MINUTES OF A MEETING OF THE HEALTH INEQUALITIES TASK AND FINISH GROUP HELD AT COUNTY HALL, CHELMSFORD ON 14 JULY 2010 AT 10AM

Membership

*	County Councillor Joe Pike (Chairman)		Maldon District Councillor Alison Warr
*	County Councillor Bob Boyce		Heybridge Parish Councillor L Schnurr (representing Mid Essex Parish Councils)
	County Councillor Mrs Sandra Hillier		Judy Cuddeford (Braintree District Voluntary Support Agency)
*	County Councillor Mrs Maureen Miller		Lorraine Jarvis (Chelmsford Council for Voluntary Services)
*	Braintree District Councillor Tony Shelton	*	Paul Murphy (Maldon Council for Voluntary Services)
	Chelmsford Borough Councillor Jean Murray	*	Michael Blackwell (Mid Essex LINk)

* Present

Officers in attendance were:

Graham Hughes	-	Committee Officer
Graham Redgwell	-	Governance Officer
John Zammit	-	Area Co-ordinator, Mid Essex

Also in attendance:

Carol Winser	-	Interim Commercial Director
Jane Richards		Assistant Director of Public Health

1. Apologies and Substitution Notices

The Health Overview and Scrutiny Committee (HOSC) had delegated authority to the Mid Area Forum to establish a Task and Finish Group to look at health inequalities across Mid Essex. Membership comprised three County Council members of the Mid Area Forum, a County Councillor from HOSC representing a constituency outside of Mid Essex and providing a HOSC overview function, and representatives from the District and Borough Councils and voluntary organisations in the area as listed above.

The Committee Officer reported apologies from County Councillor Sandra Hillier and Heybridge District Councillor Lew Schnurr who had provided the Group with some comments on issues in the Maldon and Heybridge area (these were tabled at the meeting).

2. Declarations of Interest

There were no declarations of interest declared.

3. Focus of scrutiny

Members discussed the clarity of the proposed scrutiny project and noted that the Mid Area Forum scrutiny had directed that it should be focussed on equality of access to services and transport issues rather than equality of services being provided (commonly known as services by 'post code' lottery).

4. NHS Mid Essex

The Committee received a report comprising statistical data (MAFHI/01/10) from Carol Winser, Interim Commercial Director and Jane Richards, Assistant Director of Public Health, NHS Mid Essex who were both in attendance at the meeting.

Questions had been submitted to the PCT on behalf of Members and the PCT had provided statistical information on GP and other referrals for the Mid Essex PCT for 2010 by provider, on Mid-Essex Residents with a GP outside of the area and on Inpatient spells by provider for 2009/10. Each of the questions was addressed in turn as recorded below.

(i) What hospital provision do residents who live in mid Essex (Braintree, Chelmsford, Maldon) use?

Statistical information on GP and other referrals for the Mid Essex PCT for 2010 by provider had been supplied by NHS Mid Essex. Total referrals for 2009/10 were 70,660. Clearly the majority of Mid Essex PCT referrals to secondary care providers were to the Mid Essex Hospital NHS Trust (Broomfield Hospital) comprising 86% of total GP referrals. Referrals to Essex Rivers Healthcare Trust (Colchester Hospital) comprised 8.1%. Members discussed the initial choice of referrals given by GPs to patients and the guidance given by GPs on the suitability of options. It was **Agreed** that the Mid Essex PCT provide further information on choice of referrals including referral to private specialists.

Other referrals listed totalled 64,101. Other referrals comprised referrals for eye conditions to ophthalmic opticians etc, referrals to dentists, referrals made within hospitals after being admitted for another reason (i.e. A&E). It was confirmed that as a result of the last category there would be some element of double counting.

A number of constituents in the Braintree area were served by GPs in Suffolk and this was reflected in the list.

Mid Essex PCT had the highest number of hospital admissions to A&E. It was **Agreed** that NHS Mid Essex would provide further data on A&E admissions including ambulance admissions and non GP referrals.

It was suggested that the disproportionately higher incidence of hospital admissions in Mid Essex could correlate with health inequalities if there was any evidence to support that patients were waiting longer until their condition warranted hospital treatment rather than seeking earlier preventative treatment. Members also discussed whether patients who lived closest to hospital and other facilities would use them disproportionately more due to their convenience. Members agreed that it was important to distinguish between inequality and inequity of access. It was **Agreed** that: (a) further data analysis by post code be undertaken to look at geographic spread and ascertain if referrals came disproportionately from deprived areas; and (b) that Mid Essex NHS extract re-admissions from the data.

(ii) What provision is there for patients with transport problems i.e. some older people, those who are disabled, socially disadvantaged etc?

Patients on benefits are entitled to claim back travel costs. A range of transport options are available for patients unable to use public transport or without their own transport through East of England Ambulance Service. Although not a primary role for the PCT it would try to recognise transport issues and availability when it was planning health services. For example additional dental services had been located in Maldon as it had easier transport links for people travelling in from outside Maldon. However, it was recognised that sometimes it was difficult to configure services and appointment times with transport links.

Members discussed the area north of Braintree bordering Suffolk and suggested that access to dentists was poor in that area and that people often would travel to Halstead or Suffolk for treatment rather than coming down to the Braintree area. Members mentioned the possibility of greater provision of periodic (part-time surgeries) in rural areas and local outpatient facilities. In the end it came down to patient choice and GP advice. The PCT strategic plan was looking to move as many services as possible to community clinics, homes and hospitals so as to be nearer to people’s homes.

Members discussed transportation links and services in other isolated areas with particular reference to the use of Community or Neighbourhood

Transport Schemes supplementing bus services that were not particularly suitable for appointments. Members questioned how such schemes could be supported and how they could link in with the locations of GP practices for example. However, there had also been feedback that some people had felt that getting to appointments was not necessarily a problem particularly with the extension of GP opening hours.

(iii) How many Essex patients are registered with GP practices located in Mid Essex?

As at 1 April 2010 the number of patients registered with Mid Essex practices was 377,969 broken down as follows:

Chelmsford 166,646
Braintree (NHS Mid Essex Boundary) 142,084
Maldon 62,619
Colchester 4,788
Uttlesford 1,031
Epping Forest 89
Basildon 561
Braintree (NHS West Essex Boundary) 35
Rochford 32
Brentwood 27
Other Essex LAs 14

(iv) How many Essex patients who live in Mid Essex are registered with GP practices located outside Mid Essex?

15,758 residents in Mid Essex were registered with a GP outside of the area and the data provided by the PCT had broken this down by PCT area with the largest numbers registering in neighbouring West Essex PCT, North East Essex PCT and South West Essex PCT with significant registrations also in the Suffolk PCT area. Registrations in South East Essex PCT area were considerably lower and there were negligible registrations in the Hertfordshire, Havering, Barking and Dagenham, and Redbridge PCT areas. As the analysis indicated concentration of large numbers with certain GP practices it was requested and **Agreed** that further information be provided mapping the locations of the GP practices listed.

(v) How many GP practices located in Mid Essex are single handed?

14 practices had only one or one WTE GP Principal but seven of these employed salaried doctors or regular locums to provide some sessions.

(vi) What provision/contingency plans are in place if the above should have an issue/fail e.g. GP is long term sick, GP retires and unable to find a replacement?

There was a duty on a GP practice to try and provide continuity of care. The PCT had a sickness and maternity leave policy that enabled qualifying practices to apply for financial assistance with locum costs. Replacement of a retired doctor in a group practice was the responsibility of that practice: retirement of a single-handed GP would require intervention by the PCT as the contract would lapse with the option, after appropriate patient consultation, to merge a practice with another, formal tender process for the practice or disperse the patient list to other nearby GP practices.

(vii) Is the PCT planning for bigger more centralised GP practices and what impact will this have on patients i.e. harder access, transport issues etc?

The PCT were not planning centralised GP practices. There was a good variety of size of GP practices in the Mid area with many single handed GPs in rural areas co-operating with other nearby GPs to provide cover for each other. The PCT gave the Maylandsea area as an example of this co-operation.

(viii) What plans do the PCT have to make hospital care more localised – some areas have turned general hospitals into A&E only and made provision locally for patients needing hospital care?

The PCT were providing more district nurses and community based services. However, as medicine became more specialist it led to two divergent trends; the increased desire and capability to maintain and monitor people at home with the increasing availability of, and need to use, specialist equipment and expertise based in hospitals.

(ix) What pinch points does Mid Essex PCT have and what plans has it got for dealing with these?

The PCT advised that they were operating in a tough and challenging financial environment. To counter these pressures they were looking to further improve their own service quality, innovation and productivity.

The Coalition Government White Paper to increase local health services, if implemented, would dramatically change the landscape and involve the PCT increasingly working with GPs during a demanding transitional period. Members questioned whether the PCT thought the proposed

reconfiguration of services would be detrimental to rural areas and could compound inequalities of access. The PCT advised that it could be dependent on how many GPs formed further practice group clusters. The presence of GP practice group clusters could be beneficial in leading to increased focus on local services and community hospitals. Alternatively, if the clusters of GP practices became too big they could become more remote to patients and have the opposite effect for patients trying to connect with local services. It was expected the bigger clusters would be nearer Chelmsford. It was possible that some rural GPs might feel that they worked better with other rural GP practices and not urban GPs.

(x) Are there big/varying gaps in waiting times for hospital admissions and appointments to see a GP?

The PCT had met national targets for treatment waiting times except for a small number of very specific specialist treatments. The PCT still sought to meet contractual standards despite many of the central targets having been lifted recently by the Coalition Government. Patient surveys generally gave positive feedback on hospital admissions and waiting times and review meetings were held with GP practices where feedback had not been good.

5. **Scoping Document**

The Committee received the draft scoping document (AFM/SCR/1). Members suggested it would be unfair to restrict the scrutiny to problems faced by only one area. Members discussed and acknowledged that representations made to the Group may be more appropriate as a witness rather than as a member of the Group.

6. **Proposed further witnesses**

The data provided by Mid Essex PCT had provided a good general overview of health issues in the Mid Essex PCT area. It was recognised that the local issues affecting Maldon had been raised a number of times during the meeting and that the Committee should consider receiving an overview of health issues in the Chelmsford and Braintree areas as part of the initial evidence to be gathered before determining the focus of the scrutiny. It was **Agreed** that John Zammit would meet with each of County Councillor Miller (for Chelmsford) and District Councillor Tony Shelton (for Braintree) to determine suitable witnesses for the next meeting.

7. **Date of next meeting**.

It was Agreed that the Committee Officer should arrange a schedule of future meetings. Next meeting to be in September.

[Committee Officer note: meetings dates were subsequently set for 8 September, 20 October and 23 November – all starting at 10am]

There being no further business the Chairman closed the meeting at 11.24