KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 25 March 2011.

PRESENT: Mr N J D Chard (Chairman), Mr B R Cope (Vice-Chairman), Mr N J Collor, Mr A D Crowther, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mrs J A Rook, Mr C P Smith, Mr R Tolputt, Mr A T Willicombe, Cllr J Cunningham, Mr M J Fittock Mr R Kendall

ALSO PRESENT: Mr R Brookbank, Su Brown, Cllr Gordon Court, Cllr R Davison, Mr Ray Harris, Mr R Kenworthy, Mr J Larcombe

IN ATTENDANCE: Mr P D Wickenden (Overview, Scrutiny and Localism Manager) Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee)

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Expression of Thanks

The Chairman and Committee thanked the Overview, Scrutiny and Localism Manager for all his hard work since the creation of HOSC and wished him well in his new role within a different part of Kent County Council.

3. Minutes
(Item 4)

RESOLVED that the Minutes of the Meeting of 4 February 2011 are recorded and that they be signed by the Chairman.

4. Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust: Update.
(Item 5)

(1) The Chairman introduced the item and explained that, in connection to this issue, it was a positive sign that the work of Kent County Council and the county's MPs had delivered a way forward on improving the A21.

(2) One Member expressed the view that the popularity of the new Pembury Hospital was also a positive sign.

(3) RESOLVED that the Committee note the attached correspondence.

5. Proposal to Establish Informal HOSC Liaison Groups
(Item 6)

(1) The general principles behind the idea of establishing informal groups were generally approved by the majority of Members of the Committee. A number of potential issues were raised as to how these would work with locality boards, Borough and District Councils as well as Town and Parish Councils and the developing GP Commissioning Consortia. More broadly the point was made that with so much change going on the health economy, there was a danger in establishing structures which would soon need to be changed.

(2) Specifically the point was made that small groups tasked with exploring a particular issue, rather than broadly liaising with a Trust could add more value.

(3) From the perspective of LINks, the question was raised as to how the proposed groups would work with LINk, particularly as LINks worked with Canterbury Christ Church University in producing comments for provider Trust Quality Accounts. The offer was made to share this work with the Committee.

(4) The Chairman agreed that many valid points were raised and stated that a refreshed paper would be presented to the Committee at the following meeting of the Committee.

6. Safe and Sustainable - A New Vision for Congenital Heart Services in England
(Item 7)

(1) One Member expressed the view that the consensus on the proposals seemed to be that reduction in the number of specialist centres was necessary, but that the real issue was which ones would be the ones to close.

(2) RESOLVED that the Committee agree that a regional response to the consultation be agreed through the South East Coast HOSC Chairman network.

7. NHS Financial Sustainability. Part 1: Commissioning.
(Item 8)

Bill Jones (Interim Director of Finance, NHS Eastern and Coastal Kent), Dr Mike Parks (Medical Secretary, Kent Local Medical Committee), Daryl Robertson (Deputy Chief Executive, NHS West Kent) and Di Tyas (Deputy Clerk, Kent Local Medical Committee) were in attendance for this item.

(1) The Chairman introduced the first of three meetings on the topic of NHS Financial Sustainability by giving his view that the question was not about the overall level of Government funding to the NHS, but rather the issues of whether Kent was receiving its fair share and how resources were prioritised locally. The intention was for the Committee to produce recommendations at the end of the three meetings and suggestions were invited from Members.

(2) One of the key issues discussed was that of legacy debt, where there was the risk that GP Commissioning Consortia (GPCC) may take over full commissioning responsibility from Primary Care Trusts (PCTs) in 2013 with inherited debt. One Member explained how this had been an issue in the past

when PCTs were established and reorganised and that there was an argument for saying that this had proved a distraction from improving local health services. Another Member explained how there needed to be an awareness of the different kinds of legacy debt, including straightforward overspends from the previous financial year, as well as ongoing commitments.

(3) Representatives from the NHS explained that both PCTs in Kent were going to break even at the end of this financial year, and that current spending information was available after two weeks so that commissioners were not in a position where spending was authorised after the budget had already been allocated.

(4) Colleagues from the NHS indicated the clear summary of the PCT allocation formula available in the Agenda and summarised even further by explaining that it was larger based on population, with an element of weighting around deprivation. Concern was expressed by Members about the level of detail the allocation formula went into and whether it went into sufficient detail to pick up the pockets of severe deprivation that existed across Kent. The offer was made to provide further details on the per capita funding and the formula itself.

(5) There was also sometimes a difference between a PCT's actual allocation and its target allocation, but both Kent PCTs were on target. There was some discussion about the actual per capita allocation for Kent. In terms of the demographic challenge in future health funding, that of ageing was highlighted as significant in that people aged under 50 consumed relatively few health resources, and most were used in the last two years of a person's life.

(6) A question was asked about the additional funding of £16 million made available to the PCTs to support social services and it was explained that the NHS and Kent County Council had already agreed on how this would best be used.

(7) Details were requested around the £2 per head allocated to support the development of GPCC. Representatives from the NHS explained that a distinction needed to be made between management costs and running costs, and this question needed to be seen in the context of the 40% reduction in management costs currently being made by PCTs, involving redundancies. Current running costs at PCTs were about the equivalent of £40 per head, but that GPCC were expected to have running costs of between £25 and £30.

(8) On pharmacy costs, it was explained that the prices were set nationally and this was an area where the finances could be used up rapidly.

(9) A representative from the Kent LINk raised the issue of PCTs consulting over recent measures both had taken to prioritise treatments in order to achieve financial balance. The opinion was given that while the consultation period of 3-10 December for NHS West Kent was too short, NHS Eastern and Coastal Kent did not hold any consultation.

(10) A number of issues were raised around the proposals in the NHS White Paper and Health and Social Care Bill. One Member felt that the proposed Health and Wellbeing Board would benefit from a greater degree of Member

involvement than was proposed in the minimum Health and Wellbeing Board membership requirements. Another Member hoped greater clarification would become available around what precisely the NHS Commissioning Board would commission against what the GPCC would be responsible for.

(11) There was a lot of discussion around the precise number and size of the developing GPCC, a question which Members hoped there would be a final and definitive answer as soon as possible. Financially the GPCC would be subject to the same rules as PCTs and would have an Accountable Office and Chief Financial Officer, as well as a support organisation.

(12) It was explained that at present there were around 12 developing consortia, the majority of which were in the Eastern part of the county, two of which were single practices. The representative from the Kent Local Medical Committee explained that this number was likely to change as a small single practice consortium was unlikely to receive authorisation from the NHS Commissioning Board and there was guidance from the British Medical Association to the effect that a consortia would need to cover 4-500,000 people to be effective. As a related supplementary point, a representative of the NHS explained that smaller consortia would experience a higher financial risk, particularly around low volume, high cost procedures, so there was a need for risk sharing between GPCC.

(13) Three models of GPCC were generally acknowledged as being workable:

1. A free standing large consortium;

2. A large consortium with a locality structure; and

3. Small consortia forming a federation.

(14) All models were likely to develop in Kent. Depending on how they were counted, 3-5 were likely across the County.

(15) It was generally agreed that one of the main challenges these GPCC would face would be resolving the tension between local freedoms around commissioning and what is sometimes referred to as the ‘postcode lottery’ where people receive different services depending on where they live. The view was expressed by the representative on the Kent Local Medical Committee that the tension needed to be accepted as differences between areas was likely. However, the point was also made that the distinction needed to be made between the equity of outcomes and the equity of service provision between GPCC areas, with the former being more important.

(16) Members felt that the following information would be useful in enabling them to properly pursue the issue of NHS Financial Sustainability in depth:

1. Details around the per capita aspect of PCT allocations;

2. Clarity around the future number of GPCCs, as well as their geographic coverage;

3. Further information around how areas of severe deprivation impacted the allocations received by commissioners;

4. Further detail around running cost comparisons between organisations; and

5. Granularity concerning the possible legacy debts which could accrue to GPCC.

(17) AGREED that Members delegate authority to the Head of Democratic Services and Local Leadership in consultation with the Chairman, Vice-Chairman and Group Spokesmen to prepare a list of recommendations to present to a future meeting of the Committee for discussion and agreement prior to their submission to the NHS for a response.

(18) AGREED that Members assist this process by suggesting recommendations to the Committee Officers following each meeting.

8. Date of next programmed meeting – Tuesday 19 April 2011 @ 10:00 am
(Item 9)