SOUTH TEES HEALTH SCRUTINY JOINT COMMITTEE

A meeting of the South Tees Health Scrutiny Joint Committee was held on 10 November 2011.

PRESENT: Middlesbrough Council:
Councillor Dryden (Chair)

Redcar and Cleveland Council:
Councillors I. Jeffrey and Mrs Wall.

OFFICERS: J Bennington and J Ord (Middlesbrough Council) and M. Ameen (Redcar & Cleveland Council).

PRESENT BY INVITATION: Councillor Brunton (Chair of Middlesbrough Overview and Scrutiny Board).

NHS Tees: A Greenley and C McEwan.

J Walker, GP, Chair of Eston Clinical Commissioning Group
Dr H Waters, Chair of Middlesbrough Clinical Commissioning Group.

APOLOGIES FOR ABSENCE were submitted on behalf of Councillors Cole and Lancaster (Middlesbrough Council) and Councillor Wilson (Redcar and Cleveland Council).

DECLARATIONS OF INTEREST

Name of Member	Type of Interest	Item / Nature of Interest
Councillor Mrs Wall	Personal/Non-Prejudicial	Any matters arising relating to North East Ambulance Service NHS Trust - related to a number of employees.

MINUTES

The minutes of the meeting of the South Tees Health Scrutiny Joint Committee held on 3 October 2011 were submitted and approved as a correct record.

SOUTH TEES HEALTH ECONOMY – FINANCIAL OUTLOOK

The Scrutiny Support Officer submitted a report the purpose of which was to introduce representatives from the local NHS and the Clinical Commissioning Groups (CCG) in South of Tees to present their views on the financial outlook for the South of Tees health economy. In order to assist deliberations a series of questions had been forwarded to the representatives prior to the meeting.

It was confirmed that the Middlesbrough Clinical Commissioning Group had been formed in May 2011 and met on a monthly basis and had set up five sub-committees focussing on referrals, acute care, planned care, unplanned care, prescribing and, finance and contracting.

Confirmation was given of good clinical engagement with one GP from each group on the Board of members the functions of which included involvement with Quality Innovation Productivity Prevention (QIPP) programme and organisational development.

In overall terms the current situation reflected four CCG across the Tees but the importance of ensuring that the correct structure was in place which was financially viable and with appropriate management costs was emphasised. The management of risk in terms of the size of CCG was also regarded as another important element which needed to be given careful consideration.

Issues to be determined included such matters as boundaries, authority of the CSGs needed to be sanctioned and delegated budgets.

As part of the overall engagement process it was confirmed that local pathfinder CCGs supported by NHS Tees would be raising awareness of local progress and seeking the views of patients, patient representatives and stakeholders on the vision for CCGs, priority areas and future mechanisms for communication and engagement.

It was suggested that careful attention needed to be given to striking the right balance when looking at minimising costs but at the same time ensuring that there was sound engagement locally. Members sought assurances as to how it would benefit patients whatever structure was adopted with particular regard to increasing NHS financial pressures. In response reference was made to clinicians taking a lead role and local authorities taking on public health responsibilities focussing on wider determinants of health. In terms of service delivery one of the main areas of focus related to ensuring that strategies were in place to meet the targets of QIPP.

The Joint Committee's attention was drawn to the areas of work by the Workstreams such as ongoing discussions with clinicians with regard to making improvements in terms of referral management. In response to Members' concerns that in certain circumstances there might be a risk of concentrating too much on achieving savings the NHS Tees representatives gave an assurance that the quality agenda remained so high a priority and continued as the main area of focus.

The Joint Committee was advised that significant improvement had been achieved in terms of collaboration with clinicians across primary and secondary care with the key aim of ensuring that patients received the appropriate management whilst in acute hospital settings but that the scope for developing more suitable primary care settings be pursued.

Although there was considerable financial pressures the NHS Tees representatives reiterated that many GPs were fully engaged and involved with examining how current procedures could be undertaken differently but with QIPP remaining at the forefront of any discussion.

An indication was given of significant ongoing work in terms of the STHFT's responsibilities in relation to community services and of other work such as that in relation to community care home settings to avoid unnecessary admission to A & E departments and re-admissions to hospitals.

Members referred to concerns which had been expressed in particular from elderly persons about an increasing trend for patients to see nurse practitioners rather than GPs who they had previously seen for many years. It was acknowledged that there were complex matters involved and there was a significant education issue to ensure that patients felt confident in the person they were seeing and that such a person was the most appropriate. It was confirmed that the issue was considered by the Clinical Commissioning Groups on a regular basis.

The Joint Committee reiterated the importance of ensuring that Joint Strategic Needs Assessments were aligned to developing appropriate commissioning plans. It was noted that a review of the JSNA was partially completed and that it was considered too early to consider a constructive view of commissioning intentions.

In order to become fully formed and autonomous CCGs and in a position to take on their statutory responsibilities for commissioning it was explained that each pathfinder CCG must apply for authorisation from the NHS Commissioning Board. Such a process included the submission of a Clear and Credible Plan, including initial Commissioning Intentions for the next three years to be submitted by January 2012.

AGREED as follows:-

1. That the local NHS and Clinical Commissioning Group representatives be thanked for the information provided and contribution to deliberations.

2. That a further update be provided in early 2012.