Minutes

Overview and Scrutiny Committee

23rd September 2015

Present

Councillors	Present	Councillors	Present
C Bailey	Yes	Mrs S Paul	Yes
K Bowers	Apologies	R Ramage	Yes
J Goodman	Yes	F Ricci	Yes
P Horner	Yes	B Rose	Yes
D Hufton-Rees	No	P Schwier	Yes
D Mann (Vice-Chairman)	Yes	C Siddall (Chairman)	Yes

Councillor Mrs J Beavis was also in attendance until 9.12pm.

7 **DECLARATIONS OF INTEREST**

INFORMATION: There were no interests declared.

In accordance with the Code of Conduct all Councillors remained in the meeting for all items and took part in the debate and decision thereon.

8 **PUBLIC QUESTION TIME**

INFORMATION: There were no questions asked or statements made.

9 **MINUTES**

DECISION: That the Minutes of the meeting of the Overview and Scrutiny Committee held on 15th July 2015 be approved as a correct record and signed by the Chairman.

10 **SCRUTINY REVIEW INTO HEALTH IN THE BRAINTREE DISTRICT – TERMS OF REFERENCE AND WORK PROGRAMME**

INFORMATION: Consideration was given to a report on the scrutiny review into health in the Braintree District which the Overview and Scrutiny Committee had agreed to undertake during the 2015/16 Civic Year. The Terms of Reference and work programme for the review were set out in the report.

The review would look specifically at the provision of health care for residents of the Braintree District with particular emphasis on access to primary health care and planning for future growth in the Braintree District. It was proposed that the review should be carried out over four separate sessions.

For further information regarding these minutes, please contact the Members and Governance Team on 01376 552525 or e-mail demse@braintree.gov.uk

The first session would take place on 23rd September 2015. This session would provide information about health services and the myriad of organisations which delivered these, and an insight into the main health priorities for the District. The second session would take place on 9th December 2015 and it would concentrate on GP provision and the service provided by the Clinical Commissioning Group. It was anticipated that the third session would take place in February 2016 (subsequently confirmed as 24th February 2016). This session would look at the District Council's role in health prevention and how the Council could implement and support appropriate alternatives to primary health care. The final session would take place on 9th March 2016 and it would review projected growth in the District and demographic trends and consider the impact these may have on the provision of health services.

DECISION: That the Terms of Reference and work programme for the Scrutiny review into health in the Braintree District be agreed.

REASON FOR DECISION: To inform the Overview and Scrutiny Committee's work.

11 **SCRUTINY REVIEW INTO HEALTH IN THE BRAINTREE DISTRICT – FIRST EVIDENCE GATHERING SESSION**

INFORMATION: Members were advised that this was the first session of the work programme for their Scrutiny Review into Health in the Braintree District.

The session would provide Members with an understanding of the structures within the NHS; an overview of the various health bodies such as GPs, Clinical Commissioning Groups, Trusts (Acute / Mental Health), NHS England, pharmacies, dentists, opticians etc. and how these were funded, commissioned, supported and delivered; and an understanding of the 'health profile' of the District. The following invitees had kindly agreed to participate in the scrutiny review and they attended the meeting to present information and to answer Members' questions:-

Dr James Booth - Vice-Chairman of Mid Essex Clinical Commissioning Group Board
Dr Mike Gogarty - Director of Public Health, Essex County Council
Mrs Caroline Rassell - Accountable Officer, Mid Essex Clinical Commissioning Group

Presentation by Dr Mike Gogarty - Director of Public Health, Essex County Council

- Overall life expectancy in the Braintree District is 80 years for a male and 83 years for a female
- The life expectancy gap for a male in the Braintree District ranges from the lowest at 75.6 years in Bocking North Ward to the highest at 88.7 years in Rayne Ward.
- The life expectancy gap for a female in the Braintree District ranges from the lowest at 78.7 years in Bocking North Ward to the highest at 88.2 years in Stour Valley North Ward.
- United Kingdom life expectancy is average compared to Europe overall. It is lower than the larger Western European economies, but higher than the Eastern European economies.
- Income deprivation is a key determinant of health. In the Braintree District, Bocking South Ward has the highest deprivation with 19.2% of the population classified as deprived and Rayne Ward has the lowest deprivation at 5.5%.

- One in five children in school Reception classes in the Braintree District is either overweight or obese. This is the highest in Essex.
- One in three children in school Year 6 classes in the Braintree District is either overweight or obese.
- Child excess weight in the Braintree District in school Reception classes is highest in Stour Valley South Ward at 31% and lowest in Rayne Ward at 8%.
- Child excess weight in the Braintree District in school Year 6 classes is highest in Stour Valley South Ward at 42% and lowest in Bocking North Ward at 20%.
- 24.5% of adults in the United Kingdom are obese which is poor compared to other European countries.
- 68.2% of adults in the Braintree District are obese.
- 56.2% of Braintree District residents state that their weekly physical activity is in accordance with the United Kingdom recommended guidelines (30 minutes of moderate/intensive activity five times per week) compared to the national average of 56%. Great Notley is the highest area of the District for activity and Bocking, Halstead and Witham are the lowest.
- The number of adults in the United Kingdom who smoke is lower than other countries in Europe. The prevalence of smoking amongst adults in the Braintree District has fallen over recent years at a faster rate than the rest of England to 17.6% in 2013. There were approximately 20,500 smokers in the District. Smoking is a key avoidable cause of death in the United Kingdom.
- Smoking costs the Braintree society an estimated £39m each year in terms of lost productivity (smoking breaks, sick days), health, social care and fires.
- 14 tonnes of cigarette waste was produced annually in the Braintree District of which more than three tonnes was street litter.
- The number of alcohol-related hospital admissions in the Braintree District had doubled over the 10 year period to 2014 and amounted to 1,298 males per 100,000 population and 665 females per 100,000 population although the overall value for the Braintree District was low compared to other parts of the Eastern region. However, alcohol was the biggest increasing cause of ill-health in the general population.
- Child well-being and educational outcome statistics indicated an increase in the level of inequality across Essex with the more affluent areas getting better and the poorer areas becoming worse off. The statistics for the Braintree District showed poor educational achievement compared to the level of affluence. Educational attainment was a determinant of affluence and deprivation was a cause of ill-health.
- The number of children in the Braintree District achieving a good level of development when starting school (Reception class) was the lowest in Essex at 57.1% generally and 35.6% for children in receipt of free school meals. Readiness for school was a key driver of future educational attainment.
- 47.4% of pupils in the Braintree District achieved five GCSE results at Grade A*-C including English and maths. This was low in comparison to other Authorities in England. The highest level of achievement was in the Stour Valley North and South Wards at 78% and the lowest was in Braintree South Ward at 36%.
- The number of hip fractures suffered by people in the Braintree District aged 65 and over was high in comparison to other Authorities in England. The highest number of hip fractures occurred in Bocking North Ward and the lowest number were in Rayne Ward.
- Steps taken by Essex County Council to improve public health included:-
  - Health checks
  - Health checks for senior citizens
  - Stroke prevention through atrial fibrillation best practice
  - Improved ‘falls’ services

    - Improved stroke services
    - Improved alcohol services
    - Improved obesity services
    - Support for the 'third sector' including winter warmth
    - Support for domestic abuse services
    - Improved drug services
    - Improved school health services
- Steps to be taken by Essex County Council to improve public health include:-
    - Improvements to blood pressure management
    - Improvements to depression management
    - Stroke prevention
    - Work to address mental health public health issues
    - Closer work with the Police and Crime Commissioner
    - Develop a clear joined-up 'early years' approach
    - Improve access to sexual health services
- Steps to be taken by Essex County Council in partnership with others to improve a broad range of determinants include:-
    - Influencing the Essex Economic Strategy
    - Developing a clear vision and strategic approach around 'early years'
    - Ensure that there is focus on inequalities and vulnerable people
    - To establish a link with 'place' commissioners eg. a joint public health report
    - Working with Environmental Health Officers on fast food outlets
    - Working with Job Centre Plus
    - Acting on opportunities with District and Borough Councils
- Steps which Braintree District Council can take to improve public health include:-
    - To 'own' public health
    - To drive economic development and regeneration
    - To support 'early years' opportunities
    - To support vulnerable people via a facilitative, flexible housing approach
    - To engage in the 'Making Every Contact Count' initiative
    - To continue to support physical activity and active transport
    - To ensure community safety
- How Essex County Council could help further:-
    - To fund the provision of public health expertise via the employment of an Officer by a mid-Essex local authority; to link the post to a local consultant in mid-Essex; and to provide the post with dedicated, recurrent funds in order to initiate small local schemes.
    - To support links with Councillors and Officers.
    - To re-visit the Health and Well-Being Board and its focus on local public health.

<u>Presentation by Mrs Caroline Rassell - Accountable Officer, Mid Essex Clinical Commissioning Group</u>

- The structure of the health service is complicated. Funding flows from the Department of Health to two main bodies which are Public Health England and NHS England.
- NHS England is a statutory organisation which has two key roles which are as a regulator of Clinical Commissioning Groups and as a buyer of services.
- There are two buyers of services in the system through which £1billion flows.
- NHS England is one of the buyers and it buys primary care services from eg. General Practitioners and specialist services from specialist hospitals located across

the Country eg. those dedicated to lung transplants. There are no such specialist hospitals in Essex.

- 80% of the available funding is passed to the 209 Clinical Commissioning Groups spread across the Country of which Mid Essex Clinical Commissioning Group is one.
- Clinical Commissioning Groups are statutory bodies and Member organisations. The Members are the local General Practitioners. The constitution of each Clinical Commissioning Group sets out the purpose and duties of the Group. The General Practitioners provide advice and drive forward the provision of services.
- The Mid Essex Clinical Commissioning Group is responsible for buying services from Hospitals, predominantly at Broomfield Hospital; mental health services; community services (eg. District Nursing and therapy); and it funds the ambulance service.
- The Mid Essex Clinical Commissioning Group funds also the provision of drugs prescribed by General Practitioners, and fully funded nursing care where required at one of nine care homes.
- Locally, NHS England in the East provides services via 47 General Practitioners and dentists and specialist services. There are seven Clinical Commissioning Groups in the East which provide services via five acute hospitals, two mental health providers, four community providers, and one ambulance trust in addition to funded prescription and nursing homes services.
- The Mid Essex Clinical Commissioning Group's budget for 2015/16 for the purchase of services amounted to £432 million. The Group was financially challenged.
- The amount of funding allocated to the Clinical Commissioning Group for the provision of services was calculated according to an NHS formula which was based on relative deprivation values and health outcomes. As health outcomes in Mid Essex were relatively good, the Clinical Commissioning Group's funding was reduced, but and it was expected to buy the same level of service. Based on a rate of £1,060 per head of the population, the Group should receive £14.4 million more than it actually did.
- Despite under-funding, critical friend conclusions had shown that the Mid Essex Clinical Commissioning Group's clinical outcomes were above average and that it was in the top quartile for the avoidance of potential years lost amongst males. The Group was the seventh lowest nationally for accident and emergency attendance rates, and the eleventh lowest nationally for non-elective admissions to hospital.
- In 2014/15 52% of the Mid Essex Clinical Commissioning Group's budget had been spent on the provision of acute hospital services mainly at Broomfield Hospital and Colchester General Hospital. The next biggest area of expenditure was GP prescribing which amounted to £53.7 million. Another large area of expenditure, which amounted £40.9 million, was community services which sought to care for people in their own homes to avoid admission to hospital.
- Performance by Clinical Commissioning Groups was highly regulated with targets changing frequently. This made the service complex and difficult to manage. National standards were monitored by regulators, quality standards were monitored by the Care Quality Commission, and the Better Care Fund was monitored by the Health and Well-being Board.
- The Care Quality Commission inspected the quality of health provision across eight core services namely accident and emergency; surgery; medicine including the care of older people; children and young people; maternity and family planning, end of life care; intensive/critical care; and outpatients. Services were assessed against five aspects which were safe; effective; caring; well-led; and responsive. Inspections were announced and lasted three to four days, followed by an

unannounced return visit usually within a month. Following the assessment, health providers were rated inadequate; requires improvement; good; or outstanding.

- Following a recent inspection by the Care Quality Commission, Broomfield Hospital had been assessed as requiring improvement and its accident and emergency service had been assessed as inadequate. The standard of performance was due predominantly to staff shortages. A detailed action plan for improvement had been agreed by the Care Quality Commission.
- The Mid Essex Clinical Commissioning Group would be required to deliver a balanced budget in 2015/16 which would necessitate some difficult and tough decisions all of which would be clinically led.
- Patient choice – Patients who need to see a consultant or a specialist as an outpatient are able to choose to go to any hospital or clinic in England offering NHS services for their first appointment. This is a legal right. Urgent referrals are excluded from the legal right to choice.
- Patients have a right also to choose which GP practice to register with. However, this was dependent on the GP practice having the capacity to take on additional patients as currently many practices were struggling to recruit GPs.
- In some circumstances patients have even greater choice over how their care is provided through the use of Personal Health Budgets (PHBs). These PHBs allowed patients to choose what services to 'buy' with their allocated NHS budget.
- Challenges being faced across the public sector included:-
  - Workforce and capacity
  - Engagement with and the expectation of the public
  - Finance
  - Regulation
  - Quality
  - Growth of population and age of population. Infill housing development causes problems in the provision of primary health care, whereas large scale developments enable better planning. New GP practices are generally viable with two or three GPs each being responsible for 1700 to 2000 patients.
- 'Livewell in Mid Essex' – working together to enable people to enjoy a healthy, safe and fulfilling life. It was hoped that this aspirational initiative could be taken forward to improve the health and wellbeing of people throughout their lives including:-
  - 'start well' (a healthy start in life: breastfeeding; childhood services; tackling childhood obesity; supporting children's mental health)
  - 'be well' (making a healthy choice: eating well; taking exercise; rapid support for illness and trauma)
  - 'stay' well' (mental wellbeing; supporting long-term illness)
  - 'age well' (remaining independent; managing dementia; planning care)
  - 'die well' (a dignified death: palliative support; support for carers /relatives)

  It was hoped that the 'livewell' initiative could be progressed in association with other organisations to provide a co-ordinated service without gaps in provision, or duplication, and to make the NHS 'local'.

<u>Summary of questions asked by Members of the Overview and Scrutiny Committee and the responses given by Dr James Booth, Dr Mike Gogarty and Mrs Caroline Rassell</u>

Question by Councillor Siddall – Are the people admitted to hospital due to alcohol issues in one particular age group?
Response by Dr Gogarty – Alcohol related admissions are not necessarily attributable to 'binge' drinking, but they could be due to liver problems related to years of alcohol abuse. The people tend to be older in age.

Question by Councillor Ricci – Are the programmes to tackle obesity, smoking and diet awareness flexible enough to tackle eg. people who over indulge on food and others who make poor food choices?
Response by Dr Gogarty – Two thirds of the population is obese and tackling this is a general issue. However, it is known for example that 57% of 'Reception Class' age children living in the Braintree District are not ready to start school and it could be that programmes should specifically target this issue. With regard to smoking, there is a general target, but particular attention is paid to people within deprived areas. Health checks were also concentrated on deprived areas. Some bespoke services were provided.

Question by Councillor Rose – With regard to childhood obesity, is damage done in a person's formative years carried through to later life? Why is there such a difference between the lower childhood obesity rate in the Uttlesford District and the higher rate in the Braintree District when the two areas are adjacent to each other geographically? Is the obesity problem made worse by children buying their own lunch on the way to school and making poor food choices such as sausage rolls and crisps?
Response by Dr Gogarty – The difference between the values for the Braintree and Uttlesford Districts is due to material wealth. Deprivation in the Braintree District is higher than in Uttlesford and all measures, except incidents of breast cancer, are intrinsically linked to deprivation. There has been a general worsening in the prevalence of childhood obesity and this tends to carry forward to adulthood. In addition, overweight parents tend to raise overweight children.
Response by Dr Booth – There is a big difference between tackling obesity amongst adults and obesity in children. It is easier to advise an adult patient that they are overweight than to inform a child and their parents. There are examples of significant obesity carrying through three or four generations of the same families. Many families do not eat meals together and they do not receive advice about sensible diets. There are challenges regarding the development of childhood diabetes and how to control what children eat, such as purchasing poor food choices on their way to and from school.

Question by Councillor Mann – As the readiness of children for school is key to their future are there any specific issues that influence it?
Response by Dr Gogarty – No specific issues have been identified for the Braintree District, but generally pre-school education, parenting and preparedness are key. The 'triple p' programme had been effective in tackling the problem. Children in receipt of free school meals were targeted. £2.5 million is required to tackle this difficult issue.

Question by Councillor Horner – Is the doubling of alcohol-related hospital admissions in the Braintree District due to a growth in the population?
Response by Dr Gogarty – It is not known as the rates are based on per 1000 people in the population.

Question by Councillor Bailey – Has the fundamental problem of obesity become socially normal as adverts on television tend to promote it?
Response by Dr Gogarty – Statistically obesity is normal as two thirds of the population is obese. This is a fact. Services are not targeted towards preventing obesity, but more towards weight loss and encouraging people to consume fewer calories.
Response by Dr Booth – Many people feel that being overweight has a stigma attached to it and bullying can take place amongst children. Whilst it is normal for people to be

overweight, there is still a social acceptability about subjecting people who are fat to ridicule and unkindness.

Question by Councillor Goodman – The figures quoted in Dr Gogarty's report relate to the year 2013/14 and show that adult physical activity in Witham is low. Have the figures been updated to take into account the impact of the recently opened Witham Leisure Centre?
Response by Dr Gogarty – The data is not updated frequently. It will be some years before the effect of Witham Leisure Centre will be known. Annual statistics are collated for children, which provide more up-to-date figures.

Question by Councillor Schwier – Could Braintree District Council and Essex County Council persuade the food industry to cut the sugar and fat content of their produce, and request the Government to decrease the rate of VAT on healthy food to 0% and to increase the rate of VAT on unhealthy food?
Response by Dr Gogarty – It is difficult for Essex County Council to influence issues nationally and there are many financial and market interests which people would not want to disrupt. A scheme has been operating in France which provides a joined–up, local approach to prevent childhood obesity. Essex County Council intends to fund a similar pilot scheme in the Braintree District in association with local supermarkets.

Question by Councillor Ramage – The figures regarding obesity are of concern, particularly those for children and the implications this could have on the health of people and cost of care in later life. Is there a forward plan to tackle the issue and is it all about diet? Why are today's children obese when they were not in the past?
Response by Dr Gogarty – The nature of foodstuff has changed and it now contains more refined sugar and fat. In addition, people generally use their cars more and children get less exercise than before. The first and urgent priority is to improve preventative services for smoking, alcohol consumption, high cholesterol and blood pressure. Currently, the public health grant is directed towards preventing people from being admitted to hospital or care homes and there is limited funding for children's services. The availability of finance determines what services are provided.

Question by Councillor Ricci – What is being done to increase staffing levels? Are people being encouraged to train as GPs and consultants?
Response by Dr Booth – It has been recognised that there are staff shortages. Discussions have taken place with schools to encourage students to train for careers in the health service. The decline in the number of GPs is a nation-wide issue which has happened quite quickly and there are now examples of GP practices closing. Many GPs are taking early retirement and this has led to an enormous 'experience deficit'. There are fewer Doctors per head of the population in the United Kingdom than in other European countries. There is a long lead-in time of at least ten years for people who wish to become a GP. Increased regulation in the health service and the degree of autonomy can put some people off becoming a GP, but it can also be very rewarding.

Question by Councillor Ricci - What percentage of expenditure on acute hospital services in Mid Essex is outsourced when there are insufficient staff resources to cope with demand?
Response by Mrs Rassell – Services are not outsourced, but patients have a choice to be treated in a private hospital. In Mid Essex £10 to 12 million is spent on care provided by a private hospital. The level of such expenditure cannot be controlled due to a patient's right to choose.

Question by Councillor Rose – Is equipment purchased either for the NHS generally or for the Mid Essex area in order to achieve cost savings through bulk purchases?
Response by Mrs Rassell – All Clinical Commissioning Groups and some hospitals in the area participate in a collaborative arrangement to purchase goods via Essex County Council in order to achieve the maximum cost benefit, although improvements could be made. Savings have been achieved through this process. However, this is not always possible if a prescriber requests a particular type of kit which may be more expensive.
Response by Dr Booth – Much of the expenditure required emanates from choices made by individual patients, for example the purchase of type 2 diabetes insulin kits. The requests received are often for more expensive types of equipment, which makes it more difficult to achieve the best deal in terms of value for money.

Question by Councillor Mann – The future of the St Lawrence GP Surgery in Braintree is uncertain. The building in which the Surgery is located has been sold and the current provider of GP services is subject to a one year contract. There are approximately 1400 patients registered with the Surgery who have been provided with a locum service. Other Surgeries in the town have indicated that they are unable to take on more patients. How will the service be provided in the future if GPs cannot be attracted to Braintree?
Response by Mrs Rassell – This situation will provide the health service with the opportunity to consider how primary care might be provided differently. Whilst there were originally eight GPs at the Surgery, it is unlikely that they would all be replaced. However, people did not necessarily have to see a GP and they could seek help from alternative sources instead such as a nurse, or a pharmacist. There would be a need in future to provide primary care in more innovative ways. In future, GP practices may provide a range of different services.
Response by Dr Booth – Primary care consists of a myriad of small, independent GP practices. Historically, these businesses were managed in the main by GP partnerships. This system operated well until the practices began to experience significant financial challenges. In particular, GP practices in Mid Essex relied on the mean price income guarantee (MPIG) which provided a reliable level of core funding. However, the Government had announced that this funding would be phased out. It was now difficult to attract GPs into partnership arrangements as they were required to make a financial investment and to take on business management responsibilities too. Higher salaries could be obtained by GPs working simply as Doctors within a practice without having to take on these additional commitments. GP practices were unable to expand without partners.

Question by Councillor Bailey - Councillor Bailey asked Mrs Rassell to provide a revised copy of the NHS structure flowchart which formed part of her presentation to include more details. Councillor Bailey questioned also if an agreement could be reached with the manufacturers of diabetes insulin kits to acquire these at a lower cost price on the basis of bulk purchases?
Response by Dr Booth – Individual GP practices are unable to achieve such economies of scale as they do not constitute a ‘national’ health service. Instead, a national service is provided by many independent purchasers and providers.

Question by Councillor Ramage – Will the Government’s proposal for a seven day a week health service be provided and is it feasible?
Response by Dr Booth – The idea is good in principle, but there is a difference between the provision of urgent care and routine care. It is possible to see a GP 24 hours a day/ seven days a week. However, the provision of routine care is a separate service. Some

GP practices offer out of hours appointments by starting early in the morning, finishing later in the evening and opening on Saturdays. If Doctors work on Saturdays and Sundays they should be entitled to time off during the week for which appropriate cover would have to be provided and paid for. It may not be possible to fund such arrangements unless extra funding is provided. Many Practices struggle to provide a five day service between the core hours of 8.00am and 6.30pm without the need to provide additional hours. The provision of primary care should be discussed nationally in order to agree a way forward. In particular, it was noted that a third of GP appointments were for non-clinical matters, but related instead to patients seeking to obtain 'a note from their Doctor' before eg. being permitted to take part in outdoor activities, for insurance purposes, or when applying for work. Such appointments took up valuable time and many GP Practices now refused to issue the letters requested. It was necessary to change the need for such letters to be obtained if the primary care system was to be improved.

At the conclusion of the discussion, the Chairman thanked Dr Booth, Dr Gogarty and Mrs Rassell for attending the meeting and for their contributions.

12 **TASK AND FINISH GROUPS 2015/16 – MEMBERSHIP**

INFORMATION: Consideration was given to a report on the proposed membership of the Task and Finish Groups which would undertake reviews during the 2015/16 Civic Year.

Members were reminded that the Overview and Scrutiny Committee had agreed that two Task and Finish Groups should be established to review 'apprentices for the Braintree District', and 'bus and community transport services in the Braintree District'. The Terms of Reference for each Group were set out at Appendix A to the report. Members of the Overview and Scrutiny Committee were requested to approve the membership of each Group. It was noted that the Chairmen of the Groups would be determined by the Groups themselves.

DECISION:

(1) That the Task and Finish Group reviewing Apprentices for the Braintree District comprises:-

Councillors M Banthorpe, K Bowers, S Canning, Mrs M Cunningham, M Dunn, H Johnson, Mrs S Paul and Mrs L Walters (eight members).

Note: Councillor C Bailey had expressed an interest in being a member of this Group within the agreed timescale, but his name had been omitted from the published membership list in error. In the circumstances, the Chairman of the Overview and Scrutiny Committee had subsequently agreed to Councillor Bailey being included as a member of the Group making a total of nine members.

The full membership of the Group therefore is:-

Councillors C Bailey, M Banthorpe, K Bowers, S Canning, Mrs M Cunningham, M Dunn, H Johnson, Mrs S Paul and Mrs L Walters (nine members).

(2) That the Task and Finish Group reviewing Bus and Community Transport Services in the Braintree District comprises:-

Councillors Mrs J Allen, Mrs M Cunningham, A Hensman, Mrs I Parker, Mrs J Pell, Mrs L Walters and Mrs S Wilson (seven members).

Note: Councillor J Goodman had expressed an interest in being a member of this Group within the agreed timescale, but his name had been omitted from the published membership list in error. In the circumstances, the Chairman of the Overview and Scrutiny Committee had subsequently agreed to Councillor Goodman being included as a member of the Group making a total of eight members.

The full membership of the Group therefore is:-

Councillors Mrs J Allen, Mrs M Cunningham, J Goodman, A Hensman, Mrs I Parker, Mrs J Pell, Mrs L Walters and Mrs S Wilson (eight members).

REASON FOR DECISION: To agree the Membership of the Task and Finish Groups for 2015/16.

13 **DECISION PLANNER**

DECISION: That the Decision Planner for the period 1st October 2015 to 31st January 2016 be noted.

The meeting commenced at 7.15pm and closed at 9.17pm.

Councillor C Siddall
(Chairman)