East of England Joint Health Overview & Scrutiny Committee

Minutes of the meeting of the East of England Joint Health Overview & Scrutiny Committee held on 7 July 2008 at the Headquarters of the East of England Strategic Health Authority, Fulbourn Cambridge.

Present: Councillors, Stephen Male (Bedfordshire CC) Chairman, Ann Naylor (Essex CC), Alan Crystall (Southend BC), Janice Eells (Norfolk CC), Nick Hollinghurst (Hertfordshire CC – representing the East of England Assembly), Bernard Lloyd (Hertfordshire CC), Brian Rush (Peterborough Borough Council).

Also Present: – Fiona Abbott (Southend BC), Jane Belman (Cambridgeshire CC), Bert Siong (Luton Borough Council), Natalie Rotherham (Hertfordshire CC), Katherine Tollett-Cooper (East of England Regional Assembly), Simon Wood, Paul Toner, Martin Creswell and Ed Garratt, (East of England Strategic Health Authority) Dr. Gillian Oaker (Chairman of the Mental Health Panel) together with Ms Tanya and Mrs Christine Harrison members of the public and representing ME patients.

1. Apologies: Councillor Lister Wilson (Cambridgeshire CC), Councillor Peter Downes (Cambridgeshire CC), Councillor Lesley Salter (Southend Borough Council), Councillor David Taylor (Luton Borough Council), Councillor David Cullen (Hertfordshire County Council).

2. Declarations

Councillor Nick Hollinghurst declared that he and his wife were landlords of a property in Dunstable, Bedfordshire, which was used by a GP practice as a surgery.

Councillor Alan Crystall declared that he was a member of the Southend hospital Foundation Trust.

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Councillor Janice Eells declared that she was a member of the Older People's Mental Health Board in Norfolk.

Councillor Bernard Lloyd declared that his wife was a member of the Hertfordshire Partnership NHS Trust.

3. Communications

3.1 The Advisor reported that he had received a set of papers from the ME support groups and these would be circulated at the meeting.

4. Mental Health

4.1 The Committee heard from Dr Gillian Oaker (Chairman of the Mental Health Panel). She made a Powerpoint presentation and the committee was furnished with copies of the Mental Health Panel's report. Dr Oaker set out the key proposals in respect of mental health. They were:

a) Recognise the importance of prevention and the need to tackle the stigma associated with mental health problems
b) Ensure mental health services are recovery focused
c) Introduce a maximum wait of 18 weeks for services with shorter guarantees where appropriate
d) Seek to detect dementia earlier

e) Help more people with dementia live at home as long as possible
f) Recruit hundreds of new professionals including at least 350 new psychological therapists; older people's mental health teams; recovery, time and support workers; and carer support workers.
g) Deliver a new deal for carers through an expert carers programme.

4.2 The Committee heard from the Dr Oaker and Paul Toner about how these proposals would be delivered. The members asked questions about a number of the proposals and discussed issues with the clinicians and the officers of the Strategic Health Authority.

4.3 The Committee approached the theme of Mental Health with a particular concern. The Committee expressed the view that people with mental health needs are amongst the vulnerable in society and are amongst those least able to represent their own needs. As such the Committee believes that the NHS and their Local Authority commissioning and voluntary sector provider partners should give specific attention to developing effective and supportive mental health services. The Committee welcomed the emphasis given to mental health in the strategy. However it believed that its final report should address the following issues.

a) Action to be taken by the Strategic Health Authority and the PCTs to establish a database which accurately records, at each decision making level in the NHS in the East of England, the incidence and intensity of each category of mental health disorders.

b) The priority given to developing carers' services and the associated signposting services be endorsed and supported and that the special needs of young carers is recognised and that appropriate support and methods of recognition of their contribution are developed.

c) That the Strategic Health Authority and PCTs review and develop their mental health services for prisoners, over 75% of which have mental health conditions, and where their period of incarceration offers a real opportunity to diagnose and treat their conditions.

d) That the Strategic Health Authority and PCTs review their implementation of NICE guidelines on post-natal priorities especially where patients exhibit symptoms of depression or bi-polar disorder and where the patients can harm themselves or others in their care.

e) That the Strategic Health Authority and the PCTs review their services for children with Mental Health conditions

f) The Strategic Health Authority and the PCTs take steps to secure sustainable long-term funding for mental health workforce development.

g) Action is taken to establish and embed measures of clinical effectiveness that can be monitored and can form the basis of an annual report on progress with meeting the aims set out in the strategy.

h) Action is taken at each policy making and commissioning level within the NHS and the Local Authorities to ensure that their commissioning frameworks are designed to accommodate the movement of patients and clients between the sectors.

i) Each GP surgery (or consortia of surgeries in rural areas) should be encouraged to ensure that at least one GP has a good knowledge of mental health conditions to facilitate referral for diagnosis and assessment.

j) Patients presenting with medically unexplained symptoms should be screened for mental health conditions, while ensuring that no patient with a mental health condition is denied needed medical treatment.

k) The Strategic Health Authority, the PCTs and Local Authorities, together with their workforce development partners, develop opportunities for professional staff to learn from successful protocols and treatments in the East of England and nationally.

l) The Strategic Health Authority and PCTs develop clear and publicly available information on the patient pathways and maximum waiting time guarantees for each mental health condition.

4.4 The Committee thanked Dr Oaker and Mr Toner for their presentation and for their response to Committee's many questions.

5. **PLANNED CARE**

5.1 The Committee heard from Dr Jane McCue (Co-Chairman of the Planned Care Panel). She made a Powerpoint presentation and the committee was furnished with copies of the Planned Care Panel's report. Dr McCue set out the key proposals in respect of Planned Care. They were:

a) Deliver more care closer home, away from acute hospitals
b) Guarantee better access to GPs, dentists and radiotherapy services
c) Provide direct access to specialist advice and diagnostics and more local provision of diagnostics
d) Guarantee a maximum 18 week wait for more of our services including speech therapy, podiatry, orthotics, wheelchair services and orthodontics
e) Ensure that all patients have a full and free choice of where to go for planned care
f) Develop better local support for post-operative recovery
g) Agree, and measure, new clinical, quality of life and experience outcomes
h) Ensure that there is appropriate centralisation for complex care, particularly specialised surgery.

5.2 The Committee heard from the Dr Mc Cue and officers of the Strategic Health Authority about how these proposals would be delivered. The members asked questions about a number of the proposals and discussed issues with the clinicians and the officers of the Strategic Health Authority.

5.3 the Committee while generally endorsing the proposals for Planned Care believed that a number of issues need to be included in their final report. They were:

a) Reference to the Air Ambulance Service, its role and importance, method of funding and payment, clinical governance arrangements, whether voluntary contributions were an adequate funding mechanism.

b) Mechanisms and barriers to separating out elective and emergency surgery. Role of independent treatment centres. What is Impact on hospital revenue streams and on surgeon training.

c) Welcome the streamline models of care

d) Case review & rehabilitation – integration of health and social care spectrum of intermediate care arrangements. Change remit of community beds. Role of community beds/community services to de differentiated across their disparate functions (medical convalescence to social care) needs to be established and properly reflected within the commissioning regime

e). Welcome arrangements for centralisation of complex care – 24/7 senior cover, casework minimisation, cost-effective use of trained staff and expensive equipment

f) In determining access to services need to recognise time and distance especially as affects rural/urban, closeness to other NHS infrastructure (eg London) compared with sparsely populated areas (eg Norfolk)

g) Scope for developing GP computer aided diagnosis and computer based patient self diagnosis. Need to support early reporting of symptoms to GP

h) Support for more GP based screening, diagnosis, testing, and treatment including minor surgery where facilities and skills exist

i) Although there is secondary and tiertiary specialisation, ensuring that the lessons and experiences of that specialisation are reflected in practice-based and PCT commissioning – support for StHA position on this.

j) Support the rolling out national and regional good practice in hospital and community beds and other asset utilisation

k) Support extension of maximum waiting time guarantees to other planned care services and support provision of public information and signposting of the commitments. Establish when the guarantees will be in place and operating.

l) Need to stress joint funding and joint commissioning

m) Recognise that this could be a fundamental change of process informed by choice, locality treatment, minimum length of stays on specialised facilities, local recovery/convalescence

n) Need to address the locations for different specialisations and while this may be a subject of local consultation there is also a need to take a strategic/regional view to ensure that that there is equality of access to services across the region.

5.4 The Committee thanked Dr McCue for her presentation thanked the officers of the Strategic Health Authority for their contribution to the debate and Committee's understanding of the proposals.

6. Adjournment

6.1 The Committee adjourned until 9 July 2008.