KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Darent Room, Sessions House, County Hall, Maidstone on Tuesday, 19 April 2011.

PRESENT: Mr N J D Chard (Chairman), Mr B R Cope (Vice-Chairman), Mr R Brookbank, Mr N J Collor, Mr A D Crowther, Mr D S Daley, Mr K A Ferrin, MBE, Mr C P Smith, Mr K Smith, Mr R Tolputt, Mr A T Willicombe, Cllr M Lyons, Mr M J Fittock, Cllr Mrs A Blackmore (Substitute for Cllr Mrs M Peters) Cllr R Davison (Substitute for Cllr J Cunningham)

ALSO PRESENT: Gordon Court

IN ATTENDANCE: Mr P Sass (Head of Democratic Services) Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee)

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Minutes
(Item 4)

RESOLVED that the Minutes of the Meeting of 25 March 2011 are recorded and that they be signed by the Chairman.

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

(1) In response to questions from Members, clarification was provided that Borough/District representatives on the Committee would have an equal right and opportunity to participate and lead any of the proposed groups.

(2) Members expressed the views that it was important to try new ways of working in order to add value and that flexibility was important given the varied progress localism was making in different areas.

(3) RESOLVED that authority be delegated to the Head of Democratic Services 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.

4. NHS Financial Accountability: Part 2 - Acute Sector
(Item 6)

Susan Acott (Chief Executive, Dartford and Gravesham NHS Trust), Stuart Bain (Chief Executive, East Kent Hospitals NHS University Foundation Trust), Colin

Gentile (Interim Director of Finance, Maidstone and Tunbridge Wells NHS Trust) and Patrick Johnson (Director of Operations/Deputy Chief Executive, Medway NHS Foundation Trust) were in attendance for this item.

(1) The Chairman thanked the representatives of the Acute Sector in Kent and Medway for attending and asked if they were each willing to provide a short overview of the subject from the perspective of their respective organisations.

(2) The position of Dartford and Gravesham NHS Trust needed to be seen in the context of its Private Finance Initiative (PFI) scheme which added complexity to the financial challenge. Broadly, the challenges fell into four areas. The first was the requirements of the Quality, Innovation, Productivity and Prevention (QIPP) challenge which meant £6 million worth of efficiency saving were needed within this financial year. Secondly, there were the actions of the Primary Care Trusts (PCTs) intending to spend less on acute care and decommissioning certain services which equated to £25 million less income for Dartford and Gravesham over the next four years. Thirdly, the NHS Operating Framework for the current year meant that Acute Trusts would be receiving less for what they did do. Fourthly, there was a limit on what efficiencies could be achieved as things stood, so a partnership with Medway NHS Foundation Trust was being explored. The temporary closure of accident and emergency and maternity services at Queen Mary's Sidcup did add work pressures on the Trust but also added income. Among other developments at the Trust was repatriating services to Kent, normally accessible only in London, like a number of cardiology services.

(3) Medway NHS Foundation Trust echoed the interest in a partnership between it and Dartford and Gravesham NHS Trust, though this was a change from the view a year ago. However, the proviso was made that while a merger would save money, particularly in back office costs, it would not completely offset the financial pressures. Medway NHS Foundation Trust had to make 7% efficiency savings. This was challenging, but the national decision for no pay inflation helped produce a seven figure saving. Reducing the number of bed days at the hospital was a key drive for the current year with different initiatives being pursued to realise this, such as nurses being able to discharge patients and providing the capacity to care for twenty patients in their own homes; the latter policy was going to expand to cover Swale and non-medical patients, neither of which were included in the scheme at present. Following questions from Members, further detail was provided on the scheme for allowing nurses to discharge patients which was due to be implemented in a month's time. It was explained that there was not the capacity at the Trust to enable patients to be seen by consultants each day, but if the requirements set by the consultant for discharge were met, then the appropriate nurse would have the ability to approve discharge to prevent patients staying in hospital longer than necessary. This point was supported by East Kent Hospitals NHS University Foundation Trust arguing that keeping patients in hospital longer than necessary increased the clinical risks of infection.

(4) Several Members expressed broad approval for the potential of merging Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust, as long as the levels of service provision remained the same at both sites. It was explained that the populations served by both meant this was not likely. The

two Trusts were invited to return to the 22 July meeting of the Committee in order to explore the merger potential further.

(5) The perspective from East Kent Hospitals NHS University Foundation Trust was that there were three macro-level challenges. Firstly, there were stricter criteria being used for referrals to treatment by commissioners so that some were not done at all and others treated as a low priority. Comparing the last quarter of 2009/10 to the last quarter of 2010/11, there was a 6.8% reduction in referrals. The QIPP challenge meant services were being redesigned to take place in lower cost settings; this applied to areas such as dermatology and long term conditions. The Government's set price for the tariff was deflationary and meant the equivalent of finding 5% efficiency savings, or £24 million in year. This had to be seen against a budget of £480 million and the wider savings target of £67 million set by commissioners in East Kent, of which this £24 million was a part. Added to this was the requirement to make a surplus of 6-7%. Without making a surplus, there would be no service reinvestment. The close relationship between financial balance and service stability was explained carefully.

(6) Rising public expectation was named as a key demographic challenge. The impact of the new hospital at Pembury on patient remained to be seen, but it was a possibility that some people around Maidstone may choose to go to William Harvey Hospital at Ashford and not Pembury. The development of the Any Qualified Provider policy also had the possibility to destabilise Acute Trusts as tariffs were largely based on average prices and if alternative providers took the easier procedures (for example, cataracts), then Acute Trusts would lose money providing the more complicated ones. The broader point was also made that Foundation Trust Terms of Authorisation included a list of services which the Trust needed to provide, even if they lost the Trust money, as was often the case with maternity services. The current Health and Social Care Bill made provision for Monitor to maintain a list of local designated services which would need to be provided on an ongoing basis.

(7) The challenges as seen from Maidstone and Tunbridge Wells NHS Trust could be divided between national and local ones. Nationally there was a tension and possible conflict between the moves to increase competition and increase collaboration on clinical pathways. The tariff changes meant the Trust had to save 4% just to stand still and so any decommissioning of services would add an additional financial strain. On top of this there was a strong desire to ensure there was no reduction in quality; a goal supported by the outcomes framework which would be measuring outputs. Locally there was a need to collaborate on pathways in the context of the ageing population. NHS West Kent had its own QIPP programme aimed at realising £59 million in savings, part of which involves £10 million worth of income diverted from the Trust to other providers. The new PFI hospital at Pembury was currently 40% open, and would be 100% operational in September. While this added to the cost base, it could attract work from East Sussex and elsewhere, and needed to be fully open in order to run efficiently. There were also financial pressures on social services and the emergence of GP Commissioning Consortia, all of which also added to the difficulties of resolving the tension between competition and collaboration.

(8) As a positive model, the primary angioplasty service based at William Harvey Hospital was given as it involved all four Acute Trusts collaborating to provide cover for the one rota.

(9) The Chairman made the observation that the proposed Health and Wellbeing Board, involving Kent County Council as it will, may be able to play a useful role in promoting future service collaboration.

(10) Developing the theme of the impact of PFI schemes, the point was made that each one is different. This was illustrated by car parking. At Dartford and Gravesham NHS Trust, though they had planning permission to extend car parking, it was not actually the Trust's car park and any change needed to be agreed with the hospital company. In the shorter term, changes were being made to staff car parking. At the new Pembury PFI development, the car park was owned by Maidstone and Tunbridge Wells NHS Trust.

(11) The actual cost to the NHS of patients receiving treatment under the tariff varied from Trust to Trust because of the Market Forces Factor. Treatment in London was more expensive than in Kent, so the point was made that if patients either chose to go to London, or needed to be referred there, that was an additional cost to the commissioners in Kent and a loss to the providers. For this reason, establishing services locally which were otherwise only available in London, a process known as repatriation, was reported as being a double win. Looking locally, one Member of the Committee made the observation that the two Acute Trusts in West Kent had the highest Market Forces Factors in Kent and Medway, but that NHS West Kent had the lowest per capita PCT allocation. To this was added the point made by East Kent Hospitals NHS University Foundation Trust that the Market Forces Factor for the Trust had got lower, though it had increased for the others in Kent and Medway. This meant the Trust was receiving less income for each service provided and needed to improve efficiencies even more to keep up. The Trust representative also noted that staff costs were nationally set in most cases.

(12) The role of the Acute Trusts in Kent and Medway in training was discussed, and all were involved. As an example, East Kent Hospitals NHS University Foundation Trust currently had 400 medical undergraduates from King's College and 400 doctors ranging from junior doctors to those undergoing specialist training. In addition the Trust worked with nursing colleges. At the Trust the roles of specialist nurses was being looked at, and the skills of Healthcare Assistants being improved. The number of junior doctors was controlled by the Deaneries and the main challenge was that it took 6-7 years to train a junior doctor, and another 6-7 for specialist training, meaning a total of around 14 years to make a consultant. However, the medical landscape often changed faster than the training could produce doctors, so there was inevitably always going to be a shortfall in some areas.

(13) Members picked up on information provided by the Trusts on the proportion of their annual budgets which was spent on administration. In response, further detail was given on what this covered and how necessary it was to the medical activities. Administration included medical records as well as staff like receptionists, porters and cleaners.

(14) A distinction was made during the discussion between the two Trusts which were based on a single site and the two which covered a number of sites. This meant a different challenge in planning and providing services in Medway where there was a defined population and one Acute hospital site and East Kent, where there was a less defined population and three main sites. As Acute Trusts were not simply nine-to-five businesses, telemedicine and other complex systems were involved to ensure there was always a consultant accessible. The observation was made that currently East Kent Hospitals NHS University Foundation Trust had one main commissioner, but that in the future there was likely to be a number of GP Commissioning Consortia, possibly up to nine. This would bring additional ethical and design challenges as different commissioners may wish to commission different services from the one Trust covering several GP Commissioning Consortia populations.

(15) The Chairman expressed his hope that the Committee would be able to meet with the emerging GP Commissioning Consortia in the future and undertook to explore this possibility.

(16) Clarification was sought on the policy that Acute Trusts were financially responsible for readmissions and it was explained that the policy only applied if it was for the same condition as the original admission. The intention of the policy was to reduce inappropriate hospital discharges. However, there were a number of unintended consequences. Firstly, the majority of patients were elderly, many of whom had long term conditions, and a readmission to hospital may have more to do with the nature of the condition and the patient's age than any action on the part of the hospital. Secondly, there was a chance that Acute Trusts could be penalised for the failure of other organisations and the example of stroke care was given where it could be the after care which let down the patient.

(17) This returned the Committee to the earlier discussion about the tension between competition and collaboration. There was a perceived danger that where there was a lack of collaboration on a patient pathway there could instead be the shunting of debts between organisations.

(18) A similar point was made around the provision of GP out-of-hours services in the past where doctors involved in providing the service were averse to risk and lacked knowledge of local services meaning attendances at Accident and Emergency departments increased.

(19) A number of Members of the Committee echoed the same plea that through all the changes and financial challenges, the core business of providing care not be forgotten. Trust representatives accepted this but indicated the progress which had been made, with the 18-week referral to treatment target having largely been met along with the 2-week wait for cancer appointments following GP referral.

(20) The specific issues was raised that, whilst the care received may be very good, customer care for patients entering the system and between appointments needed to be looked at so that patients had certainty about who they were going to see and when. East Kent Hospitals NHS University Foundation Trust conceded cancelled outpatient appointments were a struggle

and there was a cost involved in remaking appointments. The Trust was moving to a full booking system, where all the appointments for a patient on a pathway could be made in advance, though this did require capacity in the system.

(21) The Chairman thanked the Committee's guest for the useful and open discussion and asked Committee Members to forward any suggestions for recommendations on NHS Financial Stability to the Officers supporting the Committee.

(22) AGREED that Members delegate authority to the Head of Democratic Services 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.

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

5. Date of next programmed meeting – Friday 10 June 2011 @ 10:00
(Item 7)