not professionally qualified).

(i) Conclusion

It was confirmed that, as part of any reconfiguration and relocation of services, discussions would be held with public transport providers to ensure that there were suitable public transport links to any new service locations.

Members questioned whether the reorganization had been driven solely by the required financial savings and/or a desire to operate a more streamlined organisation. Mr Pike confirmed that he was sure of the steps taken to address the financial challenges but that it also reflected a need for a cultural change in SWE to eliminate waste and inefficient service delivery. However, vigilance was needed to ensure there remained sufficient staff resource to address the significant remaining challenges.

Members acknowledged the difficulties involved in achieving a challenging financial turnaround and congratulated Mr Pike on the progress made to date. The Chairman thanked Mr Pike for his frankness during the discussion. Thereafter Mr Pike left the meeting.

41. Dementia Task and Finish Group: final report

The Committee received a report (HOSC/19/11) comprising the final scrutiny report and conclusions of the Dementia Task and Finish Group (the Group).

The scrutiny had been established to discuss issues around dementia in Essex, look at examples of good practice and discuss options for the way forward.

(a) Overview

Councillor John Baugh, Chairman of the Group, introduced the report referring to the setting up of the Group and its remit. Evidence from the Royal College of Psychiatrists had shown that long term hospitalisation and nursing/residential care comprised over two thirds of the total cost of dementia care despite the fact that the condition was usually concentrated in a comparatively short period of time at the end of the care pathway. The Group had looked at the current level of carer support including access to information, the role of GPs and their future role, and highlighted two local projects being piloted which could prolong active life and delay the onset of dementia for those who currently had mild cognitive impairment. It was highlighted that it was estimated that 95% of patients suffering from mild cognitive impairment would develop dementia within five years. Both the local projects highlighted potentially could maximise the time a patient was able to remain out of formal residential care thereby minimising the period of time spent in, and the overall cost of, formal care for people with dementia.

The findings and conclusions of the report had already been relayed to ECCs dementia strategy team.

Members commended the report. During subsequent discussion the following issues were highlighted and/or discussed:

(i) It was suggested that trauma sometimes could start a medical condition and that this might be another opportunity to emphasise to GPs the importance of falls prevention programmes for elderly people;

(ii) Through feedback from dementia carers it seemed that there was less use of personalised budgets than for other areas of social care.

(iii) Studies had revealed that between 40-60% of carers could suffer from depression compared to one in four of the population as a whole suffering some form of mental health illness sometime in life. The report had stressed the importance of respite care for carers. The Essex and Southend LINk representative at the meeting confirmed that a LINk project would be looking further at this;

(iv) Members noted that much of the evidence was anecdotal and that a ‘living bereavement’ was a haunting but truthful description of the effect of dementia;

(v) Members acknowledged the need to minimise the use of anti-psychotic drugs in treating dementia;

(vi) Members suggested that a register of people with dementia could be beneficial to identify and plan for future local care needs. At the moment there did not seem to be one common diagnostic point or a template of risk factors to provide a simple diagnostic tool;

(vii) Members of the Group had been disappointed by an apparent lack of engagement by GPs despite the Group inviting contributions from them;

(viii) Dementia was not exclusive to the elderly and could occur at younger ages;

(iv) Innovative research work was being undertaken although it was too early to draw conclusions or ascertain value for money. As a fundamental principle the Group had recommended that all projects being trialed should run their course, and then be fully evaluated and the outcomes audited and monitored by an appropriate body. It was acknowledged that, in view of the various projects underway, this would be undertaken by a number of different bodies.

The Cabinet Member welcomed and commended the report and highlighted the importance of further integrating support structures in the community and particularly highlighted increasing the prominence of Telecare with St John Ambulance.

The report would also be considered by the Community and Older People Policy and Scrutiny Committee the following week. Subject to this further review, Members **agreed** (i) that an ECC press release on the publication of the report should be issued highlighting the report and recommendations and the concern over GP engagement; and (ii) that a copy of the report should be sent to the Local Medical Committee asking them for their views and recommended actions. An appropriate Review Date to revisit the recommendations would be determined.

42. Mid Essex Forum Task and Finish Group: Health inequalities

The Committee received a report (HOSC/20/11) comprising the final scrutiny report and conclusions of the Mid Essex Area Forum Task and Finish Group looking at health inequalities and provision of services in Mid Essex with particular reference to access to services (the Group). Councillor Bob Boyce, who chaired the Group, introduced the report referring to the setting up of the Group and its remit. Some conclusions from the scrutiny applied across the whole mid Essex area (such as improved and consistent provision of phlebotomy and audiology services) and were not solely localised findings. It had been agreed at the Mid Area Forum in March 2011 that, in view of additional comments made at the meeting during the review of the Group's report, the minutes on the discussion should also be forwarded with the report to highlight the further issues raised. In particular, representations had been received by Witham Town Council on issues applicable to their area. In recognition of that it was **Agreed** that NHS Mid Essex be asked to provide an

update on health services in Witham and to comment on the issues raised by Witham Town Council. It was noted that Priti Patel, MP for Witham, had raised similar issues in the House of Commons earlier in the year.

Members also discussed and suggested that all GP practices should be encouraged to provide a phlebotomy service, although it was acknowledged that the main problem would be the associated logistical challenge to provide a
co-ordinated collection service of the samples from the various practices for analysis.

The Chairman thanked Councillor Boyce for the work and recommendations from the Group and, subject to the response received from NHS Mid Essex on issues in Witham (see above), the report was **Noted** and recommendations directed appropriately for comment and review. An appropriate Review Date to revisit the recommendations would be determined.

43. Care Quality Commission Review of Stroke Services 2011

A report (HOSC/21/11) from Graham Redgwell, Governance Officer, on the Care Quality Commission review of stroke services, published in January 2011, and their ratings on the five Essex Primary Care Trusts (PCTs), had been circulated. Additional information which had been received the previous day from the North Cluster of PCTs in Essex had been circulated. However, it was **Agreed** that consideration of the item be deferred, and the five Essex PCTs be invited to attend the next HOSC meeting to further comment on, and detail actions planned, in response to the CQC ratings.

44. General update

The Committee received a report (HOSC/22/11) from Graham Redgwell, Governance Officer, advising on various other local health issues arising since the last meeting and these were **Noted**.

In particular, Quality Accounts had been received for comment from a variety of Health Trusts. Draft responses prepared by the Governance Officer on behalf of the Essex HOSC were circulated to give Members a brief opportunity to comment before the final responses were sent. Members expressed concern at some issues raised in the Quality Accounts for Basildon and Thurrock Hospital Foundation Trust.

45. Date and Time of Next Meeting

It was confirmed that the next scheduled meeting of the Committee would be held on Wednesday 6 July 2011, at 10.00 am in Committee Room 1.

Meeting closed at 12.03 p.m.

Chairman
6 July 2011