East of England Joint Health Overview & Scrutiny Committee

Report on the Committee's consideration of the East of England Strategic Health Authority's Strategic Plan,

"Towards the best, together –
A Clinical Vision for our NHS,
now and for the next decade"

July 2008

Contents

1. Executive Summary

1.1 The Joint Committee welcomes the publication by the East of England Strategic Health Authority (SHA) of the strategy, "*Towards the best, together – a Clinical Vision for our NHS, now and for the next decade".* The Joint Committee,

1.1.1 Agrees that the provision of NHS patient services closer to the public is desirable, as long as 'closer' means measured and judged in terms of travel time.

1.1.2 Welcomes the definition of NHS services into Primary Care Intermediate Care and Acute Services (including specialist tertiary services) and believes that this graduated system has particular merit in respect of Long Term Conditions, Staying Healthy, Mental Health, Children's Services, Planned Care and End of Life Care.

1.1.3 Supports the development of a network model for Major Trauma Services and other areas where specialised services will be needed to treat patients' conditions.

1.1.4 Welcomes the retention of Accident & Emergency departments in all acute trusts in the region.

1.1.5 Supports the proposals for Maternity and New Born services and the increase in the number of Level 3 cots (high level), and Level 1 cots (low level) centres and a consequential reduction in the number of the Level 2 (intermediate) cots.

1.1.6 Supports the proposition that the NHS should place increased emphasis on staying healthy and also believes that patients and the public should take more responsibility for staying healthy.

1.1.7 Supports the proposition that patients with Long Term Conditions should be given personal health plans and along with them also given greater responsibility for managing their own conditions and provided with personal health budgets.

1.1.8 Supports the SHA's and the PCTs' commitment to target areas of known need, including the needs of marginal groups.

1.2 The Committee also has a number of **concerns**. The Committee,

1.2.1 Is concerned about the cost of implementing the strategy, whether there is the capacity to divert resources from existing spending patterns and whether the new money (only the first three years of which are known in detail) will be sufficient to fill the gap between the current service levels and patterns and those aspiration set out in the strategy.

1.2.2 Believes that more progress in the field of IT will be necessary to secure the aims of the strategy. In particular further progress in respect of better diagnosis and diagnostic tools, inter-changeability of patient records (especially diagnostics between Primary Care, Intermediate Services, Acute Care and the Ambulance & Paramedic Services) and, in respect of hub and spoke and other network arrangements, the better transfer of diagnostics, medical images, patient records and other data records.

1. Executive Summary

1.2.3 Believes that there is a need to give further attention to the travel implications of the provision of NHS services in rural areas and proposals for improving them by examining further issues relating to the accessibility of services, both in terms of ease of access and travel times, both by car and by public transport.

1.2.4 Recognises that there are examples of excellent and good practice across the region, but is less convinced that there are proper arrangements in place effectively to roll-out this good practice across the region. The Committee believes this is a priority issue and that the strategy will fail unless the SHA has an effective, flexible and responsive best practice roll-out process. There is much that could be imported from other sectors of the economy and more needs to be done in this area.

1.2.5 Believes that because of the overlapping nature of NHS and Local Authority services there is a need for greater commitment to the provision of NHS services that are integrated with those of the respective Local Authorities, together with more joint commissioning and better integrated service delivery. Previous experience in this area leads the Committee to question whether this will be achieved without it being afforded special emphasis. The involvement of the voluntary and not-for-profit sector in designing, and helping to shape the commissioning of, such services would be beneficial.

1.2.6 Believes, notwithstanding the commitments given in the Strategic Health Authority's Vision and Pledges and the promises given in respect of each of the themes, that there is a need for the Strategic Health Authority to establish objectives for the strategy, that baseline data is collected and analysed, that these are shaped into indicators and that SMART targets are set at each level of the strategy. The Committee also believes that this process will need to be replicated at the level of the PCT, as the strategy is rolled out at the local level. At both the strategic and local level the Committee believes that the focus should be on outcomes rather than process, what is going to be achieved, rather than what is going to be done.

1.2.7 Believes that better integration with the Ambulance and Paramedic service will be necessary if the integrated graduated service model and the network model are to be effective. In respect of Maternity and New Born services the operation of an effective 24/7 mother and baby transfer service by the Ambulance and Paramedic Service is an essential pre-requisite.

1.2.8 Believes that the SHA should consult sooner rather than later on the location of the specialist facilities within the network models, including the location of the Level 1, 2 and 3 baby units.

2. Introduction

2.1 The publication of the East of England Strategic Health Authority's strategy "*Towards the best together – A Clinical Vision for our NHS, now and for the next decade"* is welcomed by the Committee as it represents an important step forward in improving the health of the population of the east of England. The local authorities in the east of England have joined together to discharge their responsibility of examining the proposals in the strategy through the mechanism of a statutory Joint Health Overview & Scrutiny Committee. The composition and membership of the Committee is given in Appendix A, while the terms of reference of the Committee are described in Appendix B. Details of how the Committee went about its work are set out in Appendix C.

2.2 The Committee has scrutinised the strategy overall as well as each of the themes in the strategy. The Committee's report sets out the issues it has examined and then makes recommendations on each issue.

2.3 The Committee is grateful to the clinicians, NHS officers and members of the public that gave evidence and supported its work.

2.4 In this document references to "the Strategic Health Authority (or SHA)" should be interpreted as references to the East of England Strategic Health Authority. Equally references to "PCTs" should be interpreted as references to all of the Primary Care Trusts in the area of the East of England Strategic Health Authority. Except where otherwise indicated, references to "Local Authorities" should be interpreted as references to social services authorities in the east of England. References to NHS organisations in the east of England refer to all of the NHS organisations within the area of responsibility of the East of England Strategic Health Authority.

3. Overall Strategy, Finance and Workforce Issues

3.1 Introduction

3.1.1 From the evidence it has considered, the Committee believes that there are a number of general points it should make about the strategy as a whole. These can grouped under a number of headings, as set out below.

3.2 Strategic Commitments

3.2.1 The Committee welcomes the fact that all of the recommendations contained in **the** Darzi report, *High Quality Care for All,* have already been addressed in *"Towards the best, together"*. The Committee welcomes the involvement of clinicians in the development of the strategy.

3.2.2 The Committee has considered each of the Principles for Progress (see Appendix D). The Committee agrees with the suggested "Principles for Progress" to take forward the service design proposals set out in the strategy subject to the explicit recognition of the role of NHS staff in delivering the strategy and subject to there being an achievement oriented focus in respect of the strategy.

Recommendation

3.2.2.1 That the SHA endorses the principles with the following additions:
Principle 4 – should include reference to a well led, skilled, valued and well-motivated workforce, and
Principle 6 – should include reference to the need for outcomes that deliver measurable and meaningful improvements to be underpinned by a suite of outcome based objectives, evidence based indicators and SMART targets

3.2.3 The Committee also supports the strategy's focus on the provision of services closer to home. It recognises that this will also involve at some levels the delivery of services from specialised centres on a networked or hub and spoke basis. The committee believes that this will require, and it welcomes, a patient-focused graduated system of diagnosis, assessment treatment and care. Integrated systems across primary care, acute/ tertiary services, step down intermediate care and community care will need to be set in place for this to be successful in terms of patient care and patient satisfaction. The Committee welcomes the retention of Accident and Emergency facilities in each acute trust in the region.

Recommendations

3.2.3.1 That the SHA implements with the local PCTs, in each locality, the redesign of NHS services based on the approach of providing services "closer to home" as long as 'closer' means measured and judged in terms of travel time.

3.2.3.2 That the SHA implements with local PCTs and Acute Trusts the development of network arrangements for Major Trauma Services and other areas where specialised services will be needed to treat patients' conditions.

3.2.3.3 That the SHA implements its proposal that Accident and Emergency facilities are retained at each of the Acute Trusts in the region.

3. Overall Strategy, Finance and Workforce Issues

3.2.4 The Committee believes that for large scale improvement projects a coherent hierarchy of objectives, evidence based indicators and outcome focused SMART targets are set in place to achieve *Towards the best, together,* rationally and numerically. (By SMART targets the Committee means targets that are **S**pecific, **M**easurable, **A**chievable, **R**elevant and **T**imely). The Committee believes, notwithstanding the commitments given in the Strategic Health Authority's Vision and Pledges and the promises given in respect of each of the themes, that there is a need for the Strategic Health Authority to establish a coherent hierarchy of outcome based objectives for the strategy, that baseline data is collected and analysed, that these are shaped into indicators and that outcome based SMART targets are set at each level of the strategy. The Committee also believes that this process will need to be replicated throughout the structure of the NHS in the east of England. The SMART targets for the Strategic Health Authority should become the objectives at the level of the PCT. The PCTs should then develop a set of evidence based outcome focused indicators as the strategy is rolled out at the local level, especially where this involves collaborative work with local authorities. At both the strategic and local level the Committee believes that the focus should be on outcomes rather than process, what is going to be achieved, rather than what is going to be done.

Recommendations

3.2.4.1 That the SHA should ensure that
a) for the Vision as a whole, and,
b) within their local strategies, PCTs
set high level strategic objectives, collect and analyse baseline data, shape a set of strategic indicators and set SMART strategic targets focused on outcomes rather than process, what is going to be achieved, rather than what is going to be done.

3.2.4.2 That the Local Authorities should work closely with their local PCTs to secure the aims of each authority's Local Area Agreements, (including the strategic targets set referred to in paragraph 3.2.4 above) with a focus on outcomes rather than process, what is going to be achieved, rather than what is going to be done.

3.2.5 The Committee supports the development of world class commissioning at both the strategic and the local level. However the Committee believes that for it to be effective it will need to reflect the philosophy set out in the regional and local strategies, that it is focused on outcomes rather than process, what is going to be achieved, rather than what is going to be done

Recommendation

3.2.5.1 That the Strategic Health Authority in developing its approach to world class commissioning takes steps to ensure that it is outcome focused, rather than input or process focused.

3. Overall Strategy, Finance and Workforce Issues

3.2.6 The Committee supports the need to develop a quality and safety ethos within the NHS organisations in the east of England. The Committee believes that it is necessary to have a system for uplifting the quality in service delivery across each of eight themes. The Committee welcomes the high priority that will be afforded to this work especially where it will lead to, for example, a reduction in the incidence and indeed the risk of acquiring hospital acquired infections. The Committee believes that this can best be secured and developed by the introduction and roll-out of statistical, evidence based, monitoring systems

Recommendation

3.2.6.1 That the SHA and PCTs through their commissioning actions and Acute Trusts through their internal management systems develop, introduce and roll-out statistical, evidence based, monitoring systems to secure a quality and safety ethos within the NHS organisations in the east of England

3.3 Implementation

3.3.1 The Committee believes that the SHA and local PCTs should focus their attention on implementation and service delivery issues, once the strategy has been adopted. The Committee understands that, following adoption of the strategy by the SHA, local PCTs will consult on their local health strategies. The Committee believes that once local strategies have been adopted, PCTs should respond with implementation plans to achieve the strategic targets set by the SHA. The Committee believes that such implementation plans should be characterised and driven by outcome focused SMART targets. The Committee believes that this will enable the regional strategy to be cascaded through NHS organisations in the east of England through a hierarchy of plans and targets. The Committee believes that the implementation plans should be supported by a system of business planning which will tie together the financial and other resource aspects with the service delivery priorities.

Recommendation

3.3.1.1 The Committee urges the SHA, PCTs and Local Authorities, as soon as possible, to focus on the implementation of the strategy, especially the financial implications of change which should be taken forward through a rigorous process of implementation plans and business planning, enabling the service and resource implications of the plans to be dovetailed

3.3.2 The Committee also believes that, historically the NHS and Local Authorities are relatively poor at the delivery of joint partnership arrangements. The local NHS Bodies will need to work with each other and with their Local Authorities to secure the implementation of health and social services that are client and patient focused, and that there is appropriate interweaving of the initiatives within and between the themes (for example that End of Life services also apply to dying babies and their parents).

Recommendation

3.3.2.1 That the local NHS Bodies work with each other and with their Local Authorities to secure the implementation of health and social services that are client and patient focused, and that there is appropriate interweaving of the initiatives within and between the themes

3. Overall Strategy, Finance and Workforce Issues

3.3.3 The Committee supports the need to improve the understanding, dissemination and roll-out of national and regional best practice. The Committee has heard evidence that in a number of areas there are difficulties in rolling-out innovation and best practice and that adequate roll-out mechanisms over the whole NHS organisation in the east of England do not yet exist. The Committee is concerned that, in time, this may come to be a significant barrier to the successful implementation of the strategy and the ambitions for improved service delivery. The Committee believes that the SHA could learn much from the approaches and methodologies adopted by other sectors of the economy, including private sector practice. The Committee further believes that this is one area where the new SHA responsibilities for innovation could be applied.

Recommendation

3.3.3.1 That the SHA develops strong and effective roll-out mechanisms over the whole NHS organisation in the east of England with the aim of improving the understanding, dissemination and roll-out of national and regional best practice and in this regard that the SHA considers using its responsibilities for developing innovative approaches.

3.4 Resources

3.4.1 The Committee, recognising that much of the change envisaged in the strategy will need to be internally funded by the redirection of resources, urges the SHA and local NHS bodies recognise and engage the public in discussions and debate on the possibility that there may need to be the retrenchment, curtailment or closure of some services alongside the development and expansion of other services and facilities.

Recommendation

3.4.1.1 That the SHA and the PCTs define, publicise and engage the public in discussions and debate on the possibility that there may need to be the retrenchment, curtailment or closure of some services alongside the development and expansion of other services and facilities.

3.4.2 The Committee believes that more progress in the field of information technology and digital technology will be necessary to secure the aims of the strategy. In particular further progress will need to be made in respect of the use of better diagnosis and diagnostic tools, the electronic availability and transmission of inter-changeable patient records (especially between Primary Care, Intermediate Services, Acute Care and the Ambulance & Paramedic Services) and, in respect of network arrangements, the better transfer of medical images, patient records and other data records. The Committee also supports the revisions to patient pathways to minimise the number of times that the patients and their records are transferred between different parts of the NHS. The Committee supports the development of information systems, the use of Information Technology and digital technology to gather and analyse patient and outcome data as part of a better evidential base for decision making. It believes that this will help to minimise the risk arising from patient transfer between organisations. The committee also believes that there is a need to develop links between the local authority and the NHS IT systems, avoiding the ‘two computers on one desk’ syndrome.

3. Overall Strategy, Finance and Workforce Issues

Recommendations

3.4.2.1 That the SHA and the PCTs take the necessary steps to support the necessary levels of patient-focused IT investment across General Practice, between GPs and the Acute Trusts, across the wider clinical networks and between the Ambulance and Paramedic Service and other parts of the NHS.

3.4.2.2 That the SHA embraces the use of better IT based diagnosis and diagnostic tools, the electronic availability and transmission of patient records (especially between Primary Care, Intermediate Services, Acute Care and the Ambulance & Paramedic Services) and, in respect of network and hub and spoke arrangements, the better transfer of medical images, patient records and other data records as part of a wider initiative to streamline and improve patient pathways to minimise risks associated with the number of times that the patients and their records are transferred between different parts of the NHS.

3.4.2.3 That the SHA supports the development of information systems and the use of information technology and digital technology to gather and analyse patient and outcome data as part of a better evidential base for decision making,

3.4.2.4 That the SHA, the PCTs and the Local Authorities work together to set in place patient and client focused IT systems which are able to link to each other, on the basis that confidentiality should not be used as barrier to integration.

3.4.3 The Committee believes that for the proposals in the strategy to be successful it is necessary for the east of England NHS organisations to have a well-led, skilled, motivated and valued workforce. The Committee supports the further focus on workforce planning being based on the service requirements and principles set out in the strategy,

Recommendation

3.4.3.1 That the SHA bases its workforce planning on the demands of the revised clinical assessment and treatment models and the improved patient pathways and ensures that initiatives and action in this area should be evidentially based.

3.4.4 The Committee has received evidence that while there is to be growth in the region's PCTs' funding levels over the current and two subsequent years, the financial outlook for the remaining seven years of the strategy is uncertain. This is because prospective changes to the funding allocation mechanisms and the distribution formula. Currently the NHS in the east of England is about £100 million per annum short of funds as represented by its aggregate "distance from target", the measure of the difference between what the region's PCTs should receive under the funding formula and what it actually receives under the distribution mechanisms. The Committee would support the SHA in its endeavours to secure a fair share of national funding for the NHS in the east of England.

3. Overall Strategy, Finance and Workforce Issues

Recommendation

3.4.4.1 The SHA continues, and engages local health overview & scrutiny committees, in its endeavours to secure a better annual funding settlement for the NHS in the east of England, which is currently c£100 million short of its assessed target funding allocations for PCTs.

3.5 Monitoring the impact of the strategy.

3.5.1 The Committee supports the SHA's proposals for an improved, systematic and evidential base for developing and collecting information on patients' experiences of using NHS services and using the findings to improve service design and delivery. The Committee believes that it will be necessary to establish and agree the required performance and quality measures, indicators and metrics sooner rather than later as these will be necessary to progress the publication of quality performance information for patients and NHS management and before quality improvements can be recognised and rewarded. Accordingly the Committee believes that this is an initiative which should be given priority.

Recommendation

3.5.1.1 That the SHA sets in place proposals for an improved, systematic and evidential base for developing and collecting information on patients' experiences of using NHS services and using the findings to improve service design and delivery.

3.5.1.2 That the SHA establishes and agrees the required performance and quality measures, indicators and metrics for gathering information on NHS performance and patient satisfaction soon rather later, as these will be necessary to progress the publication of quality performance information for patients and NHS management and before quality improvements can be recognised and rewarded

3.5.2 The Committee has received evidence about the longer term function and role of the clinician-based Implementation Boards. The Committee supports their role in monitoring, from a clinical perspective, the implementation and outcomes arising from the recommendations of the Clinical Pathway Groups as they are translated into the strategy approved by the SHA and PCT Boards. The Committee believes that the relative independence of these clinician based forums should be consolidated and that that they should be required to produce publicly available annual reports setting out progress with securing the objectives and the desired outcomes of each element or theme of the strategy.

Recommendation

3.5.2.1 That to assure clarity of purpose and to ensure that the proposed Implementation Boards are successful, the SHA invite each of them to prepare and publish publicly available Annual Reports which monitor and review progress with achieving the SMART targets for each of the themes in the strategy (see paragraph 3.2.4 and recommendation 3.2.4.1 above).

4. Staying Healthy

4.1 Introduction

4.1.1 The Committee concurs in the view that Staying Healthy is the cornerstone of the vision and the strategy. Good health contributes fundamentally to an individual's quality of life. The Committee believes that healthcare will be unaffordable if the individual citizens, the public, public authorities, large private employers and others do not tackle the issue of staying healthy. The Committee is very concerned about the levels of obesity, especially in young people and the danger this presents for the increase in the incidence of diabetes and other consequent health problems. The Committee supports the view that Staying Healthy cuts across and underpins the other themes of the strategy. While endorsing the vision for the Staying Healthy aims of the strategy the Committee believes that there are some areas which need further emphasis or attention. These are set out below.

4.2 Strategic Intent

4.2.1 The Committee supports the priority given to staying healthy and believes that the initiative would be more successful if the emphasis of certain aspects of the proposals was adjusted. There are three levels where this is pertinent, the strategy level (or strategic intent), the programmes and the specific deliverables. The strategy focuses on individual programmes and specific deliverable at the expense of the objectives and aims of the strategy. There is a need to establish greater clarity between the strategic intent on the one hand and the individual programmes and specific deliverables on the other. Again the emphasis should be on achieving as well as doing.

Recommendation

4.2.1.1 That the Strategic Health Authority seeks to secure a better balance between the strategic direction and strategic success factors for Staying Healthy and the specific deliverables set out in the strategy, with more of the former, focusing on achieving as well as doing.

4.3 Resources

4.3.1 For the preventative nature of the staying healthy programme to be effective it will need to be properly resourced. There is evidence that healthy practices promoted early in life and as people make the transitions at different stages of their lives show a positive benefit. Accordingly this is an area where it can truly said that there will be investment that shows a return. The Committee believes that this is not just an NHS responsibility and that there needs to be widespread acceptance and support of the programme's aims. The Committee believes that funding of the necessary level will be needed, will show a return and believes that a detailed supporting plan will be needed.

Recommendations

4.3.1.1 That the SHA and the region's PCTs allocate the necessary NHS resources to the projects and programmes that address the issues covered in the Staying Healthy theme, that the SHA and local PCTs use their influence to ensure that Staying Healthy is a community, not just an NHS, issue and that local authorities (including district councils), other public authorities as well as large private employers embrace the necessity for every person to ensure that they adopt lifestyles that enable them to stay healthy.

4.4 Rights, Obligations and the Role of Public Bodies

4.4.1 The Committee accepts that the responsibility for staying healthy is a personal as well as community responsibility, a part of the rights and obligations inherent in a modern society. It believes that in this respect there are some omissions in what is otherwise an important priority. The Committee also believes that the role of statutory and voluntary community based and community development oriented organisations has been understated in promoting an understanding of the healthy living message. There is a role for schools in this regard, in line with the healthy schools initiative, albeit that there are already enormous demands on them to find space in the curriculum for many other priorities. The role of the Local Authorities in promoting health could, it has been argued, be much increased. At a minimum however all public authorities should share the responsibility for promoting healthy living and should reflect that priority in their approach to decision-making where it should sit alongside other corporate priorities.

Recommendations

4.4.1.1 That the SHA and the local PCTs together with their public and private partners develop and implement measures for shifting public perceptions to a position where, within a partnership approach with the NHS, individual citizens take responsibility for their own health and that complementary, successful and subliminal messages are developed over the period of the strategy.

4.4.1.2 That the SHA and the PCTs recognise the role of, support and if necessary fund, the statutory and voluntary agencies in their work in community development and similar projects where there are opportunities to promote health living.

Recommendations

4.4.1.3 That the SHA and the PCTs recognise the role and explicitly encourage the involvement of Schools and Colleges in health promotion work to help secure the aims of the Staying Healthy theme.

4.4.1.4 That local PCTs should work with the Local Authorities to ensure that School and College Travel Plans have a health dimension.

4.4.1.5 That the SHA, the Local Authority Associations and other public bodies should promote a debate on whether local authorities should be taking responsibility for public health and promoting healthy living .

4.4.1.6 That the SHA invites all public authorities in the east of England to ensure that reports to decision-making forums should explicitly include reference to the health implications of the proposed decision, alongside the current norm for declaration of equal opportunities, legal, finance, risk and sustainability implications.

4. Staying Healthy

4.5 Other priority areas

4.5.1 The Committee believes that two areas, which it believes are important, have been neglected or afforded lower priority within the Staying Healthy work. These are drug abuse and sexual health. By the measures that are often used by the NHS, national comparators, this is perhaps understandable. However if local data on drug abuse and sexual health is set against that from their respective Audit Commission families of similar authorities the position is quite different in parts of the region.

Recommendation

4.5.1.1 That the SHA in considering the response to the consultation and determining a way forward recognises the need to address the issues of drugs other than alcohol.

4.5.1.2 That the SHA in considering the response to the consultation and determining a way forward recognises the need to address the issues arising from sexual health.

4.6 Priority Groups

4.6.1 The Committee recognises that all groups can lay claim to priority treatment and that it is the job of public administration to establish, on an evidential base, priority programmes that can be justified and where action will show benefits. The Committee believe that one such area is the health needs and, to a degree, the understanding by the traditionally "hard to reach groups" of the need to live healthily. The Committee believes that this is an area which requires special attention as it does not feature sufficiently or explicitly in the strategy at present, although the Committee accepts that the drive on health inequalities is relevant in this regard.

Recommendation

4.6.1.1 That in the SHA promulgates advice to PCTs on addressing the needs of the traditionally hard to reach groups and others who find it difficult to live a healthy life and to access NHS services for advice and action.

4.6.2 The other area where there significant difference in health and mortality rates is in the difference between men and women. The Committee accepts that there are some genetic aspects to this issue. It also accepts that some of the mainstream programmes, (smoking, vascular screening, taking exercise, diet eating and obesity) address the health needs of men. However the Committee believes that if any other single group were to have such a disparity in health terms they would become a priority group. In particular the Committee would like to see a move away from the "that's how it is" mentality that appears to pervade some elements of the NHS.

Recommendation

4.6.2.1 That in considering one of the most fundamental health inequalities, the difference in the health and the mortality rates between men and women the SHA rejects the "that's the way it is" approach and develops health promotion and service design arrangements which addresses this differential mortality rate.

4.7 Other Issues

4.7.1 There are two other issues which the Committee wishes to bring to the attention of the SHA and its PCTs. The first is the need to provide information and advice on screening. The Committee has heard that effective screening processes are not always available. In other instances there are some screening processes that might identify conditions which are not terminal or which will not unduly affect a patient length or quality of life, but which might cause them to worry or seek clinically unnecessary medical or surgical interventions. The Committee believes that the roll-out of screening programmes is important and has beneficial effects and outcomes, as with breast screening or cardio vascular screening. However it believes that more could and should be done to educate the public about the benefits and disadvantages of screening programmes.

4.7.2. The second is that the Committee was advised that the SHA was considering using broadcast media to promote healthy living. The Committee would request the SHA to take account of the different broadcast media received in different parts of the SHA area.

Recommendation

4.7.2.1 That the SHA and PCTs promote information and education material in the benefits and drawbacks of regular and/or periodic health screening programmes.

4.7.2.2 That the SHA and its media advisors recognise that the coverage of the broadcast media in the east of England varies in different parts of the region and that any Staying Healthy communication and information campaigns should be designed with this in mind.

5. Mental Health

5.1 Introduction

5.1.1 The Committee approached the theme of Mental Health with a particular concern. This is rooted in the Committee's 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 supports initiatives to tackle the stigma of mental health which can affect a relatively high proportion of the population at some stage in their lives. While supporting the proposals set out in the strategic plan the Committee has a number concerns. They are set below.

5.2 Evidential Information and Data

5.2.1 The Committee noted with concern that there was an acknowledged information deficiency in the information base relating to mental health conditions. Without a proper, comprehensive, evidential base the opportunities for establishing the right mental health services in the right locations will be compromised. The Committee found that the evidential base for setting priorities was lacking.

Recommendation

5.2.1.1 Action be taken by the SHA and the PCTs to establish a database which accurately records, at each decision making level in the NHS organisations in the east of England, the incidence and intensity of each category of mental health disorders.

5.3 Priorities

5.3.1 In the absence of a proper evidential base the Committee has found it difficult to endorse the four priorities for mental health set out in the strategy. It recognises that carers are important, and indeed endorses and welcomes the commitment to carers' services. The Committee believes that there is a need to recognise the special needs of young carers (both in respect of mental health and long-term conditions) and that this is a deficiency in the strategy. It supports the approach to treatment that adopts the recovery model. The Committee understands that the focus on dementia and on psychological therapies is as a result of them being recognised as local demographic and national priorities and which, in respect of the psychological therapies, the east of England is comparatively poorly ranked in national terms. However the Committee believes that there are other patient groups (for example prisoners, prisoners leaving prison care or mothers suffering from post-natal depression) which may have an equal or greater call on resources because of the potential health and financial payback they offer or because of the risk to others that these patients being afforded a low priority may not be realised. The Committee also recognises that mental health diagnosis and treatment needs to take account of the diversity of patients in our communities and this does not currently appear to be a feature of the mental health strategies and proposals.

5. Mental Health

Recommendations

5.3.1.1 That the SHA and PCTs endorse the priority and support given to developing carers' services and the associated signposting services and that the special needs of young carers is also recognised with appropriate support and methods of recognition of their contribution being developed.

5.3.1.2 That the SHA and the PCTs review and develop their mental health services for prisoners (over 75% of whom have mental health conditions) during their sentence and on release, and where their period of incarceration offers a real opportunity to diagnose and treat their conditions.

5.3.1.3 That the SHA and the 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.

5.3.1.4 That the SHA and the PCTs ensure that mental health diagnosis and treatment takes account of the diversity of patients in our communities

5.3.2 The issue of mental health services for children and young people has been a priority for each of the authorities represented on the Committee. The authorities recognise that there is a spectrum ranging from disruptive behaviour at school and at home through to children and young people experiencing mental health conditions of varying intensity, including self harming. The Committee recognises that this is an issue that affects not only the young patient but also his or her siblings or classmates.

Recommendation

5.3.2.1. That the SHA and the PCTs review their services for children with Mental Health conditions, working closely with their local authorities.

5.4 Funding Information

5.4.1 The Committee noted that the funding information relating to mental health represents a mix of expenditure by the NHS, by Local Authorities and by voluntary/not for profit sectors. It is concerned to ensure that adequate funding is made available to sustain high quality effective mental health services. It believes that the funding for mental health should be based on a rigorous analysis of the mental health needs of patients. The Committee believes that it is important to gain a clear picture of mental health spending by each sector, in each of the key service areas of mental health.

Recommendation

5.4.1.1 Action be taken by the SHA, each PCT and each Local Authority to establish a clearer understanding of the funding of mental health in the SHA area and that steps are taken to identify and coordinate the commissioning budget for each key service area by each commissioning PCT and Local Authority.

5. Mental Health

5.5 Staffing and Workforce Issues

5.5.1 The Committee noted the position in respect of the shortage of mental health professionals in the east of England. It welcomes the evidence it received that action was being taken to fill the gaps in the staffing levels. While cautiously welcoming the additional funding for training of professionals, the Committee is concerned that the short term nature, or the tapering of funding regimes, for such training and workforce development could in the medium term compromise the ambitions in this area.

Recommendations

5.5.1.1 The NHS, Local Authorities and relevant voluntary sector organisations continue with their programmes to skill new entrants to the field of mental health and up-skill those professional and support staff who have experience of working in mental health and who wish to develop their capacity to contribute to a better range and quality of mental health services across the whole community.

5.5.1.2 The SHA and the PCTs take steps to secure sustainable long-term funding for mental health workforce development.

5.6 Success Criteria

5.6.1 The Committee was concerned that within the strategy, and notwithstanding the general recommendation to develop SMART targets, there were few measures of clinical effectiveness in the field of mental health. It was not possible from the information provided for the Committee, or it believes, for the NHS to be able to judge success.

Recommendation

5.6.1.1 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.

5.7 Inter-Agency Coordination and Integrated Services

5.7.1 The Committee has recognised that mental health (along with Staying Healthy) underpins the rest of the *Towards the best, together* strategy. It understands that the individual patients may pass between NHS commissioned and Local Authority commissioned services and as such believes that, if the strategy is to be patient/client focused, then there is an absolute requirement for such services to work across their respective agency boundaries. The Committee believes that this is a challenge for the SHA, for PCTs, for Practice Based Commissioning Groups and for the Local Authorities.

Recommendation

5.7.1.1 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.

5. Mental Health

5.8 Central Role of Primary Care in Mental Health Services

5.8.1 The Committee has heard evidence that GPs are central to the identification and diagnosis of mental health conditions. The Committee has also heard that in the region of 95% of all patients with mental health conditions are cared for within the primary care setting. The Committee has heard that there is not an effective arrangement for systematically recording the number and populations of patients with each condition (see recommendation at paragraph 5.2.1 above). The Committee has also heard that not all GPs are well versed in recognising mental health conditions. There is a need to improve the incidence of correct diagnosis. Some NHS settings may not recognise that some patients who are presenting symptoms could be recognised as having mental health conditions. In other instances some GPs and some outpatient settings may not recognise that when they are dealing with medically unexplained symptoms then there may be a mental health issue. Thirdly there is the case that some mental health patients present symptoms which need to be diagnosed and treated per se. The Committee believes that this is an area where further action should be taken, with the emphasis on correct diagnosis.

Recommendations

5.8.1.1 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.

5.8.1.2. 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.

5.9 Rolling Out Good Practice

5.9.1 The Committee has heard evidence to the effect that there are many pockets of good practice in respect of mental health services. This is underpinned by Committee members' own experience from their health scrutiny and representational roles and from their dealings with constituents' problems. The Committee believes that best practice from outside the NHS, nationally and internationally, should be adopted in securing the effective roll-out of best practice

Recommendation

5.9.1.1 The SHA, 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, nationally and internationally and that effective roll-out procedures are adopted.

5. Mental Health

5.10 Maximum Waiting Times Guarantees

5.10.1 The Committee has understood and welcomed the fact that certain maximum waiting time guarantees would be applied to patients with mental health conditions. The Committee recognises that in some instances a same day service response is the norm, where a patient's condition so requires. However it also believes that in other circumstances there is a need for greater clarity about the application of the maximum waiting time guarantee. The Committee believes that this is an area which could benefit from greater clarity and from better information and publicity.

Recommendation

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

6. Maternity and Newborn

6.1 Introduction

6.1.1 The Committee recognises the importance of good maternity and newborn services. While endorsing the Vision for the Maternity and New Born aims of the Strategy, the Committee believes that there are some areas which need further emphasis or attention. These are set out below.

6.2 Strategic Organisation of Maternity and New Born Services

6.2.1 The Committee has heard evidence that there are proposed changes in the structures to deliver Neonatal services. The Committee is concerned that the proposals are not yet sufficiently firm to have been included in this strategy and to have been the subject of, and benefited from, wider public discussion during the consultation process. Details of the reconfiguration for the centralisation of services needs to be published and consulted upon and the implications for service delivery clearly set out.

Recommendation

6.2.1.1 That the SHA should provide details of the proposed reconfiguration of maternity services including the centralisation of services, publish those proposals and commence a consultation process on the proposals, clearly setting out the implications for service delivery.

6.2.1.2 That the SHA should provide greater clarity and transparency in the justification of the proposed geographical spread of Level 1, Level 2 and Level 3 baby units and should consider whether, notwithstanding whether the arguments may be sound, this service delivery arrangement may be a step too far, until the neo-natal ambulance transport system is fully functioning, operating 24/7 and effective and this is not currently the case.

6.2.1.3 That the SHA and the relevant PCTs provide and publish further information on the numbers of cots in each of the Level 1, Level 2 and Level 3 facilities.

6. Maternity and Newborn

6.3 Transport

6.3.1 The Committee has heard that for the neo-natal network specialisation arrangements to be able to work properly there needs to be a fully functioning neo-natal transport service operating 24/7 and this is not currently the case. The Committee believes that this is a deficiency and presents a barrier to the effective operation of the system.

Recommendation

6.3.1.1 That the SHA and the East of England Ambulance and Paramedic Service should take steps to ensure that the neo-natal transport system has the capacity to operate effectively 24/7.

6.4 Vulnerable groups

6.4.1 The Committee was not satisfied that the strategy made sufficient provision for the treatment and care of vulnerable groups and for families with new born children with disabilities or abnormalities. The Committee believes that this is a significant omission.

Recommendation

6.4.1.1 That the SHA, the PCTs, the relevant Acute Trusts and Local Authorities provide a greater focus on the provision of services for the treatment, care and support available to vulnerable groups (e.g. looked-after children) and to new born children with disabilities or abnormalities and their parents.

6.5 Pre-conception and Antenatal Services

6.5.1 The Committee believes that the stated policy on IVF is less than explicit or clear. The Committee believes that this should be rectified. The Committee is also concerned that mothers and those women intending to have children should be supported through addictions other than smoking. The Committee believes that there is scope for developing ante-natal services through the emerging network of local authority children's centres and believes that this opportunity should be embraced by the NHS organisations in the east of England. The Committee was concerned to find that there was no policy on terminations within the strategy and looks forward to receiving the regional sexual health strategy planned for March 2009.

6. Maternity and Newborn

Recommendations

6.5.1.1 That the SHA policy on IVF treatments should be more explicit in setting out how the standardisation of the service level and the increase in the number of IVF cycles will operate and that NICE guidance will be supported by PCTs throughout the east of England.

6.5.1.2 That the SHA, PCTs and Acute Trusts focus on alcohol and drugs, in addition to smoking, in developing the pre-conception and ante-natal services and ensure that the mechanism by which a member of staff brings their concerns about a child to targeted/ specialist services, should be through the Common Assessment Framework (CAF) process.

6.5.1.3 That the SHA, the PCTs and the Local Authorities support proposals for developing the scope for local authority Children's Centres to provide antenatal services.

6.5.1.4 That the SHA and PCTs address and rectify the omission from the strategy of the policy framework for terminations.

6.6 Integrated Post natal services

6.6.1 The Committee has received evidence that there is scope for better collaboration between the roles of the midwife and the health visitor to provide a patient centred service. The Committee believes that this opportunity should be taken. The Committee was concerned about the incidence of HIV and welcomed the universal screening in this regard. The Committee was also concerned that there seemed to be a gap in the responsibility for end of life care of new born babies and that appropriate support needs to be provided to the parents of stillborn children.

Recommendations

6.6.1.1 That the SHA and the PCTs set in place integrated post-natal services covering the complementary roles of midwives and health visitors

6.6.1.2 That the universal screening relating to the high incidence of HIV in newborn babies and their mothers be welcomed, supported and developed by the relevant PCTs and Acute Trusts.

6.6.1.3 That the SHA, the PCTs and the Acute Trusts commission good quality end of life support services for the Maternity and Newborn services.

7. Children's Health

7.1 Introduction

7.1.1 The Committee, while endorsing the vision for Children's Services believes that there three areas that require further consideration of emphasis with the strategy. These are set out below.

7.2 Needs Analysis

7.2.1 The Strategy accepts that there are variations in service provision for children across the region. The Committee believes over time these variations should be addressed, accepting that different local circumstances and needs may require different emphases in service design in different localities. The Committee has also heard evidence that children have different medical and social care needs at different ages. The Committee believes that there should not be a "one size fits all" approach to children's health services.

Recommendations

7.2.1.1 That the SHA undertakes further work in the form of gap analysis, and benchmarks services on a European, national, regional and local level.

7.2.1.2 That the PCTs undertake local benchmarking and comparative analysis based on the Audit Commission families of authorities.

7.2.1.3 That the SHA undertakes further work to focus policies and services on outcomes, rather than structures and processes.

7.2.1.4 That the SHA and the PCTs should explicitly recognise that children have different medical and social care needs at different ages (for example toddlers and young children, those children in their middle school years and teenagers) and that processes for the analysis and diagnosis of children's needs should reflect this view.

7.2.1.5 That the PCTs in commissioning services pay specific regard to the service needs of those young people making the transition from childhood to adulthood.

7.3 Commissioning

7.3.1 The Committee believe that the commissioning of services is vital to securing the provision and delivery of appropriate health and social care services for children. It would wish to endorse proposals for clinicians in the secondary and tertiary sectors to participate and support their primary care colleagues and the practice based commissioning groups in commissioning children's services. The Committee also believes that this is an area where there is a need for better collaboration between the statutory

authorities. The Committee has heard that there are different models of integrated care across the SHA area. It has also recognised that schools are central to the life of children and that health should be theme that runs through the experience of children while they are at school.

Recommendations

7.3.1 That the SHA and the PCTs develop improved joint commissioning for Children's Services with both the education and children's social care services of Local Authorities in respect of both primary and secondary care.

7.3.2 That the PCTs, while recognising that primary care commissioning involves clinicians at the level of the practice based commissioning groups and the PCTs, also involve hospital based and other specialist secondary and tertiary clinicians in the commissioning of children's services, as envisaged by the SHA in its strategy.

7.3.3 That the SHA undertakes work to evaluate and monitor the impact and success of the different models of integrated care, rolling out the more successful practices and models across the region.

7.3.4. That the SHA and PCTs develop a "Vision for the role of Health in Schools" within the context of relevant partnership arrangements and the healthy schools initiative.

7.4 Specific Needs

7.4.1 The Committee recognises that all children will need to be served by the strategy and by the PCTs' commissioning of relevant services. The Committee does however recognise that there are some groups of children who will need specific care, attention and treatment. The Committee has also considered the issues of end of life care for children.

Recommendations

7.4.1.1 That the SHA and the PCTs in delivering the strategy should particularly focus on the needs of looked after children, ensuring that there is service integration and regular monitoring across NHS, Children's Services and Education Services.

7.4.1.2 That within the context of the range of services for children and young people the SHA and the PCTs should secure greater focus on the health needs of children with learning disabilities and their access to NHS services.

7.4.1.3 That the SHA and the PCTs accord end of life services for children sufficient weight and take steps to ensure that the adopted strategy addresses this issue in greater depth, with appropriate support services for children, their relatives and their carers.

8. Planned Care

8.1 Introduction

8.1.1 The Committee welcomes the proposals for improvements in Planned Care. It believes that the streamline models of care and clearer patient pathways will lead to improved clinical outcomes. The Committee does have some concerns which are set out below

8.2 Strategy

8.2.1 The Committee believes that the success of planned care is at least in part dependent on the separation of elective and emergency surgery. The Committee understand that some progress had been made in this regard over the past few years, addressing concerns about funding, surgeons' training and the integration of the elective service with other aspects of the operation of local hospitals. The Committee believes that there is a need for the SHA to set out the role of independent elective treatment centres in supporting planned care. While the Committee welcomes the arrangements for centralisation of complex care, with 24/7 senior cover, casework minimisation, and the cost-effective use of trained staff and expensive equipment, it also believes that there is a need to be clearer about the distribution of the specialist centres. The Committee also believes that optimum bed utilisation is a critical success factor.

Recommendations

8.2.1.1 That the SHA and the Acute Trusts address the mechanisms and barriers to separating out elective and emergency surgery.

8.2.1.2 That the SHA and the Acute Trusts clearly define the role of independent treatment centres, including their impact on,
a) hospital revenue streams and the costing and charging mechanisms, and,
b) on surgeon training.

8.2.1.3 That the SHA addresses the issue of the locations for different specialisations for planned care and recognises that 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.

8.2.1.3 The SHA sets mechanisms in place so that the lessons and experiences of secondary and tertiary specialisation are reflected in practice-based and PCT commissioning.

8.2.1.4 That the SHA sets in place arrangements to support the rolling out of national and regional good practice in hospital and community beds and other asset utilisation.

8. Planned Care

8.3 Access

8.3.1 The Committee believes that access to planned care is a fundamental issue that will need to be addressed. It has a number of dimensions. There is a need to address waiting times. The role of graduated treatment and care is important as is the issue of physical location and access. The Committee recognises that the proposed new arrangements could represent a fundamental change in the care process informed by choice, locality treatment, minimum length of stays in specialised facilities and local recovery/convalescence.

Recommendations

8.3.1.1 That the SHA maintains its support for extension of maximum waiting time guarantees to all planned care services and supports this by the provision of public information and signposting of the commitments, starting with a public declaration of when the guarantees will be in place and operating.

8.3.1.2 That the SHA, the PCTs, the Acute Trusts and the Local Authorities recognise the importance of case review and rehabilitation and work to secure the integration of intermediate care arrangements across the health and social care spectrum, including where necessary bringing clarity to or changing the remit of community beds.

8.3.3 That the SHA, the PCTs and the Acute Trusts in determining access to NHS services recognise that travelling time and distance is an important issue and that there are different levels of access to services across the east of England in respect of both the rural/urban debate and in respect the proximity to other NHS infrastructure (e.g. Hertfordshire or parts of Essex in respect of London) compared with sparsely populated areas (e.g. Norfolk).

8.4 Role of Primary Care

8.4.1 The Committee has heard evidence of the critical role of primary care in respect of planned care. The Committee endorses that view. It believes that there is an opportunity to deepen GP's involvement through the use of better diagnostic tools. The Committee also believes that within the context and spirit of Staying Healthy, more should be done by way of informing and educating to enable patients to recognise, and then report to their GPs their own symptoms,

Recommendations

8.4.1.1 That the SHA supports the extension and scope of GP based screening, diagnosis, testing, and treatment, including minor surgery where facilities and skills exist

8.4.1.2 That the SHA, the PCTs and the Acute Trusts explore the scope for developing computer aided GP diagnosis and computer based patient self diagnosis.

8.4.1.3 That the PCTs encourage and facilitate early reporting of symptoms by patients to their GP by informing and educating patients of the main symptoms of the main conditions.

8. Planned Care

8.5 Joint Commissioning

8.5.1 The Committee heard evidence that there was a need to be clearer about the responsibilities and role of the NHS and Local Government in respect of the provision of intermediate care and step-down beds. The Committee believes that this issue could be resolved by having greater clarity about the role of such beds and by the adoption of joint commissioning and joint funding arrangements across the convalescence/social care spectrum.

Recommendations

8.5.1.1 That the SHA, the PCTs and the Local Authorities work together to develop world class joint commissioning and funding arrangements for the range of step down, convalescence and social care intermediate beds.

8.5.1.2 The NHS and the Local Authorities work together to clarify the role of community beds/ community services, clarifying their disparate functions (medical convalescence to social care) and including them within commissioning plans that provide for integrated, seamless care.

9. Acute Services

9.1 Introduction

9.1.1 The Committee understands that the term "Acute Services" in the context of the strategy refers to unplanned emergency surgery and medical care. The Committee supports and endorses the proposals for the improvements in acute care. It has identified some issues that it believes need to be reflected in the adopted strategy. These are listed below.

9.2 Strategy

9.2.1 The Committee agrees with the need to improve the quality of urgent care to move the east of England nearer to best clinical practice. It supports the concept of specialisation and the development of clinical networks. The Committee welcomes the development of integrated graduated acute care across the spectrum of primary care, urgent care centres, A&E and specialised units. The Committee supports the senior clinician involvement in initial assessment arrangements.

Recommendations

9.2.1 That the SHA takes steps to improve the quality of urgent care in the east of England to bring it into line with best national and international practice.

9.2.2 That the SHA addresses the issue of the locations for different specialisations for emergency, unplanned acute care and recognises that 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.

9.3 Access

9.3.1 The Committee was concerned that it did not have before it information relating to the timescales and locations of the specialised centres and was not therefore able to make any judgements about the accessibility by patients to these services. The Committee welcomes the reconfiguration of triage and patient pathways to provide a patient focus and perspective. The Committee also welcomes the provision of 24/7 acute urgent services.

Recommendation

9.3.1 That at an early date the SHA publishes and consults on its proposals for the function and location of specialist centres.

9.4 Information Technology

9.4.1 The Committee was concerned to hear that the early promise of IT imaging has not yet been universally fulfilled and believes that such technological advances are essential to the operation of distributed clinical networks where specialists in one medical setting can review patient data and images from doctors in another location, which may be an ambulance

Recommendation

9.4.1 That the SHA supports action to improve the effective use of IT imaging as an essential feature of the network model of care.

9. Acute Services

9.5 Air Ambulance

9.5.1 The Committee welcomes the review of pre-hospital critical care. However the Committee believes that where core competencies are vital to the operation of the NHS they should be the subject of integrated governance, clinical standards, management arrangements and funding by the NHS. In this context the Committee is concerned that the Air Ambulance Service is subject to the vagaries of voluntary fund-raising. The Committee believes that where such services are a part of the core NHS service response they should be subject to a formal contract, with a proper service contract setting out planned deliverables.

Recommendation

9.5.1.1 The SHA and the East of England Ambulance and Paramedic Services set in place for the Air Ambulance Service appropriate integrated governance, clinical standards and management arrangements and that the Air Ambulance Service should be subject to a formal contract with a proper service contract setting out planned deliverables.

9.6 Outcome based indicators

9.6.1 The Committee believes that the Acute Care proposals should be underpinned by a suite of outcome based objectives, indicators and SMART targets.

Recommendation

9.6.1.1 That the SHA sets in place for acute care services a suite of outcome based objectives, indicators and SMART targets.

10. Long Term Conditions

10.1 Introduction

10.1 The Committee, while being broadly supportive of the proposals in respect of Long-Term Conditions has some concerns about the proposals set out in the strategy. These are set out below

10.2 Evidence and baseline information

10.2.1 The Committee considers that there is a lack of evidence and baseline information on the numbers of patients with each long-term condition to enable priorities to be established and any potential improvements to be captured. It believes that this is an issue which needs to be addressed if the strategy is to achieve its stated intentions.

Recommendations

10.2.1.1 That the SHA and each PCT uses levers (such as the Quality Outcomes Framework) to establish a baseline of the numbers of patients with each long-term condition, together with data about categorisation or intensity of condition where that is relevant and pertinent to the treatment and care of the patient with the condition.

10.2.1.2 That the SHA and each PCT identify the service gaps in the volume, nature and range of services it offers in respect of each condition, identifying where the intensity of the patients' conditions cannot be treated or where they cannot receive care locally.

10.2.1.3 That the SHA and the PCTs identify, for each locality, the number and distribution of specialist services for each long-term condition and from that identify how many long-term conditions do not have a locally accessible specialist services.

10.2.1.4 That the SHA, the PCTs and the Local Authorities' social services should set in place appropriate mechanisms for ensuring that patients receive integrated, seamless health and social care which is sufficiently flexible to cope with variations or deterioration in an individual patient's condition

10. Long Term Conditions

10.3 Adequate services in terms of diagnosis and care

10.3.1 Evidence was presented to the Committee on long term conditions. The Committee also heard and received written evidence from patients with ME/CFS, and their carers and advocates, that ME/CFS sufferers do not receive adequate services in terms of diagnosis and care. Concerns were raised with the Committee that some GPs and some PCTs do not recognise the incidence or nature of some long-term conditions The Committee understood that the experience of the ME/CFS patients may be indicative of low levels of care for other long term conditions.

Recommendations

10.3.1.1 That the SHA and its NHS partners should satisfy themselves that that the proposals set out under the Long Term Condition section of the strategy will meet the concerns expressed about adequate diagnosis and care.

10.3.1.2 That the SHA and the PCTs address the issue of the locations for different specialisations for long term care and recognises that while this may be a subject of local consultation there is also a need to take a strategic/regional view to ensure that there is equality of access to services across the region.

10.3.1.3 That the SHA and its workforce partners take steps to improve the understanding of, and diagnostic skills of, GPs, nurse practitioners and other health professionals in respect of some long-term conditions and to reflect that better understanding in the treatment and care offered to patients with those conditions.

10. Long Term Conditions

10.4 *Pre-diagnosis* information and advice and *post-diagnosis* treatment and care

10.4.1 The Committee believes that there are issues relating to two separate elements in respect of long-term conditions. First, there is the *pre-diagnosis* information and advice and secondly there is the *post-diagnosis* treatment and care. In respect of *pre-diagnosis* the Committee believes that there are benefits in supporting and enabling patients to understand that they have a responsibility for their own health, that they may need support in helping them to self examine and the confidence to report symptoms to the GPs. Secondly, there is the *post-diagnosis* support of people with long-term conditions as well as their carers and families. However this needs to be set in a comprehensive framework of ongoing care.

Recommendations

10.4.1.1 That the SHA and PCTs continue to develop processes and strategies for patients to take early responsibility for their own health, for undertaking self-examination and for identifying symptoms and reporting them to their GP early.

10.4.1.2 That the PCTs develop and adopt programmes of self-management of long-term conditions, including the wider roll-out of the expert patient programmes.

10.4.1.3 That the SHA and each PCT develop a range of local service information sources in respect of service availability and the availability of patient support services for long-term conditions.

Recommendations

10.4.1.4 That the SHA initiates a rapid introduction and roll-out of Personal Health Plans and patient-held budgets for patients with long-term conditions.

10.4.1.5. That the PCTs establish, within an overall strategic methodology, the varieties of care programmes that are needed to match the different conditions (and their severity) avoiding the provision of a "one size fits all" approach to care and treatment.

10.4.2 The Committee is also concerned to ensure that as services are provided closer to the patient the experience of the specialist is not lost. The Committee believes that appropriate arrangements should be set in place to ensure that this does not happen.

Recommendation

10.4.2.1 That appropriate arrangements should be set in place by the SHA, the PCTs and the Acute Trusts to ensure that as services are provided closer to the patient the experience of the specialist is not lost.

11. End Of Life Care

11.1 Introduction

11.1.1 The Committee, while endorsing the vision and wishing the NHS organisations in the east of England well in realising its vision in respect of End of Life Care, has some concerns which it wishes to bring to the attention of the SHA and local PCTs. They are set out below.

11.2 Shift in attitudes

11.2.1 The Committee believes that there is a need for a significant shift in attitudes if the SHA strategy's ambitions to secure better End of Life Care are to be achieved.

Recommendations

11.2.1.1 That the SHA and the PCTs address the issue of attitudes towards death and dying through promoting public debate and in personal dealings with dying patients, their carers and relatives

11.2.1.2 That the SHA and its workforce training partners develop the skill base of GPs, nurse practitioners and associated professions in the area of end of life care.

11.3 Appropriate commissioning arrangements

11.3.1 The Committee believes that the key to securing better End of Life Care lies in the development of appropriate commissioning arrangements.

Recommendations

11.3.1.1 That the SHA, PCTs and Social Services authorities ensure that there are appropriate joint commissioning arrangements for End of Life Care and that the funding mechanisms are aligned to deliver such arrangements.

11.3.1.2 That the SHA, the PCTs and Local Authorities and the Care Homes they commission from deliver the choice agenda for dying patients to ensure that they are able to die in their home or familiar settings, where that is their choice and ensure that at all times there is dignity in death.

11. End Of Life Care

11.4 Funding

11.4.1 In respect of the issue of funding for end of life services the Committee commends the ambition set out in the strategy but is concerned that while there will be savings from a reduction in inappropriate hospital admissions of dying people, there will be increased costs for the concomitant community services. The Committee notes that there will be a need for 24/7 services to be developed and that with the policy shift this will place additional financial pressures on local PCTs. The Committee recognises that there has been additional funding for PCTs. However it is not yet convinced that there is sufficient transparency in the funding model. Nor is the Committee yet confident that appropriate transitional funding can be put in place to meet the costs of the new 24/7 model, especially in the context of PCTs needing to recycle funding savings from reducing inappropriate admissions by the development of community services. The Committee is also concerned that the necessary funding regimes for the voluntary sector need to be set in place if they are to contribute their unique skill sets to the end of life care programmes.

Recommendations

11.4.1.1 That the SHA and PCTs ensure that 24/7 services, including access to out-of-hours drugs services, are made available, together with the necessary funding streams, to secure the ambitions of the End of Life Care strategy.

11.4.1.2. That the SHA and PCTs give further consideration to the balance between institutional hospice services and hospice at home services and in doing so ensure and secure the funding of this, and associated, voluntary services.

11.5 Service level disparities

11.5.1 The Committee shares the SHA's view that there are service level disparities in End of Life Care across the region. It also believes that while the strategy sets out the ambition it is as yet unclear as to how the success of the ends of life programmes can be judged.

Recommendations

11.5.1.1 That the Strategic Health Authority and PCTs in collaboration with national bodies and partners in other regions develop a suite of success measures and desired outcomes which can be developed into mechanisms that demonstrate measurable improvements in services.

12. Conclusions

12.1 The East of England Joint Health Overview & Scrutiny Committee welcomes the publication of the Strategic Health Authority's strategy *"Towards the best, together".* The Committee believes that the implementation of the strategy over the next decade should help to improve the health of the population of the east of England. The Committee has scrutinised each of the themes of the strategy and has made recommendations which it believes will support the implementation of the aims of the strategy.

12.2 The establishment of the Joint Committee was a significant step for local government in the east of England and I believe that the Committee has worked well. As Chairman I am very grateful to my fellow Councillors who served on the Committee for their diligence and their commitment to the task. They were required to assimilate a considerable volume of complicated material and did so with enthusiasm and good humour.

12.3 The Committee would like to place on record its thanks to those members of the public and representatives of patients who gave oral and written evidence to the Committee

12.4 As Chairman I would also like to place on record mine and the Committee's thanks to the clinicians, officers of the SHA and the scrutiny support officers from the participating authorities for their support and for the patience they showed in explaining the proposals so clearly and answering a myriad of questions.

12.5 I commend this report and its recommendations to the NHS and Local Authority organisations in the east of England.

Stephen Male
Chairman of the East of England Joint Health Scrutiny Committee
July 2008

Appendix A

Composition of the East of England Joint Health Overview & Scrutiny Committee

A.1 Following an initial informal meeting in December 2007, the East of England Joint Health Overview and Scrutiny Committee was formally established on 1st February 2008 by the ten social services authorities in the East of England Strategic Health Authority's area.

A.2 The Joint Committee comprises an elected councillor (or substitute member) from each of
a) **Bedfordshire County Council** – Councillor Stephen Male - Chairman
b) **Cambridgeshire County Council** – Councillor Lister Wilson
c) **Essex County Council** – Councillor Susan Barker (substitute Councillor Ann Naylor*)
d) **Hertfordshire County Council** – Councillor Bernard Lloyd* attended as substitute in the place of Councillor David Cullen who was indisposed for the duration of the Committee's work
e) **Luton Borough Council** – Councillor David Taylor (substitute Councillor John Titmuss*)
f) **Norfolk County Council** – Councillor Janice Eells
g) **Peterborough City Council** – Councillor Brian Rush
h) **Southend Borough Council** – Councillor Lesley Salter (substitute Councillor Alan Crystall*)
i) **Suffolk County Council** – Councillor Shirley Weymouth
j) **Thurrock Borough Council**
together with a co-opted member of the **East of England Regional Assembly** (Councillor Nick Hollinghurst (substitute Councillor Helen Levack*).

(NB * denotes a substitute member who attended at least one of the Committee's meetings)

A.3 All members were able to vote on equal terms and the cost of the Joint Committee was shared equally between the participating authorities.

Appendix B

Terms of Reference of the East of England Joint Health Overview & Scrutiny Committee

B.1 At its meeting on 1st February 2008 the Committee agreed that its terms of reference would be:

"to review and scrutinise, in accordance with Regulations under Section 7 of The Health and Social Act 2001 and the Secretary of State for Health's Direction of 17 July 2003, matters relating to the substantial developments or variations in NHS services in respect of the document "A Strategic Vision for the East of England NHS" being consulted upon by the relevant NHS bodies across the whole of the areas of the Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Luton, Norfolk, Peterborough, Southend, Suffolk and Thurrock Social Services Authorities and specifically including the documents, *"Improving Lives: Saving Lives", "Our NHS – Our Future" (the Darzi review*) and, when available, the East of England's Strategic Health Authority's 'Vision' document for Acute and other Health Services in the East of England, together with any relevant technical papers, including the Strategic Health Authority's and Primary Care Trusts' proposed plan(s) for implementing the proposals in "A Strategic Vision for the East of England NHS" over the next five years."

B.2 The strategic vision document was launched by the East of England Strategic Health Authority on 12 May 2008 under the title *"Towards the Best Together – A clinical vision for our NHS, now and for the next decade".* The Committee has therefore scrutinised the proposals in this document and also drew from the supporting papers from the reports of the review panels which undertook the clinical work prior to the launch of the strategy.

Appendix C

The Committee's Approach to its Work

C.1 After its initial meeting on **1 February 2008** the Committee met on **14 May 2008** to receive an overview briefing from officers of the Strategic Health Authority, particularly Simon Wood, Programme Director, Service Reconfiguration for the SHA and Lead for the vision, *Towards the best, together*. Mr Wood was supported by Ed Garratt, Head of Communications and Public Involvement at the SHA. At that meeting the Committee determined that it would review each of the main themes of the strategy. Accordingly it met on the following dates to review each aspect of the strategy:

23 June 2008 (informal evidence taking session as the committee was inquorate)

Long Term Conditions – the Committee heard from Dr Steve Laitner, Chairman of the Long Term Conditions Panel and officers of the SHA.
End of Life Care – the Committee heard from Dr Dee Traue, Palliative Consultant at Addenbrookes Hospital and Chairman of the End of Life Panel and officers of the SHA.

26 June 2008

Children's Services – in the absence of the Chairman of the Panel on Children's Services the Committee heard from Dr Linda Sheridan, a consultant in Children's Health and Dr Jill Challoner, also a consultant in Children's Health together with officers of the SHA.

3 July 2008

Staying Healthy – the Committee heard from Dr Denis Cox, Chairman of the Staying Healthy Panel, Dr Paul Cosford, Regional Director of Public Health, Dr Pam Hall Deputy Director of Public Health and other officers of the SHA.
Maternity & Newborn – the Committee heard

Appendix D

from Dr Boon Lim, Chairman of the Maternity and Newborn Panel, together with officers of the SHA.

7 July 2008

Mental Health – the Committee heard from Ms Gillian Oaker, Chairman of the Mental Health Panel and Pol Toner together with officers of the SHA.
Planned Care – the Committee heard from Dr Jane McCue, Co-Chairman of the Planned Care Panel and officers of the SHA.

9 July 2008
Acute Services - the Committee heard from Dr Robert Winter, Chairman of the Acute Care Panel and SHA Lead on Clinical Issues.

Review of the overall strategy, finance and workforce issues – the Committee heard from Dr Robert Winter and Simon Wood, Programme Director, Service Reconfiguration for the SHA and Lead for the vision, *Towards the best, together* along with other officers of the SHA.

C.2 The Committee also held a further meeting on **29 July 2008** to finalise the drafting of, and to approve the submission of this response from the Joint Committee to the Strategic Health Authority as its formal response to the invitation to respond to the consultation.

C.3 The Committee intends to reconvene following the SHA's consideration of the results of the consultation to formally make a determination on the adequacy of the consultation and to determine whether the final proposals from the East of England Strategic Health Authority are in the interests of health in the region, in accordance with the Committee's statutory responsibility.

Principles for Progress

1. A focus on prevention, health inequalities and timely interventions

2. Services focussed on the needs of the individual user and their carer

3. Services localised as much as possible, but centralised where appropriate

4. Services that are accessible and integrated, delivered by a flexible and skilled workforce

5. Partnership with others where possible, with patients always

6. Outcomes that deliver measurable and meaningful improvement.

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Customer Service Team

Report on the Committee's consideration of the East of England Strategic Health Authority's Strategic Plan

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