MINUTES OF A MEETING OF THE HEALTH/NHS OVERVIEW AND SCRUTINY COMMITTEE HELD ON 1 SEPTEMBER 2010 AT 10AM AT COUNTY HALL, CHELMSFORD

Membership

County Councillors:

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

District Councillors:

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

(* present)

The following officers were present in support throughout the meeting:

Graham Hughes	-	Committee Officer
Graham Redgwell	-	Governance Officer

County Councillors W Dick and A Naylor also were in attendance and contributed to the discussion at the invite of the Chairman.

64. Apologies and Substitution Notices

The Committee Officer reported apologies from County Councillors R Gooding and M Hutchon and Tendring District Councillor Steven Henderson.

65. Declarations of Interest

The following standing declarations of interest were recorded:

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 Nigel Offen	Personal interest due to being in receipt of an NHS Pension.
Councillor John Baugh	Director Friends of Community Hospital Trust Spouse employed in NHS at Broomfield Hospital

66. Minutes

The minutes of the meeting of the Health Overview and Scrutiny Committee held on 7 July 2010 were approved as a correct record and signed by the Chairman.

67. Questions from the Public

The Chairman invited questions from the Public on any matters falling within the remit of the Committee. Mr Peter Mitchell, British Medical Association, asked whether the PCT provider/purchaser split represented a substantial variation which required a formal 12 week consultation with interested parties and the HOSC. It was confirmed that the Committee would not consider the principles of the provider/purchaser split but could scrutinize the options for implementation being considered by each PCT. The consultation process for each PCT had been assumed to have started from the date when their respective Boards had first considered reconfiguration options and was to be treated as a substantial variation. As a result it was suggested that there had been ample time for consultation and comment by stakeholders.

68. Primary Care Trusts – Purchaser/provider split

Department of Health guidance issued in October 2008 had required all PCTs nationally to pursue divestment of their community provider function. This had been reconfirmed in the recent Operating Framework refresh (published by the new Coalition Government in June 2010) and was to be delivered by April 2011. Representatives from four Essex Primary Care Trusts were present at the meeting to outline their respective plans to implement a purchaser/provider split and had provided reports to members in advance of the meeting. Within the reports and during the subsequent presentations and discussions arising it was acknowledged that each PCT area had different population and cultural needs and different approaches to addressing them. The proposals submitted by each of the PCTs were at various different stages in the implementation process. Each PCT was trying to find the best solution for its own local community and, whilst emphasizing local commissioning and local decision-making, was likely to conclude different solutions.

It was noted that Mid Essex NHS currently was finalizing its proposals and would attend the HOSC in November to present these.

(i) <u>NHS North East Essex (NEE)</u>

Julie Young, Assistant Director of Transformation and Kerry Franklin, Acting Director of Corporate Development and Governance were in attendance to present a review and proposals for North East Essex PCT (NEE).

NEE planned to separate community health services in north east Essex into a separate community interest company. It was expected that this development would not lead to any substantial changes to service delivery. However, whilst NEE wanted to emphasise that there would be no change to service and to show a ‘seemless change’, Members stressed that the rationale for change should be to improve service delivery rather than to leave it unchanged.

Working with the East of England Strategic Health Authority, neighbouring provider arms, the Local Authority and neighbouring NHS trusts a number of options had been considered by NEE with structured input from Heads of Service followed by an appraisal led by an independent consultancy company to test the process was robust.

Although no formal public consultation had been undertaken, NEE had been working with staff and service users to design an effective new model to bring added value to the health and well-being of the communities it served. A stakeholder engagement plan currently underway was to run through to the end of November. NEE wanted to encourage more staff input into decision-making so that it could become a slimmer and more responsive organization. It was anticipated that there would be a more streamlined governance structure with further empowerment to service heads whilst acknowledging that robust governance arrangements would need to be maintained.

Members were impressed with the level of stakeholder consultation but voiced concern that no detailed analysis of the financial impact of the proposed changes was available. It was confirmed that an integrated business plan had been approved by the NEE Board but was commercially sensitive. However, in due course, a summary financial document could be made available to Members along with the assurance testing and due diligence undertaken as part of the review process. It was confirmed that the financial models used had included both best and worst case scenarios.

NEE agreed to revisit the content of the literature provided to HOSC so as to include more explicit reference to financial and cost analysis having taken place. Also, it was felt that the public leaflet needed to be further reviewed for clarity.

There had been discussions with other PCTs to look at opportunities for joint working and minimize management costs and maximize front-line services. As part of the assurance process NEE were looking at joint procurement arrangements.

In their paper NEE suggested that when evaluating an option to integrate with an acute foundation trust they had concluded that maintaining a community and health improvement focus could be problematic, particularly in times of financial stress and that these services were unlikely to be viewed as a high priority when set against acute care. On the evidence available, Members felt that this assertion was unproven.

(ii) NHS West Essex

Clare Steward, Associate Director Strategy and Transition and Toni Coles - Director of Primary Care and Localities from NHS West Essex joined the meeting to present a review and proposals for West Essex PCT (West Essex). West Essex had developed and implemented detailed engagement and consultation plans since first looking with their staff at potential organizational models for community health services nearly two years ago. Some suggested assurance tests had been cascaded from the Department of Health and staff and other stakeholders had been engaged on whether these were the most appropriate tests. West Essex also had looked at opportunities offered by other Trusts in the area, particularly those with excellent CQC ratings. Due to the timelines indicated in the national guidelines issued for the reconfiguration, West Essex had concluded that there was insufficient time to implement an integration with another community based provider which had originally been in the list of options for consideration and that this would have meant staff moving organizations twice.

Consequently West Essex had decided upon an acquisition model for its community provider function and two specific proposals for the acquisition of these services were currently being evaluated. It was confirmed that there had been full evaluation undertaken for all the models initially considered. West Essex had not estimated management costs and savings for the preferred option but acknowledged that the new model would have to work in an environment of tight cost control and it anticipated opportunities for cost efficiencies.

A Member advised of a petition being raised in the Loughton area complaining that community services had changed too quickly. West Essex contended that there had been significant consultation and engagement with stakeholders and that the process pathway had been staff led as they had originally been looking at a staff led social enterprise. Members felt that the West Essex options had not been easy to understand and questioned whether attendees at consultation exercises had understood the models. Department of Health guidance had changed during the process which had complicated the task to maintain staff 'hearts and minds' throughout. It was confirmed that hospital trusts were included in the consultation process as they would need to integrate into the new set-up.

West Essex confirmed that it was obligated to transfer staff under TUPE regulations. Indeed, the social enterprise model had not been further pursued as an option due to staff raising concerns on the value of transferred staff pension and service rights.

The Strategic Health Authority had asked that West Essex arrive at a preferred provider and reserve by the end of October. Accordingly a final recommendation would be made by the Evaluation Panel by the end of September with recommendations made to the Transition Board (7 October) and the PCT Board (21 October).

(iii) South West Essex

Barbara Stuttle, Deputy Chief Executive and Chief Nurse for NHS South West Essex (SWE) joined the meeting. SWE had undertaken joint work with NHS South East Essex to look at commissioning capability, service line analysis and reporting and service specifications and care pathways. However, after a subsequent internal options appraisal exercise, it had been recommended to, and agreed by, the PCT Board that a foundation trust would be sought to manage the PCTs Community Services for a fixed two year period prior to market testing of all services. Ms Stuttle confirmed that SWE had concluded that a foundation trust offered the best solution in protecting front line services to patients and staff terms and conditions.

On 16 June 2010 the PCT Board had agreed to announce North East London Foundation Trust as the preferred bidder and work was now underway with the new partner foundation trust (subject to contract) to deliver the transfer within the Government's timeframe of March 2011.

Members felt that the SWE paper presented to the Committee had been the most clear and easiest to digest and understand. However, they suggested that there was much in common across south Essex (from east to west) and were

disappointed that a joint approach with NHS South East Essex had not been possible and that differentiating local factors clearly had had a significant effect on the preferred options being pursued across the four PCT areas.

(iv) South East Essex

Ian Stidson, Interim Director of Primary and Community Care, and Jo Apicella, Assistant Director of Communications, both NHS South East Essex (SEE), joined the meeting. SEE had undertaken an engagement and discussion programme between December 2009 and March 2010. Two options had been presented to the SEE Board in March 2010 (a) a merger with Mid Essex and South East Essex provider arms to form a social enterprise; (b) integration with an existing NHS or social care organisation through managed dispersal. However support for the social enterprise model was not forthcoming from patients, staff and local partner organisations and the PCT Board decided to pursue integrating with an existing NHS or social care organization through managed dispersal. Since the Board meeting it had been concluded that social care organizations would be unable to fulfil the requirements of the process within the set timescales, and following liaison with those partners, the selection criteria was limited to existing NHS organizations within a 50 mile radius of south east Essex. There were four short listed applications from potential providers with a prospectus to be sent to them by the end of the week with subsequent evaluation and interviews. The PCT was planning to have a preferred provider identified by the end of October 2010 with services transferred to a new provider by 1 April 2011.

Mr Stidson confirmed that there had been rigorous SEE Board debate on the options available with different views expressed, particularly around pursuing a social enterprise model.

SEE and NHS South West now shared a Chief Executive. Where opportunities arose in future there would be closer working together in South Essex as well as other Essex PCTs. Mr Stidson stressed the importance of increased dialogue between PCTs on working closer together.

Members questioned whether there were potential costs savings under SEEs proposed model for dispersal and integration with an existing NHS or social care organization. Financial evaluation of the model had been undertaken but was commercially sensitive at this time but would be shared with HOSC members at an appropriate time.

SEE confirmed that the PCT had sought to engage all practice based commissioning (PBC) groups in the process. Engagement was variable across PBC groups.

Conclusion

Whichever models were implemented by the PCTs they would still be subject to regulatory monitoring. Any flexibility to change a structure would need to be outside the contractual commitments for delivery of the services. Members raised the issue of monitoring and scrutinizing contracts and whether complaints about health and social care provision would need to be put to the commissioner or provider of services in future.

There had been earlier criticism of the regional Strategic Health Authority wanting to complete the purchaser/provider split quicker in the region than elsewhere in the country and members questioned whether PCTs had had enough time for proper evaluation of the options available. The PCTs all had learnt to meet the challenges and adjust their resources to deliver on the required timelines and each had solutions that they believed to be deliverable.

The Chairman thanked the representatives from the four PCTs for attending. Personally he was disappointed that solutions had been sought within existing administrative boundaries and questioned whether sufficient time really had been given to PCTs to fully explore all possible options for reconfiguring their services. He recognized that the PCTs genuinely had the interest of patients at heart whilst wanting to provide good quality services in a cost effective and efficient manner. The Chairman specifically confirmed that the HOSC wanted a joint response from the Essex based PCTs on the overall cost of the reconfiguration and cost benefits arising and a re-assurance that the quality of service would not diminish nor extra administrative costs be created. In addition, the Chairman invited a combined speculative future response from the PCTs on the potential decrease in total PCT management costs in Essex had there been a smaller number of PCTs in Essex.

The PCT representatives left the meeting at this point.

69. Coalition Government White Paper: Equity and Excellence – Liberating the NHS

Members received and noted a report (HOSC/39/10) from Graham Redgwell on the proposals for changes to health provision put forward by the Government. In particular, Members considered the proposals set out in the paper 'Local democratic legitimacy in Health' and the likely implications for the future role and work of the Committee.

The White Paper proposed stronger institutional arrangements, within local authorities, led by elected members, to support partnership working across health and social care, and public health. Whilst NHS commissioners and local authorities could devise their own voluntary local overview arrangements the Government preferred the establishment of a statutory role, within each upper tier local authority, to support joint working on health and wellbeing. Members discussed the proposal for these Health and Wellbeing Boards and were concerned about the potential size of the Board, its specific functions and that the scrutiny function should not be absorbed into it. Members supported the continued clear legal separation of executive and scrutiny functions as it was felt that it would be entirely inappropriate for a committee to end up scrutinising its own decisions. It was **Agreed** that these views form the Committee's formal response to the consultation and that Mr Redgwell respond accordingly for and on behalf of the Committee. It was noted that the Community Wellbeing and Older Persons Policy and Scrutiny Committee would also be considering the White Paper proposals particularly as it impacted on social care and their comments would be incorporated with other feedback from Essex County Council service areas by the Cabinet Member for Adults Social Care before making a further formal response back to the consultation.

70. Dementia Task and Finish Group

Councillor Baugh updated the Committee on the activities of the Task and Finish Group established to consider dementia care in Essex.

71. Regional Health Chairs Forum

Members received and noted a report (HOSC40/10) from Graham Redgwell, on issues discussed at the most recent Regional Health Chairs Forum (held on 16 July 2010). Essex had been the host authority for some time and the Leader of the Council was keen for it to continue to play that role, subject to the agreement of the other HOSCs in the region.

72. Essex Transition Project: progress report

Members received and noted a report (HOSC/41/10) from Graham Redgwell on recent senior appointments within the Transition Team and which also contained a copy of national guidance note published by the Chief Executive of the NHS in England. At present it looked likely that no formal merges of PCTs would be taking place although there would be joint management structures put in place.

73. Non substantive service variations

Members received and noted a report (HOSC/42/10) from Graham Redgwell, outlining five non substantive service variations.

74. Forward Look

Members received a report (HOSC/43/10) from Graham Redgwell, setting out a proposed forward plan for the Committee for the November, December and January 2011 meetings. This was **Agreed** subject to the addition of the NHS Mid Essex purchaser/provider split presentation for the November meeting. It was noted that all the PCTs, rather than just NHS South West, would be invited to attend and present on the Pharmacy Needs Assessment at the November meeting.

75. Date of Next Meeting

The next meeting of the Committee was confirmed for Wednesday 3 November 2010.

76. Urgent business:

(i) Health for North East London

Health for North East London was holding a series of engagement events in September for local authority councillors and senior officers, clinicians, GPs, patients and the public to help develop proposals for change. It was **Agreed** that Councillor Knapman should attend three particular events for and on behalf of the HOSC: Stakeholder Discussion Event (1), Travel Advisory Group and the Stakeholder Discussion Event (2) and that these be classed as an approved duty.

(ii) Public Question - CAHMS

At the request of a member of the public it was **Agreed** that the paper on CAHMS, which had been withdrawn from the agenda, would include details on thes funding allocation, when presented to the HOSC in future (currently scheduled for the November meeting).

There being no further urgent business, the meeting closed at 11.55 am.

Chairman
3 November 2010