HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 19th April, 2011

10.00 am

Darent Room, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 19th April, 2011, at 10.00 am		Ask for:	**Paul Wickenden**
Darent Room, Sessions House, County Hall, Maidstone		Telephone:	**01622 694486**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (10):	Mr N J D Chard (Chairman), Mr B R Cope (Vice-Chairman), Mr R Brookbank, Mr N J Collor, Mr A D Crowther, Mr K A Ferrin, MBE, Mr C P Smith, Mr K Smith, Mr R Tolputt Mr A T Willicombe
Labour (1):	Mrs E Green
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Councillor J Cunningham, Councillor C Kirby, Councillor M Lyons and Councillor Mrs M Peters
LINk Representatives (2)	Mr M J Fittock and Mr R Kendall

Webcasting Notice

Please note: this meeting may be filmed for live or subsequent broadcast via the Council's internet site – at the start of the meeting the Chairman will confirm if all or part of the meeting is being filmed.

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UNRESTRICTED ITEMS
(During these items the meeting is likely to be open to the public)

Item Timings

1. Introduction/Webcasting

2. Substitutes

3. Declarations of Interests by Members in items on the Agenda for this

meeting.

4. Minutes (1 - 6)

5. Proposal to Establish Informal HOSC Liaison Groups (7 - 8)

6. NHS Financial Accountability: Part 2 - Acute Sector (9 - 52)

7. Date of next programmed meeting – Friday 10 June 2011 @ 10:00

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services and Local Leadership
(01622) 694002

11 April 2011

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

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)

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By: Peter Sass, Head of Democratic Services and Local Leadership

To: Health Overview and Scrutiny Committee – 19 April 2011

Subject: Proposal to establish informal HOSC liaison groups

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1. Background.

(a) At the previous meeting of the Health Overview and Scrutiny Committee members discussed the proposal of establishing informal HOSC liaison groups as one possible way of realising the twin challenge of deepening Members' understanding of health services in Kent and improving the process of prioritisation.

(b) 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.

(c) With these issues in mind, the Chairman undertook to present a revised paper at the subsequent meeting of the Committee.

(d) Given the situation of ongoing change, it may be that a more ad hoc arrangement will be more appropriate in the first instance. For example, where a Member wished to lead an informal liaison group with any of the main provider Trusts listed below, possibly with the intention of produce a response to the Trust's Quality Account, this could be done without any requirement for all Trusts to be covered, or for a formal reporting mechanism to be out in place. There may also be specific issues which will arise, possibly involving more than one Trust, where a small group of Members may wish to take a lead for a time-limited piece of work such as a Task and Finish Group Report.

(e) Main provider Trusts:

- Dartford and Gravesham NHS Trust
- East Kent Hospitals NHS University Foundation Trust
- Kent and Medway NHS and Social Care Partnership Trust
- Kent Community Health NHS Trust
- Maidstone and Tunbridge Wells NHS Trust
- Medway NHS Foundation Trust
- South East Coast Ambulance Service NHS Foundation Trust

2. Recommendations

Members of the Committee are asked to delegate authority to the Head of Democratic Services and Local Leadership in consultation with the Chairman, Vice-Chairman and Group Spokespersons, to establish informal HOSC Liaison Groups where a Member of the Committee wishes to lead one, or establish a time-limited Task and Finish Group where this is the more appropriate way of dealing with a specific issue.

By: Peter Sass, Head of Democratic Services and Local Leadership

To: Health Overview and Scrutiny Committee – 19 April 2011

Subject: NHS Financial Sustainability: Part 2 – Acute Sector

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1. Background

(a) Following the approval of the Forward Work Programme of the Health Overview and Scrutiny Committee on 7 January 2011, this will be the second of three meetings dedicated to the topic of NHS Financial Sustainability. In overarching terms, the intention is to determine answers to the following strategic questions:

1. What are the challenges to ensuring the NHS in Kent is financially sustainable?

2. Are there any implications for the range and quality of health services available to the people of Kent as a result of any measures being taken to achieve or maintain financial sustainability?

(b) The focus of the previous meeting was on the Primary Care Trusts. The four main Acute Trusts have been invited to today's meeting (19 April). The intention is to consider mental health services, community health services and ambulance services at the meeting of 10 June.

(c) For background information, the questions asked of the Acute Trusts in advance of the meeting are contained in the Appendix to this report.

2. Recommendations

The Committee is asked to agree the following:

1. Members are asked to 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.

2. To assist this process, Members are asked to suggest recommendations to the Committee Officers following each meeting.

Appendix – Questions from the Health Overview and Scrutiny Committee for the meeting of 19 April 2011.

1. Why is achieving financial balance across the local health economy important and what are the potential consequences of not doing so?
2. What kinds of measures have been taken in 2010/11 in terms of changing what services you provide and the way in which they are provided within your organisation in order to try and achieve financial balance?
3. What kinds of measures are being considered for 2011/12?
4. What do you see are the main challenges to achieving financial balance across the health economy as a whole?
5. What has been the impact of the NHS Operating Framework for 2011/12 and the financial settlement for this next financial year?
6. How is the QIPP challenge being met within your organisation?
7. Are there any particular demographic trends in Kent that will have an impact on the kinds of services you provide?

By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee, 19 April 2011

Subject: NHS Financial Sustainability. Part 2: Acute Sector.

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1. Introduction

(a) The previous Background Note on NHS Financial Sustainability provided an overview of NHS Finances. The focus then was on Primary Care Trusts (PCTs) who are responsible for around 80% of NHS funding. Budgets are allocated to individual PCTs using a weighted capitation formula. PCTs use this money to commission services to meet the health needs of their populations. For reference, a selection of information around PCT allocations for 2011/12 in Kent and Medway is contained in Section 4.

(b) The focus of this Note is on the acute sector. There are four acute hospital Trusts based in Kent and Medway providing secondary care and hospital based healthcare services. They also provide a range of tertiary services (more specialised care) as well as services in the community. These are:

1. Dartford and Gravesham NHS Trust
2. East Kent Hospitals NHS University Foundation Trust
3. Maidstone and Tunbridge Wells NHS Trust
4. Medway NHS Foundation Trust

(c) Under the current proposals as set out in the NHS White Paper and Health and Social Care Bill, all NHS Trusts are to become Foundation Trusts (or part of an FT) by 1 April 2014 and NHS Trust legislation would be repealed (meaning non-FT NHS Trusts will not exist). Monitor currently regulates FTs but under the proposals it would become the economic regulator for the health sector. A Provider Development Authority will be set up to performance manage NHS Trusts until they become Foundation Trusts; this Authority will then be wound down. A number of changes are also being made to the governance and financial freedoms of FTs.

(d) As things are now, there are a number of differences between NHS Trust and NHS Foundation Trust (FT) status. One of the areas of difference is around financial duties:

1. NHS Trusts have a duty to break even, meaning that their expenditure must not exceed their income, taking one financial

year with another. Spending on capital and cash held must be within certain limits.

2. FTs are not statutorily required to break even, but must achieve the financial position set out in their financial plan. One main measure of an FT's financial performance is EBITDA (earnings before interest, tax, depreciation and amortisation)[1].

2. NHS Finances – Acute Sector

(a) The majority of the income received by NHS Trusts and FTs comes from the commissioning process with PCTs and other NHS Trusts[2]. A little over 50% of acute trust income comes from the Payment by Results (PbR) tariff, which equates to around a third of PCT budgets. Providers also receive income from locally agreed payments which do not come within the scope of PbR. Some hospitals receive funding for education and training and/or research and development[3].

(b) PbR was introduced in 2003/04 and was designed to link the payments made to healthcare providers (NHS Trusts, FTs and the independent sector) with the activity undertaken by them. It currently covers the majority of acute inpatient and outpatient care as well as accident and emergency. For example, the tariff is £59 for a minor A&E attendance and £8,226 for a coronary artery bypass graft[4].

(c) A distinction is made between currencies and tariffs in NHS finances. A currency is the unit of healthcare for which a payment is made and the tariff is the price paid for that unit of healthcare.

(d) The tariff prices are largely based on the reported average cost of services. In 2010/11, best practice tariffs determined by best clinical practice rather than average cost was introduced for a small number of area and these are likely to expand significantly in the future.

(e) Unbundling a tariff refers to occasions when the individual service elements of a care pathway is separated out so that it is possible to commission them separately.

(f) The tariff may be adjusted for long/short stays, specialised services or for supporting particular policy goals. Taking this into account, the tariff received by a provider is multiplied by the market forces factor (MFF).

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[1] Academy of Medical Royal Colleges and Audit Commission, *A Guide to Finance for Hospital Doctors*, July 2009, p.23, http://www.audit-commission.gov.uk/health/audit/financialmgmt/hospitaldoctors/Pages/hospitaldoctors9jul2009.aspx

[2] Ibid., p.15.

[3] Department of Health, *A simple guide to Payment by Results*, September 2010, p.63, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119985

[4] Ibid., p.8.

This is nationally determined and unique to each provider. This is used to reflect the fact that providing services in some areas of the country is more expensive than in others due to staff costs, land and so on.

(g) PbR income can thus be set out as: activity x price x MFF[5].

(h) There are two versions of the MFF index. The first is the underlying index used in the weighted capitation formula and the second is the payment index used in PbR.

Table 1: Market Forces Factor[6]

Trust	**Market Forces Factor Payment Index Value for 2010/11**
Dartford And Gravesham NHS Trust	1.149808
East Kent Hospitals University NHS Foundation Trust	1.052939
Maidstone And Tunbridge Wells NHS Trust	1.111648
Medway NHS Foundation Trust	1.102137

(i) NHS standard contracts are used by commissioners when contracting healthcare services. The contract includes activity plans. If there is a difference between the value of the activity and the planned contract value, this may result in an additional payment being made by the commissioner to the provider, or a refund from the provider to the commissioner[7].

(j) The Commissioning for Quality and Innovation (CQUIN) payment framework is a national framework within which local quality improvement goals can be agreed between commissioner and provider. A proportion of provider income is made conditional on achieving the goals of the CQUIN scheme. In 2011/12 the full CQUIN payment value is 1.5% of the Actual Outturn Value of the provider contract[8].

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[5] Ibid. p.14.
[6] Information for Table 1 taken from: Department of Health, *2010-11 tariff information spreadsheet*, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_115898.xls#'13. MFF Index Values'!A1
[7] Department of Health, *A simple guide to Payment by Results*, September 2010, p.15, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119985
[8] Department of Health, *Using the Commissioning for Quality and Innovation (CQUIN) payment framework – A summary guide*, 20 December 2010, p.6, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_123008.pdf

(k) The private finance initiative (PFI) is a way of funding major capital investments in the NHS. Contracts with the private consortia that design and build hospitals (for example) typically last for 30 years. The NHS Trust or FT leases the building during this time. PFI scheme assets and liabilities are generally included in the Statement of Financial Position of both NHS Trusts and FTs[9].

(l) There are two PFI schemes related to Acute Trusts in Kent - Dartford and Gravesham NHS Trust and Maidstone and Tunbridge Wells NHS Trust[10].

(m) Under the proposals contained in the NHS White Paper, *Equity and Excellence: Liberating the NHS*[11], and the Health and Social Care Bill[12] currently progressing through Parliament, the majority of health services will be commissioned by GPs and their practice teams through consortia. This will include the majority of services in the acute sector.

(n) Under the same proposals, some acute sector services will be commissioned by the NHS Commissioning Board as it will be responsible for commissioning a number of specialised services currently commissioning regionally or nationally. The NHS Commissioning Board will also commission primary care services such as community pharmacy, ophthalmology, dentistry along with primary medical services provided by GPs.

3. Any Willing/Qualified Provider

(a) The areas covered by patient choice, and the Any Willing Provider model (AWP), will be gradually extended in the future. The 2011/12 Operating Framework made clear that AWP will be introduced for community services during 2011/12.[13]

(b) On 30 March 2011, the Department of Health published further details on provision in *Making Quality Your Business. A guide to the right to provide*[14]. This document shifted to discussing patient choice of Any

[9] Audit Commission and Healthcare Financial Management Association, *NHS Trust accounts A guide for non-executives* and *NHS foundation trust accounts A guide for non-executives*, 2010, http://www.audit-commission.gov.uk/health/audit/financialmgmt/nhsaccountsguidesfornonexecutives/pages/default.aspx

[10] Department of Health, *New hospital schemes*, November 2010, http://www.dh.gov.uk/en/Managingyourorganisation/NHSprocurement/Publicprivatepartnership/Privatefinanceinitiative/Newhospitalschemes/index.htm

[11] http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm

[12] http://services.parliament.uk/bills/2010-11/healthandsocialcare.html

[13] Dear Colleague Letter from Sir David Nicholson, NHS Chief Executive, *Equity and Excellence: Liberating the NHS – Managing the Transition*, 17 February 2011, p.14, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124479.pdf

[14] Department of Health, 30 March 2011, *Making Quality Your Business. A guide to the right to provide*,

Qualified Provider (AQP). It provides the following outline of how AQP will work in the future:

1. "Patients choose any provider who meets NHS standards and prices. Money follows them and the choices they make about where and by whom to be treated."

2. "To qualify as an AQP, providers will be subject to a qualification process. They will be required to show that they can meet the conditions of their licence with CQC and/or Monitor (if necessary), provide safe quality services to the contractual standards set by the NHS Commissioning Board and meet NHS prices – either set nationally or locally."[15]

(c) This same document also provided information on the development of staff-led enterprises through right to provide (R2P).

1. "At the widest level, the right to provide is for all staff working within health and social care. Depending on where you work, the process you go through will differ."[16]

4. NHS Operating Framework

(a) The NHS Operating Framework for 2011/12 was published by the Department of Health the same day as the PCT allocations were announced (15 December 2010). This document sets out what the NHS needs to achieve during what it refers to as a 'transition year'[17].

(b) The key points of the NHS Operating Framework for 2011/12 are as follows:

1. Average growth in PCT recurrent allocations of 2.2%.

2. PCTs will receive allocations totalling £648 million to support social care in addition to the £150 million funding for reablement services incorporated into recurrent PCT allocations.

3. The delivery of the QIPP (Quality, innovation, productivity and prevention) challenge of £20 billion efficiency savings for re-investment has been extended by one year to the end of 2014/15.

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http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125578

[15] Ibid., p.32.

[16] Ibid., p.8.

[17] Department of Health, *NHS Operating Framework 2011/12,* 15 December 2010, p.3, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122738

4. No automatic capital allocation for PCTs – any capital funding to be granted on a case-by-case basis.

5. An overall tariff reduction between 2010/11 and 2011/12 of 1.5%.

6. New outpatient attendance tariffs to be introduced. New currencies and tariffs to be developed (and led locally).

7. Hospitals will not be reimbursed for emergency readmissions within 30 days of a discharge from an elective admission. Other readmission rates to be agreed locally.

8. Where providers and commissioners agree, services can be offered below the tariff price.

9. Strategic Health Authorities are to oversee the development of PCT 'clusters' with a single executive team to oversee the transition and support emerging GP consortia (including the assignment of PCT staff to consortia).

10. GP consortia will not be responsible for PCT legacy debt prior to 2011/12. PCTs and consortia to work closely together to prevent PCT deficits prior to 2013/14, when GP consortia will have their own budgets.

11. Developing consortia will receive £2 per head to support this process. Running costs of £25 to £35 per head are expected by 2014/15.

12. A number of new commitments were made on health visitors, family nurse partnerships, the cancer drugs fund, military and veterans' health, autism, dementia and carers support.

13. The areas listed as areas for improvement include healthcare for people with learning disabilities, child health, diabetes, violence, respiratory disease and regional trauma networks.

(c) QIPP (Quality, Innovation, Productivity and Prevention) is a series of 12 workstreams[18] aimed at making efficiency savings to be reinvested in services. These twelve are divided into three areas, as set out in the following table:

[18] Department of Health website, http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPP/index.htm

Table 2: QIPP Workstreams[19]

Commissioning and Pathways	Provider Efficiency	System Enablers
• Safe care • Right care • Long term conditions • Urgent and emergency care • End of life care	• Back office efficiency and optimal management • Procurement • Clinical support • Productive care • Medicine use and procurement	• Primary care commissioning • Technology and digital vision

4. PCT Allocations for 2011/12.

Table 3: PCT Allocations in the South East for 2011/12[20]

PCT	2011/12 Total Revenue Allocation (£000s)	Total Revenue Allocations Per Head (£)
Brighton and Hove City	481,688	1,822
East Sussex Downs and Weald	567,802	1,692
Eastern and Coastal Kent	1,277,363	1,725
Hastings and Rother	333,765	1,900
Medway	435,279	1,601
Surrey	1,683,186	1,523
West Kent	1,027,962	1,499
West Sussex	1,299,123	1,615

[19] Adapted from Department of Health, *QIPP workstreams*, http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPPworkstreams/index.htm
[20] Extracted from Department of Health, *Exposition Book 2011-12*, (Book A), 8 March 2011, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124949

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Kent ME14 1XQ

By email and post

Our Ref: SB/PM/jc

6 April 2011

From the Chief Executive: Stuart Bain

Dear Nick

Thank you for your letter dated 3 March 2011. As Chief Executive of East Kent Hospitals University NHS foundation Trust, I will be pleased to attend the KCC Health Overview and Scrutiny Committee at 10:00 on 19 April 2011. As requested, my email address is stuart.bain@ekht.nhs.uk.

Please find below, the answers to the specific questions you raise in your letter, and which I think also cover the two areas that the Committee wish a greater understanding of:

1. **Why is achieving financial balance across the health economy important and what are the potential consequences of not doing so?**

   Achieving financial balance is a requirement of our Terms of Authorisation as a Foundation Trust and without financial balance across the whole health economy in East Kent runs the risks of temporary or permanent unplanned closures or changes to health service provision. Indeed without year end surpluses East Kent Hospitals University NHS Foundation Trust (EKHUFT) will not be in a position to invest in new services, technologies, drugs, buildings or increased staffing levels. Recovering any previous overspends will also mean less money available for patient care. In the new "Liberated NHS" this may become even more difficult as other willing health service providers may take the routine and financially beneficial services away from NHS acute hospital providers, leaving the latter to run the more costly and intensive acute emergency services on a reduced overall income.

However, financial balance alone is not the challenge, at the same time we must maintain access to quality emergency and elective services for the acutely ill patient. Providing these sustainably does require the organisation to remain in financial balance. For EKHUFT the consequence of not achieving financial balance, is a deterioration in the quality and number of services we provide, a serious breech of our Terms of Authorisation and the intervention of the Regulator, Monitor's, intervention.

2. What kinds of measures have been taken in 2010/11 in terms of changing what services you provide and the way in which they are provided within your organisation on order to try and achieve financial balance?

Our strategy over recent periods has been to repatriate appropriate services from London back into East Kent, deliver existing services more efficiently by changing the way we work, and concentrating on those services that must be delivered in a hospital setting. By implementing this strategy in 2010/11 we developed a Kent wide stenting service for heart attack victims built on our repatriated coronary angioplasty service, both of which increased income and provide care closer to home for the people of East Kent. We also extended our local neurology services and in addition more efficient one stop clinics have been developed for numerous services such as Urology. The speed of investigation and treatment has been improved to aid recovery and reduce times in hospital.

Improvements in the efficiency of existing services have included reducing our usage of agency staff, reduced reliance on sub-contracted activity, improved theatre utilisation so that more operations are undertaken during the normal working day and therefore reduced activity during premium payment periods. Revised working arrangements were also implemented in radiology and we reduced usage of private ambulances. We have also worked with Commissioners to ensure Referral Criteria have been adhered to, in order to help reduce unnecessary attendances at hospital, and that doctors switch from high cost drugs to those that represent value for money (where there is sound clinical evidence).

3. What kinds of measures are being considered for 2011/12?

In 2011/12 we intend to continue with this strategy with more emphasis on delivering £24m of efficiencies. These efficiencies will be delivered within EKHUFT, whilst we will also support and contribute to the County wide QIPP programme. Thus internally we will work to eliminate any unnecessary time spent in hospital, further improve theatre utilisation and day case rates. As part of the QIPP programme we will look to improve our procurement processes, streamline back office functions and rationalise elements of Pathology provision. We will also look to use technology to reduce travel across our patch and speed up work and decision making so that clinical care improves and workforce efficiencies are delivered. Given our turnover of staff and levels of expenditure on temporary staffing costs it is expected that this can be done through natural wastage without incurring redundancy costs. Though our strategy is also to maintain three DGHs

in East Kent the financial situation will mean that we may have to look at reducing the provision of some specific services to fewer sites. Thus, though services will be maintained in East Kent some may have to be delivered on fewer of the sites within our area.

4. What do you see are the main challenges to achieving financial balance across the health economy as a whole?

Through the contracting process we will continue to support the delivery of the PCT Strategic Commissioning Plan. However, with the demise of the PCTs and the rise of GP Commissioning, one of the challenges will be the avoidance of service duplication between numerous "willing providers" and losses of economies of scale in the Trust as GP clusters require services to be delivered differently between the various local hospitals. In an effort to avoid this we are trying to develop joint understandings of GP Cluster requirements. This is in an environment of unprecedented financial efficiency requirements within the NHS, limited availability of growth funding, a reduced Market Forces Factor for East Kent, a growing and aging population in East Kent, reduced funding available to colleagues in social services and a new organisation for community NHS services that combines East and West Kent. The effective operation of the latter two organisations are essential if we as an Acute Trust are able to operate efficiently, otherwise patients can stay too long in hospital and not recover as they should. The combined effect of these drivers and others such as innovation and regulation mean that Kent and Medway need to find over £300m of additional value/costs over the next five years. At the same time we will still need to deliver against all the access and quality standards such as 18 week referral to treatment and cancer waiting times.

5. What has been the impact of the NHS Operating Framework for 2011/12 and the financial settlement for this next financial year?

The Operating Framework for 2011/12 tasks us with achieving higher quality standards and increases the financial penalty for not doing so, whilst providing a net reduction of 1.5% in the tariff we receive for the work we do. It also requires the health economy to agree on the definitions of a number of standards and means EKHUFT needs to make c£24m of efficiencies savings in 2011/12 on a turnover of c£415m. Without these efficiencies we will not be able to meet the demographic pressures on us, or fund any new investment in our health system

6. How is the QIPP challenge being met within your organisation?

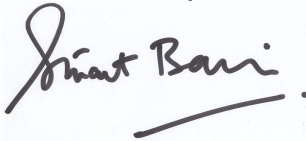
We are supporting the PCTs to deliver QIPP by making efficiency savings and working with the commissioners in developing effective services that avoid costly and unnecessary acute episodes of care. As a senior management team we in the acute Trust are also active participants in numerous groups that drive the county wide QIPP programmes in such areas as workforce efficiency, estates and back office functions. All this is aimed to ensure that East Kent NHS deliver savings of £67m in 2011/12.

7. Are there any particular demographic trends in Kent that will have an impact on the kinds of services you provide?

The movement of clinical services from Maidstone to Pembury may mean increasing pressure for some services in Ashford from the West Kent population, hence the reason why midwifery services were expanded at the William Harvey Hospital. Proposed reductions in the number of Junior Doctor posts in the NHS will also have service implications for the Trust that will need managing by re-profiling the workforce and amending the way we operate. As mentioned above this is at a time when the profile of the Kent population is expected to age. This ageing of the population will have serious implications for the delivery of acute hospital care, as over 65's are 18 times more likely to suffer heart/circulatory problems for example. By 2028 those living over 85 in Kent are expected to double and under 5's to increase by 10%. Changes in the ethnicity of our population will also impact on service provision, for example residents from Eastern Europe have increased smoking prevalence which can lead to an increase in cancer and circulatory related illnesses.

I look forward to meeting you on the day.

Yours sincerely



Stuart Bain
Chief Executive

Putting patients first

Dartford and Gravesham NHS
NHS Trust

INVESTOR IN PEOPLE

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

DARTFORD AND GRAVESHAM NHS TRUST

NHS Financial Sustainability:

Dartford and Gravesham NHS Trust – Background:

The Trust was legally established on the 1st November 1993 and is based at Darent Valley Hospital in Dartford. It offers a comprehensive range of acute services to around 270,000 people in Dartford, Gravesham, Swanley and Bexley. The hospital building is run as part of a Private Finance Initiative (PFI). The hospital now has between 470-522 beds and the specialties provided include general surgery, trauma & orthopaedics, cardiology, maternity paediatrics and general medicine. It also has an A&E department, open 24/7.

The hospital is engaged in a number of active partnerships so has visiting Consultants from Medway, Queen Victoria, Guys & St Thomas, Kings and Maidstone Oncology Centre. This allows many specialist services to be provided for the benefit of people from the wider locality at Darent Valley.

Financial Challenges:

The Trust's principle PCT is West Kent PCT and it has indicated that it intends to spend £25m less with Dartford and Gravesham NHS Trust over the next four years. This is part of a general strategy that most PCTs are developing to become less reliant on acute hospital care.

On top of this, the NHS has a QIPP challenge (efficiency and productivity) which in Kent is circa £150m.

The Board at Dartford and Gravesham NHS Trust has considered this financial context and determined that it cannot find the required savings through the normal efficiency and savings schemes alone. A structured solution is needed to make savings whilst trying to protect clinical services. A partnership with another health Trust is deemed a rational option. Dartford's location, together with a variety of mutual synergies has led Dartford's Board to declare that it will look into the feasibility of integrating with Medway NHS Foundation Trust. This is at an early stage of exploration but is based on the principle of maintaining the majority of clinical services on both sites, including A&E, maternity and outpatients.

Specific questions from the HOSC:

Financial balance is necessary to create the right framework for sensible long term planning rather than short term financial crises.

Potential Consequences of Financial Imbalance
The absence of financial balance in the Health Economy can prompt an accelerated change in the distribution of funds between service sectors.

In the short term, such changes can be too fast, too soon and cause financial instability as organisations/services adjust to the new funds available. This adjustment can cause risk to patients and service users.

Loss of Public Confidence/ Loss of Reputation for Good Governance: there is already concern over the pace of change of Health Service Reforms – financial deficits simply add damage to the reputation of the Health service and wider Public Sector.

When organisations are financially challenged, cost reductions and savings are made through short term disinvestment.

- Holding vacancies of staff
- Waiting times/lists increase
- Transfer/Closure of services to another part of the NHS
- Restriction of access to services – time or geographic location
- Increased Uncertainty
- Withdrawal of services

2010/11: a number of actions have occurred which cover the range of QIPP areas. The following are just some examples.

Quality – 'Enhanced Recovery' programme which aims to 'optimise' patients prior to major surgery leading to a faster recovery and a shorter length of stay.

Innovation – Development of electronic ordering and reporting for radiology and pathology tests. This saves time, paper and reduces semantic error. Ultimately, we expect this to help in reducing length of time in hospital.

Productivity – The closure of the maternity unit at Queen Mary's in Sidcup has led to an increase in the number of women giving birth in the hospital. This has been managed through maintaining choice for women, with a Midwifery Led Unit but also by developing 'triage', which helps us look after women who need help but are not actually in labour. We are also opening a transitional care unit allowing women to stay with babies who can't go home but are not ill enough for SCBU (special care).

Prevention – Fracture Neck of Femur pathway, aimed at tightly managing very elderly and frail patients who frequently suffer this particular type of fracture. Through the use of an agreed pathway, we have reduced delays to Theatre, improved the medical supervision post surgery and speeded the rehabilitation process. This is aimed at preventing the typical complications associated with this injury (pneumonia). So far we have seen a dramatic reduction in length of stay which saves resources as well as being better for patients' care.

Through these and a variety of other measures, £6.3m was saved.

2011/12 Plus:

- The Trust is presently finalising plans with the PCTs, but those plans are likely to result in the Trust losing income so needing to close down capacity through bed and ward closures.
- The Trust has been working with the PCT to redesign services for patients with the aim of reducing the need for a hospital attendance. A good example of this is the cellulitus pathway which once implemented, will enable GPs to treat patients with strong antibiotics under protocols agreed with the hospital's microbiologist.
- 'Green' projects save resources and are better for the environment. To this end the Trust is working with its suppliers and contract partners to reduce waste and energy consumption and looking at how it might source sustainable energy in the future.
- The Trust will continue work commenced in 2010-/11 to reduce back office costs by working with other providers across Kent, notably Medway NHS Foundation Trust.

The Trust needs to achieve a QIPP saving of £6-7m.

The Main Challenges to Achieving Financial Balance:

The Financial balance across the Local Health Economy is important to ensure that frontline Health services can continue to be provided to patients.

Those services which are commissioned and provided by the NHS are:

- Primary Care
- Community Services
- Acute Services
- Mental Health
- Other specialist services
- Social Care
- Funding for the Voluntary Sector.

A Health economy in financial balance is necessary to ensure that the resources are sufficient across the providers of Healthcare to meet the needs of the complex and varying needs of the population in the short term.

A significant challenge is whether cooperation or competition is best for long term financial sustainability. Current policy is conflicted on this matter.

Impact of the NHS Operating Framework for 2011-12

- Marginal Payment for Emergency/ Non-elective inpatient admissions -
  The hospital will receive 30% of the full tariff for non elective admissions – above the volume of March 2009 levels. The Trust estimates it could lose £1.7m.

- 4% reduction in commissioned activity, with £4.5m impact.

- 1.5% reduction in NHS tariff means £2.1m reduction in income

- NHS Tariff – the new tariff builds in a 4.0% savings requirement. £6.4m savings needed to counteract the underlying inflation in costs of 2.5%.

- In 2011/12, Market Forces factor (MFF) will be adjusted from 14.98% in 2010/11 to 14.56% which causes a reduction of £0.5m in MFF income.

- Readmissions within 30 days will not be paid – the Trust is anticipating a risk of £0.7m arising from this change of policy.

- New contractual terms and conditions: unknown impact but greater emphasis on outcomes places greater pressure on the SLA between the Trust and PCTs.

QIPP Challenge:
The QIPP challenge is being met at a number of levels.

Within the hospital we are taking a Programme approach by planning and managing individual schemes. By this approach, £6.3m was saved in 2010/11.

There is a County QIPP Programme whose aim is strategic, looking for a benefit from Procurement, Estates and Workforce.

Lastly, Dartford and Medway hospitals have started to work together on specialist services, sharing investments and knowledge. For example, Urology is provided on both sites, but the cancer patients are operated on in Medway and the stone patients are operated on at Dartford.

Demographic Trends:
We use the key models to understand demographic trends:

Age	% change 2011 to 2016
0-15	9%
16-24	0%
25-44	4%
45-64	6%
65-84	13%
85+	29%
Total	6%

Overall growth is likely to be 6% but is much higher in the very old and very young – who are the biggest users of healthcare

In Dartford, the changes to the hospital provision at Queen Mary's hospital Sidcup, may lead to a demographic shift.

The restructuring of services at Queen Mary's Sidcup has effectively increased our population footprint by 20,000 (12%). This equates to 1,000 extra births, 6,000 A&E attendances and 2,000 extra admissions.

Susan Acott
Chief Executive
April 2011

<u>Report for the Kent HOSC Meeting 19 April 2011 from Medway NHS Foundation Trust</u>

Introduction

Medway Foundation Trust ("MFT") is based in Gillingham and provides services to the Medway community as well as to adjacent parts of Kent. In 2010/11 total revenue was £218m patient related income was £187M and included £56M (30%) for patients outside of Medway. Whilst the main hospital is in Gillingham a number of services are provided more locally to our patients such as in Darent Valley Hospital; Sittingbourne Community Hospital and Sheppey Community Hospital.

What are the challenges to ensuring the NHS in Kent is financially sustainable?

As a provider the most significant challenge is meeting the increased demand for services arising from known changes in local demographics, including an ageing population and an increase in the birth rate. In recent years increases in demand for services have been met with additional funding, although not always in full. In 2011/12 MFT is expecting to see a decrease in clinical income partially as a reduction of patients attending the hospital as a result of alternative options for patients being implemented by the PCT's.

Are there any implications for the range and quality of health services available to the people of Kent as a result of any measures being taken to achieve or maintain financial sustainability?

One of the options that MFT is exploring is a merger with Dartford & Gravesham NHS Trust as it is recognised by both organisations that there is an opportunity to improve local services by increasing critical mass.
This would create the potential to extend the range of specialist services in Kent and Medway and consequently less patients would need to travel to London based hospitals.

At the same time a merged organisation would spend less of its resources on management and administration functions which will therefore increase the proportion of our joint income that remains for delivering patient care.

1. Why is achieving financial balance across the local health economy important and what are the potential consequences of not doing so?

As part of the annual planning cycle an assessment is completed of currently funding for health services is allocated annually to Primary Care Trusts who then in turn commission services that they determine will meet the needs of the population that they cover.

Continued………….

2. What kind of measures have been taken in 2010/11 in terms of changing what services you provide and the way in which they are provided within your organisation in order to try and achieve financial balance?

No significant changes have been made during 2010/11 in the range of services that the Trust provides. Developments have taken place such as the opening of a dermatology service in Borough Green and the transfer of urology cancer surgery from Darent Valley Hospital.

The emphasis in 2010/11 has been on improving patient pathways and reducing length of stay. This has been achieved through a number of initiatives including one which involves patients being cared for in their homes by hospital based staff during the final days of what otherwise would be within the hospital.

3. What kind of measures are being considered for 2011/12?

No significant changes to services are planned for 2011/12 in order to achieve financial balance. The Trust has recently commenced a number of consultations with colleagues involved in management and administration functions with the objective of delivering a substantial reduction in the cost of these areas.

The Trust will continue to closely monitor demand on each of its services and will seek to reduce capacity if it becomes possible.

4. What do you see are the main challenges to achieving financial balance across the health economy as a whole?

In order to deliver changes that will improve the prospect of achieving financial balance across the health economy it will be necessary to increase investment in certain areas of community care that will ultimately reduce the demand on the acute hospital sector.

5. What has been the impact of the NHS Operating Framework for 2011/12 and the financial settlement for this next financial year?

The main focus of the Operating Framework is on the ongoing structural changes within the NHS but it also includes a number of patient related areas where will be continued focus and these include:-

- more detailed monitoring of performance of A&E services through the introduction of 5 new indicators to replace the 4 hour access target.
- push to reduce further the number of healthcare associated infections
- eliminating mixed sex accommodation

In all 3 of these areas, Medway Maritime Hospital performs extremely well.

Continued…………………….

The Trust is planning to receive less income in 2011/12 than it did in 2010/11 as a result of the pricing changes detailed in the Operating Framework but the bigger impact will be from an expected reduction in the number of patients seen in a hospital setting. Contract negotiations have not yet been concluded for the current year but it is currently estimated that income will be down by £4M compared to 2010/11.

6. How is the QIPP challenge being met within your organisation?

The Trust is fully engaged with other stakeholders in the wider health economy to identify ways that resources can be used more effectively.

7. Are there any particular demographic trends in Kent that will have an impact on the kinds of services you provide?

Locally the birth rate is increasing and the Trust expects to deliver more than 5,000 babies in 2011/12, which will make it the largest national unit in Kent.

Patrick Johnson
Director of Operations/Deputy Chief Executive
April 2011

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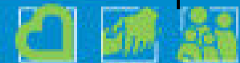
Maidstone and Tunbridge Wells NHS Trust

Presentation to the KCC Health Overview and Scrutiny Committee (HOSC)
19 April 2011

Maidstone & Tunbridge Wells NHS Trust

Colin Gentile

Interim Director of Finance



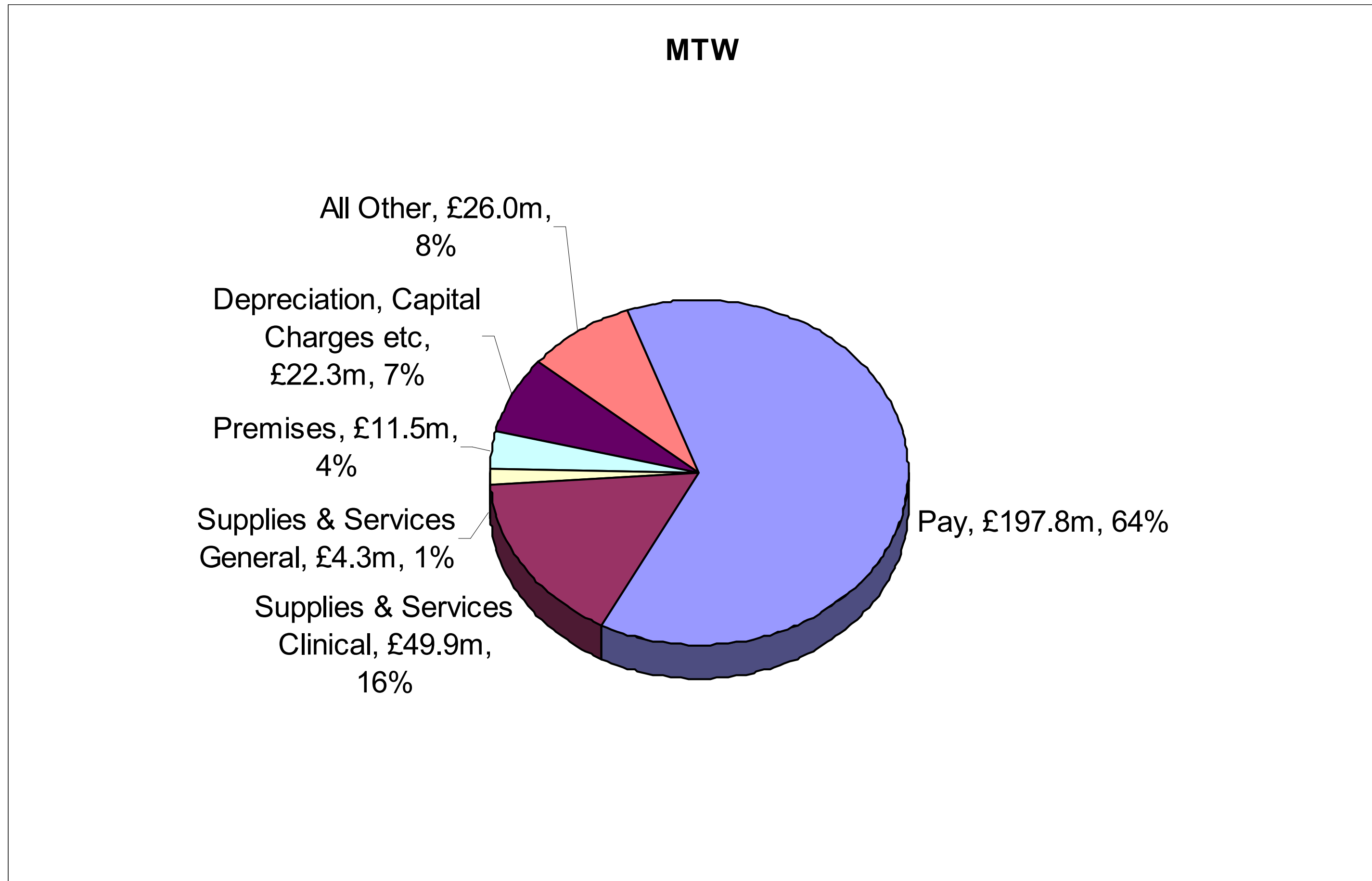
Structure

1. About Maidstone & Tunbridge Wells (MTW) NHS Trust
2. Why Financial Balance is important
3. 2010/11 Financial Balance and Service Change
4. 2011/12 and the impact of the Operating Framework
5. QIPP and MTW
6. Demographic Trends
7. Other Issues

About MTW

Maidstone and Tunbridge Wells NHS Trust

2009/10 Audited Accounts



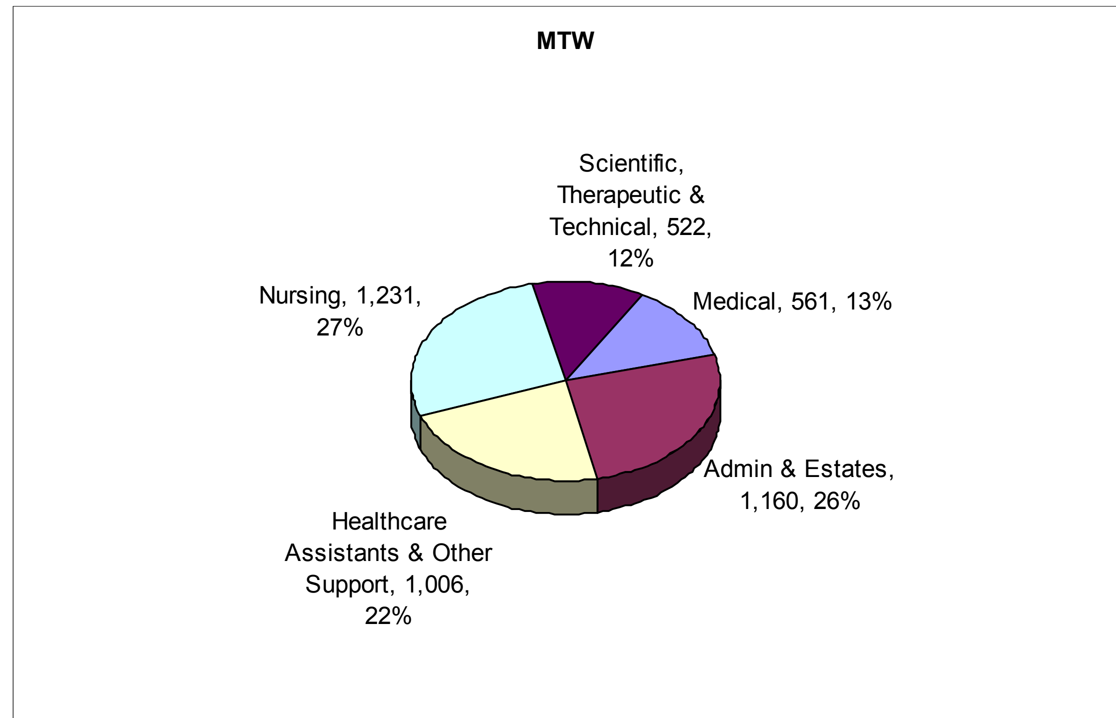
Total Expenditure £311.7m

About MTW

Maidstone and Tunbridge Wells NHS
NHS Trust

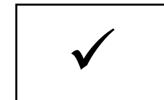
2009/10 Audited Accounts

Average No of Employees (WTE)	
Category	**MTW**
Medical	561
Nursing	1,231
Scientific, Therapeutic & Technical	522
Healthcare Assistants & Other Clinical Support	1,006
Admin & Estates	1,160
Total	**4,480**

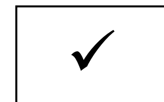


2010/11 – The Year Just Gone

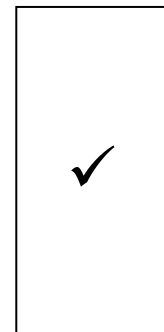
1. Must achieve a £1.6m surplus to meet 5 year break-even duty

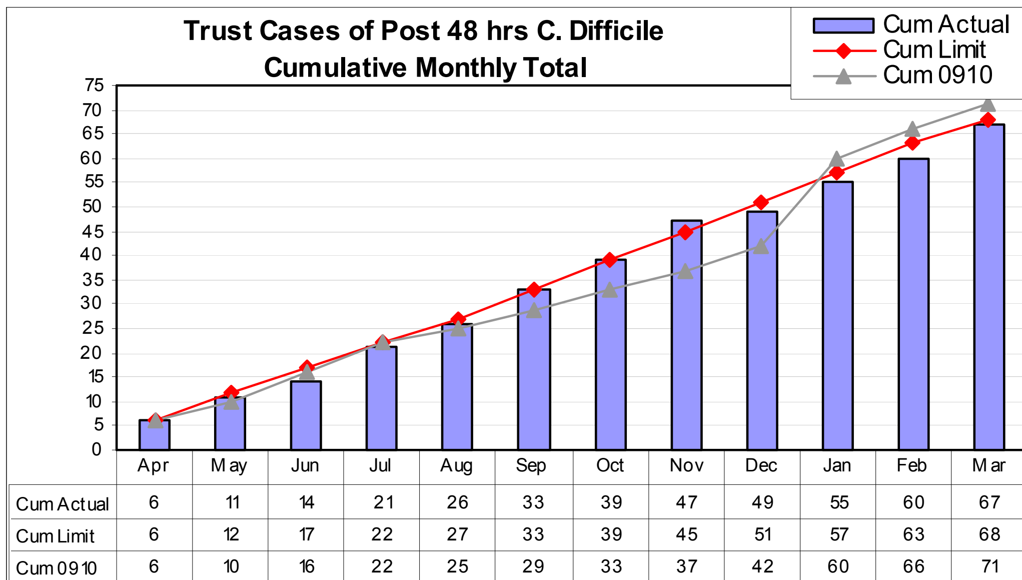


2. Delivered £15.2m efficiencies



3. Delivered:
   a) A&E waits
   b) 18 week elective surgery
   c) Infection Control targets (see overleaf)



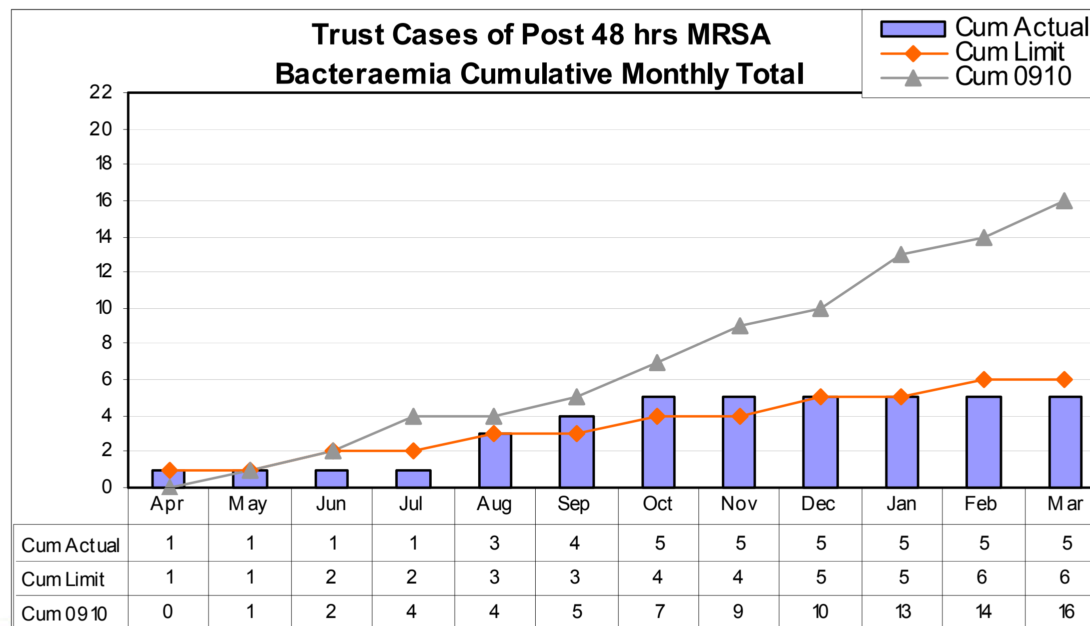


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cum Actual	6	11	14	21	26	33	39	47	49	55	60	67
Cum Limit	6	12	17	22	27	33	39	45	51	57	63	68
Cum 0910	6	10	16	22	25	29	33	37	42	60	66	71

Maidstone and Tunbridge Wells NHS

NHS Trust

2010/11 Performance



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cum Actual	1	1	1	1	3	4	5	5	5	5	5	5
Cum Limit	1	1	2	2	3	3	4	4	5	5	6	6
Cum 0910	0	1	2	4	4	5	7	9	10	13	14	16

Why Financial Balance is Important

1. Sustainable services are only possible with sustainable finances
2. Living beyond our means in any one year results in more savings required in the following year
3. Financial Balance allows secure and sensible planning into the future
4. Facilitates delivery of our strategic objectives

Maidstone and Tunbridge Wells NHS Trust NHS

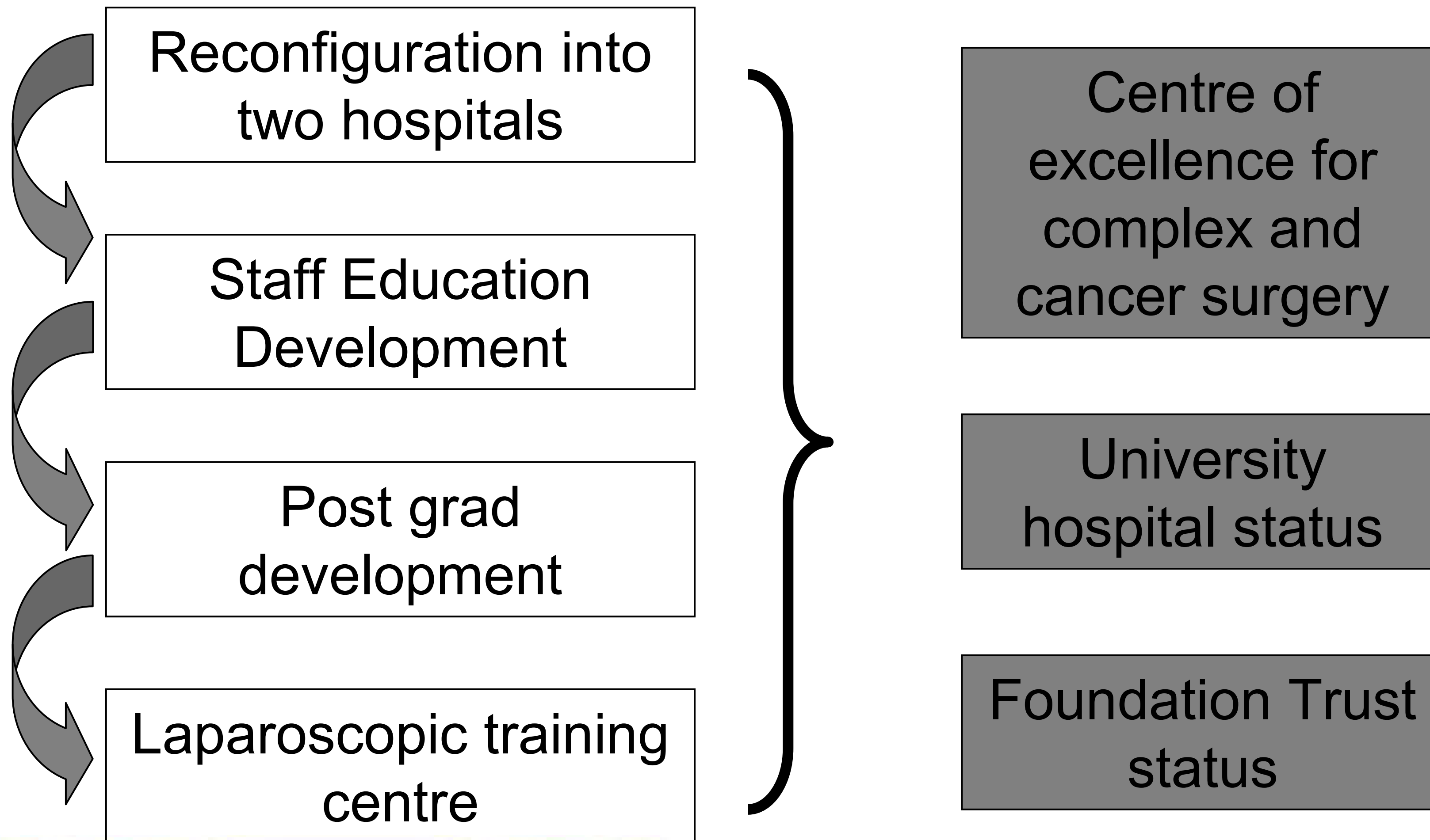
Our Strategic Objectives

- Provide safe quality services and experiences for patients, staff and the public
- Deliver services which are efficient and productive
- Ensure effective governance of the Trust and its services
- Create a high performance workforce and, as an employer of choice, encourage innovation and learning
- Delivery financial viability and sustainability
- Establish the Trust as a lead provider of health services in the healthcare economy

Why Financial Balance Is Important

Maidstone and Tunbridge Wells NHS Trust

Developments – a 5 year strategy



Maidstone and Tunbridge Wells NHS
NHS Trust

2010/11 Savings and Services

- Guiding principle – The Board of MTW will not take any action that adversely impacts on quality or safety of the care delivered.
- Our efficiency plans have delivered £15.2m or 5% of turnover. Headlines are:

	£m
Divisional Savings	8.1
Procurement	1.9
Outpatients	1.0
Trust to Trust SLAs/Private Patients	0.8
Administration	0.6
Length of Stay/Bed Management	0.5
Others in estates, diagnostics, prescribing	2.3
	15.2

- The efficiencies as well as generating savings also improve patient care.

Impact of 2011/12 Operating Framework

National

- £10.6 billion budget increase over 4 years
- £20 billion productivity improvements required over the same period
- Structural change SHAs, PCTs, Clusters, GP consortia and FT status for all NHS Trusts or…………?
- Outcomes Framework
- Patient experience and feedback

Impact of 2011/12 Operating Framework

Priorities include:

- Stronger Health Visiting Services
- Cancer Drug Fund
- Autism Strategy
- Dementia Strategy
- Support for Carers
- End of Life Care
- Cancer Reform
- Stroke Strategy
- Mental Health Strategy
- Waiting Times
- New A&E Targets
- Healthcare Associated Infections
- Mixed Sex Accommodation

Impact of 2011/12 Operating Framework

The Scale of the Challenge

- NHS West Kent 2011/12 allocation of £1.008m
- Represents £30m uplift from 10/11
- Factor in PbR uplift, enablement funding transfer to SS, RTF, 2% activity increase, recurrent impact of 10/11 commissioning spend, Non-Recurrent commitment brought forwards, a contingency – £59m challenge
- Needs to be a plan to effectively spend the allocation to the benefit of patients – not just a plan to cost cut or cost shift – QIPP is an opportunity to improve quality, innovation, productivity and performance

Source NHS West Kent

Maidstone and Tunbridge Wells NHS
NHS Trust

Initial impact of 2011-12 Annual Operating Plan

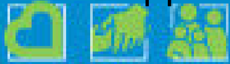
£ million

40
30
20
10
0
-10
-20
-30
-40
-50
-60
-70

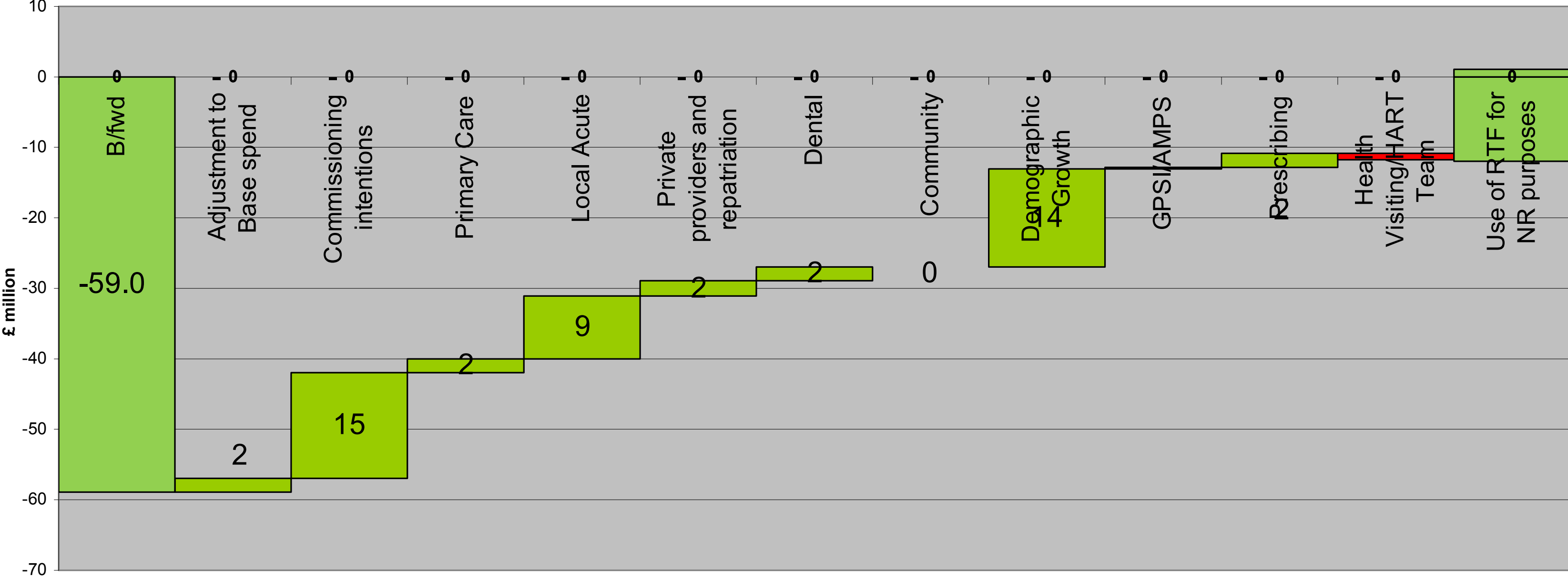
30 Uplift
8 New funds passed to Local Govt. - Joint working with social care
9 P&P uplifts - Estimated
2 Reablement Funds
8 Increase in RTF
20 Assume 2% activity increase
29 Recurrent impact of 10-11 commissioning spend
6 NR Commitments b/fwd
7 Restore contingency
Initial assessment of challenge

£59m

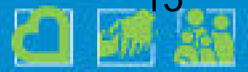
Source NHS West Kent



Maidstone and Tunbridge Wells NHS
NHS Trust



Source NHS West Kent



QIPP Expectations and Plans

- Commissioner challenge of £148.66m over next four years.
- Plus £81m expected from 2 main acute providers in WK over same period (£27.5m DVH, £53.5m MTW).
- Plus share of impact from other providers including new community trust.
- To address the scale of challenge required to deliver a balanced budget, plans above initial proposed levels are required.

Source NHS West Kent

Maidstone and Tunbridge Wells NHS Trust

Working Together to Rise to the Challenge and Deliver and Integrated Plan

- Whole System Delivery Boards - joint concordat – health and social care - focus on benefits not savings i.e. the right thing to do. Minimal bureaucracy and barriers. Identifying and driving opportunities for "win win " Agreeing strategy for long term that makes sense to all partners
- Reform and best care plans driven by clinicians eg Urgent Care Boards.
- Routine and regular Executive – to - Executive review meetings.
- Robust review of progress – including PMO/QIPP Tracker (1 plan, triangulating finance, activity and workforce metrics).
- Clear strategic communication and engagement plan (which needs to be urgently developed). Driving a change in culture towards self care by patients and staff.
- Systematic and appropriate use of improvement leads/virtual improvement academy.
- Fully explore and utilise patient engagement /patient revolution opportunities.
- Best use of re-enablement/social care funds.

Source NHS West Kent

QIPP and MTW 2011/12

Key components of MTWs efficiency plans

	£m
Back Office	1.5
Procurement	2.0
Medicines Management	1.0
Workforce productivity	5.4
Safe care	1.7
Divisional small schemes	3.9
	15.5

Demographics

Main drivers for health planning:-

1. Population growth in Kent County is expected to be 10.6% or over 148,000 over a 15 year period to 2022. Rate of growth slower in West Kent than East Kent and Medway

2. Increase in the percentage of population aged over 65, with a 32.15% increase across Kent County to 2022.

The Kent and Medway New Commissioning Cluster will factor this major change into its commissioning plans. MTW will need to be involved in this planning and respond in its service changes.

Other Issues

- New hospital at Pembury and the closure of the Kent and Sussex Hospital
  - World class facilities
  - Increases the cost of delivery (working with the SHA and Department of Health)
  - Service reconfiguration and patient flow changes
- Need for greater vertical integration of services