NHS Financial Sustainability

Key Issues and Recommendations

Health Overview and Scrutiny Committee, Kent County Council July 2011

Part 1 - Introduction

(a) The Health Overview and Scrutiny Committee of Kent County Council undertook to carry out a comprehensive review of financial sustainability across the whole health economy. Because of the interconnected nature of the subject, the Committee heard from all the major commissioners and providers across the County. Although detailed questions were asked in advance and during the meetings, the focus was on answering the following two 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 Committee held three formal meetings on the subject and heard from the following organisations:

- 25 March 2011
  - NHS Eastern and Coastal Kent
  - NHS West Kent
  - Kent Local Medical Committee
- 19 April 2011
  - Dartford and Gravesham NHS Trust
  - East Kent Hospitals NHS University Foundation Trust
  - Maidstone and Tunbridge Wells NHS Trust
  - Medway NHS Foundation Trust
- 10 July 2011
  - Kent and Medway NHS and Social Care Partnership Trust
  - Kent Community Health NHS Trust
  - South East Coast Ambulance Service NHS Foundation Trust

(c) The relevant sections of the Minutes from the above meetings are appended to this report.

(d) The Committee would like to thank everyone involved in the inquiry for their openness and informative engagement with the process. The HOSC has always aimed at a constructive engagement with the local NHS and believes that scrutiny should lead to positive outcomes. The following findings and recommendations are offered in this spirit.

Part 2 - Key Issues

(a) Throughout all the sessions and running through all the evidence provided, a number of recurring themes could be identified. The most important are set out below. While none of these should be seen as irreconcilable opposites, they do highlight some of the difficult balancing acts that our colleagues in the NHS must strike when planning, commissioning and delivering healthcare across the county.

1. Allocations v. Need

The Committee heard that Primary Care Trusts are responsible for around 80% of the total NHS budget and that their role is to use the money allocated to commission services to meet the health needs of the people living in their area. The 'weighted capitation formula' used to determine how much money PCTs receive each year is complex and so looking at the **money received per head of population** is a bit misleading. That said, doing so reveals that NHS Eastern and Coastal Kent received **£1,725** per person for 2011/12 whereas NHS West Kent has received **£1,499** per person for the same year.

2. Short term v. Long term planning

One of the many balancing acts that commissioners have to undertake is how much resource to allocate to services where there is a recognised need such as improving the time from referral to treatment and how much to allocate to preventive and public health services which will reduce demands on the health services in the future, but **possibly not for a number of years**.

3. National v. Local targets

The Department of Health sets the strategic direction for the health services and the annual NHS Operating Framework sets out what the NHS needs to achieve during that year and includes financial targets as well as areas of healthcare that need improvement. While many of these are issues that all areas of the country do need to improve on, and may be a priority locally, there will always be some areas of healthcare which are of particular importance locally.

4. Localism v. Post code lottery

Each area of the country and, more locally, each area of the county, has different health needs and preferences around how and where these services are delivered. On the one hand this is a positive thing, on the other this can be seen as providing an inequitable service if something is not available everywhere. The point was well made during our inquiry that the important point was the equity of outcomes, rather than the equity of services.

5. Providers v. Commissioners

One of the more challenging aspects of the role undertaken by Primary Care Trusts is to make decisions around what the priorities should be for health spending locally, particularly in the context of the NHS as a whole being required to make £20 billion worth of efficiency savings by the end of 2014/15. The Committee heard that the stricter criteria had been introduced over referral to treatment. This in turn had an impact on the income received by providers who have to make hard decisions about whether a certain services can be provided at all.

6. Competition v. Collaboration.

The Committee heard lots of good examples of partnership work across the NHS, and the costs to the NHS as a whole were often lower where organisations work together. Yet it was also important that patients had a **choice of where to receive treatment** and providers are understandably keen to make the case for why they should be the ones chosen.

7. Repatriation v. Centralisation of services

To be effective, health care needs to be based on clinical evidence. In broad terms this means that people need to be seen by the right people, at the right time, and in the right place. Sometimes this means that patients will go past their local Accident and Emergency Department to receive the right treatment, as with primary angioplasty at William Harvey Hospital, but there are also some treatments being provided locally which previously would have involved a journey to London

8. Transition planning v. Continuity of care

The whole NHS is currently undergoing a series of changes following on from last year's NHS White Paper and this has major implications for those responsible for both commissioning and providing health services. While it is right that everyone involved plans ahead effectively for the new system, people still require treatment and care without disruption.

Part 3 - Recommendations

To Department of Health

1. **Improved Allocations Formula**. We ask that the Department of Health consider carefully the allocation formula which will be used to determine commissioning budgets for Clinical Commissioning Groups and involve local authorities closely in any work being undertaken in this area.

2. **Forward Financial Planning.** We recommend that once agreement has been reached on a fair allocation formula, the future indicative budgets for Clinical Commissioning Groups be announced as early as possible prior to the Groups assuming full commissioning responsibility to enable effective advance planning and a smooth transition.

To Kent and Medway PCT Cluster

3. **Transition Updates.** We ask that the Kent and Medway PCT Cluster Chief Executive's Office provide a written update for the HOSC on the transition planning across the County, including the latest stage of Clinical Commissioning Groups development.

4. **Zero Legacy Debt.** In order to be assured that the Clinical Commissioning Groups, and others, are able to pursue effective commissioning plans, we ask the PCT Cluster produce a clear outline plan as to how they will ensure zero legacy debt for their successor commissioning organisations. Current financial forecasts should be included in the above report.

To all NHS Trusts in Kent and Medway

5. **Communication of Service Changes.** Despite the impression that the entire NHS is changing on a weekly basis, effective forward planning is essential if the appropriate services are to be delivered in the most effective and efficient way. We therefore encourage all provider NHS Trusts in Kent and Medway to ensure they work with commissioners on setting out a clear timeline of proposed major service changes over the next two years. We also ask the PCT Cluster to take responsibility for coordinating said timeline and making it available to the HOSC and other stakeholders.

6. **Develop Local Pricing.** While we recognise the fine details around currencies and tariffs might not engage the imagination of the wider public that easily, this review has made it clear how important these details are. While the Payments by Results tariff is fairly well established in the Acute Sector, the development of currencies and

tariffs in other areas is only slowly developing. Due to their technical nature, the Committee has no specific recommendations to make as to the form they should take. However, we ask all relevant organisations to consider how these should best be taken forward locally.

To Shadow Health and Wellbeing Board

7. **Promotion of Integrated Care.** This Committee looks forward to a positive and constructive working relationship with the developing Health and Wellbeing Board. While it is not for us to decide the priorities of the Board, we ask that the development of integrated care pathways to improve efficiencies and, more importantly, the **patient experience be put at the heart of the work carried out.**

8. **Plan for the Long Term Health and Wellbeing of People in Kent.** Sitting within the County Council, the Health and Wellbeing Board will be in a good position from which to ensure the proper balance is struck between short and long term planning and we ask that maintaining this balance be given due priority.

To HOSC

9. **Further Scrutiny Reviews.** This review of financial sustainability across the health sector in Kent has highlighted a number of key areas which pose a particular challenge in achieving it, such as **preventing unnecessary attendance at accident and emergency departments**. The HOSC will include reviews of a number of these going forwards with the aim of developing further, specific, recommendations aimed at assisting the NHS in managing and overcoming them.

Appendix – HOSC Minutes on NHS Financial Sustainability

1. 25 March 2011

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.

2. 19 April 2011

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 driver 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 patients 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 should 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 issue 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 guests 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.

3. 10 June 2011

Philip Greenhill (Interim Deputy Chief Executive, Kent Community Health NHS Trust), Chris Wright (Interim Director of Finance, Kent Community Health NHS Trust), Oena Windibank (Interim Director of Operations – East, Kent Community Health NHS Trust), Marie Dodd (Acting Chief Executive, Kent and

Medway NHS and Social Care Partnership Trust), James Sinclair (Director of Partnerships and Social Care, Kent and Medway NHS and Social Care Partnership Trust), Geraint Davies (Director of Commercial Services, South East Coast Ambulance Service NHS Foundation Trust), Robert Bell (Acting Director of Finance, South East Coast Ambulance Service NHS Foundation Trust) were in attendance for this item.

(1) The Chairman introduced the item and explained that this was the third and final meeting in a series examining NHS Financial Sustainability and that the Trusts present would be invited to provide an overview from their perspective.

(2) Philip Greenhill from the Kent Community Health NHS Trust began with the information that the Trust employed 5,700 staff and had a budget of around £200 million. They needed to find £14 million in efficiency savings. Most of the income for the Trust came from block contracts but the value of these had been reduced by 1.5% which equated to a £2.6 million cost pressure. There were also cost pressures because of pay uplifts and high cost drugs. Part of the solution was in back office savings but the biggest was in workforce productivity and this was being examined as the Trust was carrying out the largest community services staff study in England. Nationally, district nurses spend 22% of their time with patients; Kent has managed to increase this to 45-46%. Another area is improving community hospital throughput. The biggest cost pressure was identified as demand in the acute sector as the tariff increases the cost with activity. Both community services and social services have a role to play in reducing demand, as does the new 111 number which will assist in getting the entry point for patients correct.

(3) Responding to a particular question about the hospital at home scheme run in Medway, it was explained that this did not involve a double-payment as the service was provided by Medway NHS Foundation Trust and paid for out of the tariff paid to the hospital before the patient is discharged to the care of his or her GP.

(4) It was further explained that the £14 million which the Community Health Trust needed to find was 8% of the revenue budget. This provided part of the context within which the Trust was embarking on the journey to Foundation Trust status because attaining FT status meant there was more freedom to focus on the right financial strategies.

(5) On the subject of the Minor Injuries Unit at Sheerness it was explained that this was only a temporary closure on safety grounds and that it was back open 9am to 9pm Monday to Friday and would be open at the weekend again soon. More broadly on the subject of community hospitals, it was explained that the whole of community services support the work the community hospitals undertake, rather than the hospitals causing funds to be diverted from elsewhere.

(6) Marie Dodd outlined the issues for the Kent and Medway NHS and Social Care Partnership Trust as being roughly similar to those in the community health sector. The block contracts were also facing a 1.5% reduction in value and there was a 4% savings, with £13.2 million efficiency savings to find and a £2.9 million QIPP negotiation with commissioners in order to find money for reinvestment. Similarly there were also pay uplifts. There was also a need for investments in Information Technology; currently there were two systems, a paper and an IT record system and this needed unifying.

(7) The main policy drivers were in early intervention, with money invested in a second Crisis Resolution Home Treatment Team in East Kent last year as coverage there had not been as full as in Medway and West Kent. NICE guidance around the use of dementia medicine earlier has had a £3 million cost impact. Work is ongoing with the Police and Ambulance Trust on making sure people did not end up in the wrong place; there had been a big rise in the use of 136 suites, but only 20% of people ended up being detained under the Mental Health Act. There was also a project being undertaken with Kent County Council involving housing and support to move people from inpatient facilities to community ones. The Trust had 3,600 staff with 90 off on long term sick leave.

(8) The issue of sick leave at the Trust was picked up by Members, specifically around long term sickness rates within the Thanet teams. Marie Dodd undertook to find out detailed information and pass it on to the Committee Researcher. More broadly, the long term sickness rate at the Trust was 4.5% which was higher than the NHS as a whole, due to staff being attacked on duty, but average for the mental health sector.

(9) Moving forwards, money for mental health would still reside within the NHS and useful discussions were underway with future GP commissioners; they had, for example, approved the move from Ashford to Canterbury. The Strategic Health Authority had approved the capital spend for the St. Martin's development for 2013.

(10) On dementia services, the Mental Health Trust picked up referrals after it had been identified by GPs and had fully trained staff for assessments. The Community Services Trust explained that community nurses were trained to identify dementia and early intervention was being included in the training programme.

(11) Geraint Davies gave a short overview of the situation of the South East Coast Ambulance Service NHS Foundation Trust. As part of achieving Foundation Trust status, the organisation needed to have a 5 year viable plan. The turnover is £165 million and has a £10 million cost improvement programme. The Trust has around 3,000 staff.

(12) The Ambulance Trust is looking to build on the work it has undertaken with NHS Pathways to provide a single point of access service directing people to the right place at the right time. It was currently talking to Primary Care Trusts on this and the 111 service would be tendered under the Any Qualified Provider model. The ambulance service was paid for on cost and volume contracts rather than block contracts, and a local PbR tariff was being developed.

(13) In response to a question on the co-responders scheme with the Fire Service, Geraint Davies explained that the Trust had funded the scheme to the sum of £90,000, but it has been decided not to continue with it because it was not best for patients.

(14) Dealing with some specific questions on the ambulance service, it was explained that the Make Ready programme had been funded from the Trust's own resources. If necessary, a Foundation Trust was able to borrow money, under strict controls.

(15) Across all Trusts there was a feeling that the block contract was not the most helpful funding mechanism and there was a need to hold the whole health economy to account for delivering complete pathways of care. This would help ensure efficiencies with patients seeing the right people at the right time.

(16) The Chairman thanked the Committee's guests 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.