

## KENT COUNTY COUNCIL

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### HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at Sessions House, County Hall, Maidstone on Friday 8 February 2008.

PRESENT: Lord Bruce-Lockhart (Chairman), Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr A R Chell, Mr B R Cope, Mr A D Crowther, Mr D S Daley, Ms A Harrison, Mr C Hibberd (substituting for Mr J A Davies), Mrs S V Hohler, Mr G A Horne, MBE, Mr R A Marsh, Mr W V Newman (substituting for Mrs E D Rowbotham), Dr T R Robinson, Mr R Tolputt and Mrs E M Tweed.

OTHER MEMBERS PRESENT: Mr G K Gibbens (Cabinet Member for Public Health), Mr C J Law and Mr J F London

OBSERVERS: Mr J Cunningham, Mr R Kenworthy, Mr J Larcombe, Ms A Loveday, Ms C Swann, Mrs F Witherden from the Patient and Public Involvement Forums.

IN ATTENDANCE: Mr P D Wickenden, Overview, Scrutiny and Localism Manager, Dr D Turner, Research Officer to the Health Overview and Scrutiny Committee, and Miss T A Grayell, Democratic Services Officer.

#### UNRESTRICTED ITEMS

##### 5. Chairman's Announcements

The Chairman thanked the Vice Chairman, Mr M J Fittock, for chairing the Committee's meetings while he had been away undergoing medical treatment. He also thanked Members of the Committee for their support and best wishes during his treatment.

##### 6. Membership

Members noted that Mr R A Marsh had joined the Committee in place of Mr D A Hirst.

**7. Minutes**

(1) RESOLVED that the Minutes of the meeting held on 11 January 2008 were correctly recorded and that they be signed by the Chairman. The Overview, Scrutiny and Localism Manager pointed out that a scoping document for the proposed Select Committee on Transport and Access to Healthcare, referred to in Minute 3, paragraph (c), had been tabled.

(2) The Chairman proposed, and it was agreed, that the Committee should have a regular agenda item, under the Minutes of the previous meeting, to look at what progress had been made on recommendations it had previously made.

**8. Local Involvement Network (LINK) Update**

*(Item 4 – report by Mr G K Gibbens, Cabinet Member for Public Health)*

*(Mrs M Blanche, LINK Lead and Senior Policy Manager, and Ms R Gardner, Management Trainee, Kent Graduate Programme, were in attendance for this item.)*

(1) Mr Gibbens thanked the Committee for inviting him to update them on progress on the LINK. He explained that the LINK project had now reached the stage of launching the tendering process to find the host organisation. Briefings had taken place with County and District Council Members and meetings with the voluntary sector. Mr Gibbens outlined KCC's role in relation to the LINK as being to manage the tendering process, stimulate public interest in the LINK and to

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performance-manage the host organisation. He thanked Mrs Blanche and Ms Gardner for their work in developing the LINKs project.

(2) In response to questions put to them by Members and Patient and Public Involvement Forum (PPIF) representatives, Mr Gibbens and Mrs Blanche explained the following:-

- (a) A key role of LINKs was to ensure a better information flow to HOSCs. A challenge to be addressed was how to ensure representation for hard-to-reach groups, such as gypsies and travellers, refugees, black and minority ethnic groups, etc.
- (b) The LINK, if it worked well, would draw in a good range of service users and organisations. As the body responsible for commissioning the host organisation, KCC would have more influence over the LINK than it did over PPIFs. A successful meeting, hosted by the PPIFs and aimed at voluntary organisations, and carer and user groups, as well as PPIF members, had been held at Lenham on 30 January.
- (c) Regarding arrangements for the transition to the LINK, 28 volunteers had so far come forward to join a Steering Group. The Group would be meeting in March, chaired by the current Chairman of the Medway Steering Group (who could share

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lessons from Medway's experience of having been a LINK "early adopter").

- (d) Every local authority in England, regardless of size, had been allocated the same sum – £10,000 – to cover the cost of setting up LINKs; in a large county, such as Kent, this would not go far. Ten per cent of the overall annual funding allocation for the LINK – £492,000 – would be kept back by KCC to cover the cost of its ongoing performance-management role in respect of the host organisation.
  
- (e) A Member asked about the possible workload arising from the right of LINKs to refer matters to HOSCs. Concerns were also raised by a PPIF representative about whether provision had been made for transitional arrangements from 1 April, in case the LINK was not operational from that date, as planned. He also questioned the planned top-slicing of the LINK funding allocation; some local authorities were not going to top-slice – and a few had actually contributed additional funding to their LINK budgets. Mr Gibbens and Mrs Blanche replied that the HOSC hoped to start the LINK as close to 1 April 2008 as possible. Top-slicing was occurring so that Kent had enough funding to cover its performance-management role in respect of the host organisation, and to support any referrals to the HOSC (the volume of which could not be predicted).

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- (f) Mr Gibbens would be happy to meet with anyone across the county who wished to discuss the plans for setting up the LINK. Information was available on Kent TV and the KCC website, and there was an extensive mailing list for the LINKs newsletter, which included local MPs.
  
- (g) KCC's planned Healthwatch body could assist the operation of the LINK by gathering information and signposting queries to the right place. KCC could not stipulate what the LINK did with this information, but the LINK ought to consider it. The county council had allocated £300,000 in the Medium Term Plan to fund Healthwatch.
  
- (h) The draft tender specification for the host organisation was now ready. The specification could not be published, due to commercial sensitivity – but it was no secret that it was based on Department of Health (DoH) guidance. There would be 40 days during which tenders could be submitted.

(3) RESOLVED that the information given on the set up of the LINKs scheme be noted, with thanks.

**9. Budget and Financial Plan – Eastern and Coastal Kent Primary Care Trust**

*(Item 5 – Mr D Meikle, Director of Finance and Investment of the PCT, was in attendance for this item at the invitation of the Committee)*

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(1) The Chairman introduced Mr Meikle and thanked him for attending. He said that, although the HOSC had not yet been able to have any information on the PCT's budgets, he felt it was still very helpful for the Committee to have a discussion with each PCT about the budget-setting process.

(2) Mr Meikle gave a brief introduction to the PCT's Operating Plan for 2008/09. He explained that the 2008/09 financial year was a one of transition, with the PCT's system for budget-setting and monitoring being different from that in previous years. He explained that, as Director of Finance and Investment, he was in charge of both commissioning and finance within the PCT. He hoped to develop a system for the future based on need, building client intelligence from commissioners, and adding national and local priorities. Funding decisions would be based on need, with better discussion and public involvement than in the past.

(3) His aim was to bring the whole process forward in the year, hence the process of putting together the PCT's Operating Plan for 2009/10 would effectively start on 1 April 2008. The PCT would work with partners to identify needs and constraints. On this occasion budget-setting had been delayed by PCTs' not knowing their financial allocations and National Priorities (set out in the NHS Operating Framework) for 2008/09 until December 2007.

(4) The Chairman thanked Mr Meikle for his summary of the situation and said it was good that the HOSC would be able to be involved at an early stage in planning for 2009/10.

- (5) In answering questions from Members, Mr Meikle explained the following:-
- (a) PCTs had been given a one-off annual funding allocation for 2008/09, instead of the three-year allocation that was intended to be the normal pattern. This was because the funding formula was under review and would be changing soon. In future, PCTs would receive three-year allocations (which would consist of a definite figure for the year to come and indicative figures for the following two years).
  - (b) In East Kent there were now 11 'clusters' of GPs for the purposes of practice-based commissioning (PbC). It was variable how much commissioning decisions were being delegated to PbC clusters. Regarding audiology, for instance, most clusters were happy for the PCT to commission services, but three (at Whitstable, Deal and Ramsgate) had their own locally commissioned arrangements.
  - (c) Tariff splitting was an interesting challenge. As more care was shifted closer to home, more elements of patient pathways (such as diagnostics and rehabilitation) were being undertaken outside the acute hospital setting. If tariffs were not split, the PCT would end up paying for these elements twice. Acute providers, however, were reluctant to split tariffs, as they feared that financial risk would be transferred to them. It was necessary to create sustainable provision of alternative services in primary care, so that acute providers could

be reassured that they would not end up providing elements of care for which they would not be paid.

- (d) The strategic context was vital to achieving the DoH's goal of world-class commissioning. Areas of deprivation and need would be highlighted as part of this. Where priorities were driven by the demands of those who already had better services, namely the articulate middle classes, investment actually compounded inequalities in access to healthcare. PCTs now had to draw up Strategic Commissioning Plans, which took account of such issues and gave a five-to-ten-year view. On the basis of this, a one-year Operating Plan (equivalent to the old Local Delivery Plan) was produced, stating how the PCT would progress towards its strategic objectives. In addition, the PCT worked with acute providers (whether NHS Trusts or the private sector) to produce a Capacity Plan (Organisational Development Plan), showing how providers would deliver services.
- (e) 'Fit for the Future' was at the core of the Strategic Commissioning Plan and the Operating Plan, although it was not what was driving them.
- (f) Asked to comment on whether the existing weighted capitation formula was fair, Mr Meikle said that, as it currently stood, the formula

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reflected the challenges that the PCT faced; and it was up to the PCT to invest the money in the right place.

- (g) Mr Meikle was asked whether the 5.5% increase in PCT allocations for 2008/09 would be enough to cover the rising cost of drugs and fuel. He replied that the greater part of the PCT's funding allocation was spent on purchasing services from the acute sector, which were paid for under the national tariff. In so far as increases in costs were not fully reflected in the annual uplift of the tariff, they were a pressure on providers rather than commissioners.
- (h) The PCT had a responsibility to ensure that it balanced its finances. In relation to PbR, it built its budget by working out the number of operations expected and the cost of each under the tariff. Financial managers would meet monthly to monitor the level of activity and sign off the budget month by month. Any disparity between the level of services contracted and the level actually undertaken was then addressed. The PCT's budget allowed for flexibility in the range of +/- 5% over the year; if this was exceeded, the budget had to be reworked to allow for the changed level of activity.
- (i) Funds that had previously been top-sliced from the PCT's growth funding were being returned; some had come back at the start of 2007/08 and the rest would be received in 2008/09. Discussions on possible further top-slicing in 2008/09 were ongoing; the NHS

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Operating Framework did include provision for the creation of a Strategic Change Fund to pump prime change at Strategic Health Authority level.

- (j) PbC represented a challenge to the existing culture of the NHS. Commissioners would need to be certain of the availability of sustainable local services. PCTs “held the ring” as regards both commissioning and providing, monitoring clinical governance, quality, etc.
- (k) The withdrawal of acute Trusts from the Resource Accounting and Budgeting mechanism at the beginning of 2007/08 had been helpful, as previously a technical accounting issue had been impacting adversely on the planning of future services.
- (l) Accurate forecasting was a challenge. PCTs worked with providers on an annual basis, looking at sources of demand, referral patterns, etc.; and five-year public projections were used to try and map future demand.
- (m) The PCT faced two key challenges: firstly, to address health inequalities and help the whole population to access health services; and secondly, as the population aged, to take account of consequent changes in need and ensure suitable pathways.

- (n) The PCT's remit was increasingly to develop the provider market in the NHS and to promote maximum choice, with the aim of driving up quality. This was a challenge in an area such as East Kent, whose geographical location made it less likely that alternative providers would want to challenge the local monopoly NHS providers. However, there had been some success, for example in audiology over the past eighteen months, where a private-sector procurement had achieved a reduction in waiting times. There were risks, but the PCT could cope if it had good quality data to allow it to commission services effectively.
  
- (o) Responding to a question about the possibility of using patient charges to damp down demand, Mr Meikle said that the DoH's policy on charging was and always had been very clear – that health services should be free at the point of delivery. The NHS sought to reduce demand through means such as health education – for instance using “health trainers” in the community to raise awareness of the need for everyone to take care of their own health.
  
- (p) Mr Meikle clarified some terms used in the internal PCT report which had been shared with the HOSC:-
  - (i) SIGs were Service Improvement Groups, composed of clinicians from primary and secondary care, charged with looking at care pathways and work relating to ‘Fit for the Future’; and

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(ii) The CET was the PCT's Clinical Executive Team, twelve clinicians charged with providing an objective clinical view on budget proposals.

(q) Mr Meikle was asked about the possibility of patients choosing to be treated in mainland Europe, where costs were lower than in the UK. Mr Meikle said he was unable to comment on a comparison of prices for treatments in the UK and mainland Europe. He explained that patients had increasing choice about where they could be treated in England. If options for treatment in Kent, the South East and London were exhausted and the 18-week maximum referral-to-treatment target could not be met, the PCT might consider commissioning treatment further afield.

(r) There had been an absolute increase in the number of clinical staff employed by the PCT's provider arm and by East Kent Hospitals Trust. A workforce strategy group, consisting of all interested parties, met monthly to look at the Strategic Commissioning Plan and identify issues relating to staffing, skills balance, etc. Detailed figures would be sent in a written response.

(6) The Chairman then asked Mr Meikle for his views on the process of budget-setting and performance management, and the timetable for sharing this with the HOSC and allowing the HOSC a constructive role. Mr Meikle emphasised that his aim was for the 2009/10 budget process to begin much earlier than that for

2008/09. Broad outline proposals for the 2009/10 budget would be available as early as April 2008.

(7) RESOLVED that the information given in Mr Meikle's presentation, and in his responses to questions from Members, be noted, with thanks.

**10. Budget and Financial Plan – West Kent Primary Care Trust**

*(Item 6 – Mr S Phoenix, Chief Executive of the PCT, was in attendance for this item at the invitation of the Committee.)*

(1) The Chairman introduced Mr Phoenix and thanked him for attending. He said that, although the HOSC had not yet been able to have any information on the PCT's budget for 2008/09, he felt it was still very helpful for the Committee to have a discussion with each PCT about the budget-setting process.

(2) Mr Phoenix gave a brief introduction on the PCT's current financial position. The four PCTs that had preceded West Kent PCT had had widely differing financial performances and overall the outcome had not been good. In October 2006, when he had taken up his current post, the PCT had had a £30 million financial recovery plan and by March 2007 it had moved to a £15 million overspend. This and previous debts meant that the PCT had had to pay back £20 million in the 2007/08 financial year, leaving its budget very tight. In addition, the PCT had experienced unexpected expenditure in several areas, including specialist tertiary treatment outside the area and high drugs charges. However, the PCT expected to end the year in balance.

(3) Last year, the Local Delivery Plan had set out financial priorities for the three years ahead – but the PCT had not received its funding allocation until mid- to late-December 2007, preventing it from doing any effective financial planning before then. The allocation given had been for one year only, not the expected three years. The next two years' allocations from the DoH were expected in spring 2008. The allocation formula was to change and the PCT was nervous that it would be disadvantaged by the new formula. The PCT was required to meet the national targets and priorities for the NHS, set out in the 2008/09 Operating Framework and the "Vital Signs" indicators, which were a suite of national requirements and local priorities (identified through discussions with PPIFs, the 'Fit for the Future' process and work with PbC clusters).

(4) Three priority strands had been identified, which resonated with discussions that the PCT had had with the HOSC:

- (a) to reduce levels of Healthcare-associated Infections;
- (b) to improve access to healthcare;
- (c) to improve the health of the population and reduce health inequalities.

(5) In answering questions from Members and PPIF representatives, Mr Phoenix explained the following:-

- (a) The PCT was able to forecast its future demand reasonably well by looking at past patterns and emerging trends. Patient choices were

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difficult to predict, however. Choose and Book offered patients choice at referral and, under PbR, the money followed the patient. Movement here so far was slow, but the exercise of choice was expected to become more prevalent in the years ahead.

- (b) PbC was already shaping this year's one year plan and all PbC clusters had produced business plans for the coming year. PbC had been slow to get going but it had speeded up in the last six months to a level comparable to that achieved in other PCT areas.
- (c) Mr Phoenix thought that the issue of tariff splitting (or unbundling) was something of a "red herring" as regards making more use of community hospital services. Not a lot of work had been done on tariff unbundling but it was not a magic formula for community hospitals; there were other issues too. The starting point should be what the best place to treat people was, not financial processes. Tariff unbundling was a means to an end not an end in itself.
- (d) There was nothing the PCT could do to influence private dentists who chose not to accept NHS patients. A tendering process to increase capacity in the Tonbridge area and address the gap in provision would be underway by late spring 2008.
- (e) The PCT's financial turnaround plan to address its past overspends and go from a £20 million debt to break-even meant that, inevitably, it

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had had £20 million less to spend on healthcare than otherwise would have been the case. Repayment of the £20 million had been helped by: making efficiency savings; reducing posts; paying only for work undertaken; delaying investment in IT; holding vacancies for longer than usual; making more efficient use of the drugs budget; and cutting training courses. Since the PCT's budget had grown overall, the £20 million recovery had been achieved by containing spending rather than by making actual cuts.

- (f) Replying to a question about the impact of Private Finance Initiative (PFI) contracts on the local health economy, Mr Phoenix said that the Darent Valley Hospital PFI contract accounted for some 21% of Dartford and Gravesham Trust's annual budget. The Trust was doing well financially, but the cost of the PFI contract was a factor in its finances. The planned Pembury Hospital PFI contract would account for 15% of Maidstone and Tunbridge Wells Trust's annual budget. However, the cost of PFI projects for the Trusts was a financial issue for them rather than for the PCT.
  
- (g) Waiting times for some procedures had been reduced, but West Kent had not performed as well as East Kent, the latter having been a "pathfinder" for achieving the 18-week maximum referral-to-treatment target. The 2007/08 financial year had not seen as much progress as had been achieved in 2006/07, so there was a lot of catching up to do in 2008/09. Darent Valley Hospital was "on a knife-edge" to achieve

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the milestone target of 85% of referrals being treated within 18 weeks by March 2008. Maidstone and Tunbridge Wells Trust's hospitals had no realistic chance of meeting this target but would still try to achieve a decrease in waiting times.

- (h) Money saved on the PCT drugs budget, as reported in the media, would return to the PCT. Savings had been achieved by the use of more generic drugs and had been helped by management teams working with GPs' practices. However, the most expensive area of drugs expenditure was in secondary care.
- (i) Addressing health inequalities and unequal access to services would require investing in new schemes to 'add years to life and life to years'. West Kent was fortunate in having less variance than East Kent in the health levels of its population. Two particular priorities were campaigns on sexual health and smoking cessation. These campaigns needed to be targeted, as otherwise they tended to have most effect among those sections of the population that least needed them – thereby actually widening health inequalities.
- (j) The operation of Free Choice and the entry of new providers into the NHS market did have the potential to make the job of PCTs as commissioners much more difficult.

- (k) The PCT had negotiated to vary its contract with the Independent Sector Treatment Centre in Maidstone to ensure that referrals to the service were maximised (given that the PCT was obliged to pay for the full value of the contract regardless of the amount of work actually undertaken).
  
- (l) Funding for Diabeta 3 software and specialist dieticians, for diabetes patients, was not currently on the priority list – but discussions on this had not yet been concluded.
  
- (m) There was no real alternative to opting for PFI arrangements when building large-scale capital projects, as this was government policy. Mr Phoenix said that the Treasury metric showed PFI to be more cost-effective than traditional public-sector procurement. Annual PFI contract charges were more a pressure on the Trusts operating from the PFI buildings than on the PCTs commissioning services from them. The planned Pembury PFI scheme was predicated on the assumption that it would be cost-neutral to the local health economy overall (although transition costs would be borne locally). PCTs paid for most services on a tariff that was uniform across the country and so could not be affected by local PFI costs. If the PFI at Pembury did go ahead, West Kent would have among the best hospital stock in the country.

- (n) Making more cost-effective use of the drugs budget (as part of the measures to recoup the £20 million debt) had not prevented patients from having access to high cost drugs where these were genuinely needed. Changes to drugs used had not been made purely for financial reasons, but only if the efficacy of the drug was in doubt. However, newer, higher-cost drugs would present PCTs with a challenge in the future, as prescribing them for one patient would raise the expectations of others.
  
- (o) Involving clinicians in the management of the NHS was a challenge. PbC was partly about this, making GPs financial, as well as clinical, 'gatekeepers'. This had been attempted before, with GP fundholding; it remained to be seen whether PbC could do it. Clinicians tended to find finance and management boring compared to medicine. But an increasing number of managers came from a clinical background.

(6) The Chairman then asked Mr Phoenix for his views on the process of budget-setting and performance-management and the timetable for sharing this with the HOSC and allowing the HOSC Members a constructive role. Mr Phoenix said that the 2008/09 budget process had come too late to allow the HOSC any influence, but the process would start earlier for 2009/10. It was easy to have an abstract dialogue earlier in the year; the difficult bit was aligning this to hard financial numbers. He was confident that the PCT would be able to have a discussion with the HOSC in the autumn around the broad shape of the budget, even if no detail was available at that time. Mr Phoenix suggested a workshop

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format to help Members understand issues and express views. The Chairman welcomed the opportunity for the HOSC to have earlier involvement and a more constructive role in the PCT's budget setting process as the statutory role of the HOSC included the receipt of good information in good time.

(7) RESOLVED that the information given by Mr Phoenix in his presentation, and in his responses to questions from Members and PPIF representatives, be noted, with thanks.