HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 10 August 2009.

PRESENT: Councillor Dryden (Chair); Councillors Cole, Dunne, Junier, Lancaster, Purvis and P Rogers.

OFFICERS: J Bennington and J Ord.

PRESENT BY INVITATION: Councillor Brunton, Chair of Overview and Scrutiny Board
Simon Pleydell, Chief Executive, South Tees Hospitals NHS Foundation Trust
Anne Frizell, Middlesbrough Local Involvement Network (LINk).

****AN APOLOGY FOR ABSENCE** was submitted on behalf of Councillor Carter.

**** DECLARATIONS OF INTEREST**

No declarations of interest were made at this point of the meeting.

**** MINUTES**

The minutes of the meeting of the Health Scrutiny Panel held on 22 July 2009 were taken as read and approved as a correct record.

PRACTICE BASED COMMISSIONING – DRAFT FINAL REPORT

The Panel considered a draft final report on the information received and the views expressed so far in relation to Practice Based Commissioning.

Members focussed on the formulation of conclusions and recommendations for inclusion in the report based on the following: -

Conclusions

a) Practice Based Commissioning, if fully utilised, remains a hugely useful policy tool in developing local services according to local need. It does, however seem to be significantly underused and possibly even undervalued by the local clinical community.

b) On the basis of the representations heard, there appears to be a significant lack of clinical engagement, which is having a detrimental effect upon the impact of Practice Based Commissioning. The Panel also accepts that there is an element of 'Chicken and Egg' in this regard. PBC in Middlesbrough finds itself in the position whereby it would make a much greater impact if there was more extensive clinical engagement, although greater clinical engagement will (probably) only come when PBC has made some impact.

c) According to the evidence considered by the Panel, the PCT has shown considerable commitment and has invested significantly in Practice Based Commissioning in Middlesbrough, with sizeable amounts of finance being devoted to Practice Based Commissioning and a well resourced team of staff.

d) On the basis of the representations considered by the Panel, PBC in Middlesbrough has an excessively medical focus. Whilst the Panel accepts that medical matters will always heavily influence Practice Based Commissioning, there appears to be a lack of focus on wider determinants of people's health and non-medical interventions that could be of great assistance. The Panel therefore feels that Practice Based Commissioning is missing out on something that could have a huge local impact.

e) On the basis of the representations heard by the Panel, there does seem to be a great deal of work involved in getting an idea for a service to a delivery stage through PBC. Whilst the

Panel understands that a substantial amount of work is required to deliver a service, it would like to see the PCT consider whether any elements of that process could be made swifter and easier to navigate.

f) The Panel feels that there is a responsibility on General Practice to engage with PBC more than it is at present. From time to time, the Panel has heard representations from General Practice that there is not sufficient choice or variety to prescribe in certain areas, with mental health being a good example. PBC provides General Practice with an ideal opportunity to do something about such a scenario, so the Panel finds it disappointing that people do not engage more fully with the programme.

g) At present, the Panel feels that the small number of GPs that are actively engaged with Practice Based Commissioning is disappointing and ultimately places too great a strain on that small cohort.

h) On the basis of the representations that the Panel has heard, the Department of Social Care is not sufficiently involved in discussions about Practice Based Commissioning priorities in Middlesbrough despite the opportunity to do so. It therefore lacks an important perspective in its discussions.

i) The Panel feels that PBC would benefit from an overall clinical lead, with the necessary status and time to drive PBC forward. Such a development would ensure that there would be a clinical lead dedicated to working full time with cluster chairs, who would have the time, knowledge and credibility to drive the matter forward and actively engage with GPs and partners. Such a role could also take some strain off the practising GPs who are actively engaged with PBC.

Recommendations

i) That General Practice engages much more fully with PBC and takes an active role in the operation of the PCT's Strategy Delivery Groups. General Practice representation on each strategy delivery group strikes the Panel as a sensible and not too onerous way forward.

ii) That PBC and the Department of Social Care work collaboratively to take a joint responsibility and ensure that commissioning of services properly reflects the full spectrum of needs across Middlesbrough. This would assist the PBC Cluster by accessing the Department of Social Care's expertise around service design and commissioning. In addition, it would also encourage discussions around service design to focus upon the whole person, thereby complementing medical interventions with non-medical interventions, which could be just as powerful in the correct circumstances.

iii) That the PBC Cluster actively broadens its focus to consider commissioning around issues which have a wider focus than strictly medical interventions. This should include the preparation of a joint commissioning plan with the Department of Social Care, with a specified timescale.

iv) That the PCT and PBC develops a process that expedites innovations from the embryonic stage to the point where a service is operational, and looks to make that process as easy and swift to navigate as possible.

v) That the PCT employs a senior salaried clinical lead for PBC, who is principally responsible for convening and driving forward the PBC agenda across Tees.

AGREED that the draft final report be approved and the inclusion of the conclusions and recommendations as outlined above.

GOVERNANCE ARRANGEMENTS – SOUTH TEES HOSPITALS NHS FOUNDATION TRUST

The Scrutiny Support Officer submitted a report the purpose of which was to introduce Simon Pleydell, the Chief Executive of the South Tees Hospitals NHS Foundation Trust to report on the governance arrangements of the Trust.

The report indicated that the South Tees Hospitals NHS Foundation Trust was responsible for the management of the James Cook University Hospital and had recently become a Foundation Trust.

Members were reminded that Foundation Trusts differed from a NHS Trust as follows: -

‘ They are not directed by Government so have greater freedom to decide their own strategy and the way services are run;

They can retain their surpluses and borrow to invest in new and improved services for patients and service users; and

They are accountable to their local communities through their members and governors, their commissioners through contracts, Parliament and to Monitor as their regulator.

NHS foundation trusts can be more responsive to the needs and wishes of their local communities – anyone who lives in the area, works for a foundation trust, or has been a patient or service users there, can become a member of the trust. These members elect the board of governors.’

It had previously been reported that upon becoming a foundation trust, the governance requirements of organisations developed and became more complex. It had also been indicated that Board members had public, legal and regulatory responsibilities that were more onerous than NHS Trusts.

The Chair welcomed Simon Pleydell who as part of his introductory remarks gave an indication of the basic governance structure of the South Tees Hospitals Foundation Trust which was the largest in the Tees Valley and one of the top performing Trusts in the UK.

The structure of the Foundation Trust was described as follows: -

- membership was drawn from the local population (Middlesbrough, Redcar & Cleveland, Hambleton and Richmondshire) and included current and former patients and patient carers;

- as indicated in the FT Newsletter July 2009 the current membership was currently nearly 4,000;

- a Council of Governors represented the interests of members and partner organisations and comprised 34 persons of which 21 were elected by members (5 each from Middlesbrough, Redcar & Cleveland, Hambleton and Richmondshire; 3 from patient and carers; and 3 staff representatives) and 13 representing partner organisations;

- the Council of Governors appointed and determined the remuneration of the chairman and non-executive directors;

- Governors were responsible for an overview of strategic direction and annual plan of the organisation;

- the Board of Directors comprised the Chairman, 6 Executive and Non-Executive Directors.

Reference was made to the main differences of becoming a Foundation Trust, which included:

- provided greater opportunity for the local population to influence the provision of services which reflected the needs of the area;

- no longer directly accountable to the Secretary of State but closely regulated by Monitor, an independent regulator of NHS foundation trusts;

- Monitor was the authorising body for the Trust to operate as a foundation trust;

- greater financial flexibility to invest surpluses into services without needing to seek external approval;

- greater opportunity for innovation and working jointly with a wide range of organisations on how services were developed and delivered.

In commenting on the possible impact on health funding as a result of likely reductions in public spending the Trust's five year business plan as seen as helping to meet the increasing challenges without eroding the quality of service. In terms of current performance management it was noted that the Trust had scored high in relation to its patient satisfaction and staff surveys.

During the ensuing discussion the Panel sought clarification on a number of areas including the following aspects of the current governance arrangements.

It was confirmed that the Council of Governors was responsible for the recruitment and appointment of Non-Executive Directors and the day to day management of the Trust.

In commenting on NHS funding in future years the Chair referred to a health seminar to be hosted by the Panel on 8 September 2009 entitled A Tighter NHS Funding Settlement from 2011. Mr Pleydell reiterated the likely major financial pressures and acknowledged that efficiencies would have to be achieved.

The Panel referred to the extent to which the current processes were more open and transparent as a foundation trust than under the previous regime. In response Mr Pleydell confirmed that technically current procedures were more open and accountable to the local population. From a personal perspective Mr Pleydell indicated that he now met more people across the region and took part in radio phone-ins and television interviews.

Reference was made to recent publicity regarding problems, which had occurred with other hospital foundation trusts, and Members questioned a recent decision for the Board of Directors to now meet in private. Mr Pleydell confirmed that this was the case apart from four times a year when public meetings would be held to discuss the annual plan and to raise issues. Members referred to recent comments of David Nicholson, NHS Chief Executive regarding local accountability in the context of recent problems and the merits of transparency and openness. In terms of the Trust annual general meeting and mindful of current scrutiny processes Members suggested the usefulness of seeking views in an open session prior to an annual general meeting.

The Panel was advised that the Board felt that they were able to conduct the business in a more efficient and effective way if such meetings were held in private. Given the nature of some of the business to be transacted with particular regard to discussion on individual patient cases and highly sensitive issues it was noted that such business had always been conducted in private. Mr Pleydell acknowledged that it was early days and gave an assurance that the operation of such a process would be reviewed probably after one year of operation.

Members were keen to ascertain how members in particular linked into the overall consultative framework and how they could influence the decision-making process. In response, the Panel was advised of the link with the Council of Governors; opportunity to receive detailed information; receive feedback; take advice on how to develop different ways to communicate with the local communities; and attend the Trust's annual general meeting. Confirmation was given that technically the Trust operated as a public benefit company with a different constitution and licence to operate Mr Pleydell confirmed that details of the Constitution for the operation of the Foundation Trust would be made available to the Panel.

Anne Frizell, (Middlesbrough LINk) confirmed the current consultative arrangements, which included each LINk group receiving a report after each meeting of the Council of Governors the information of which was subsequently disseminated to local communities. It was acknowledged that both the direct and indirect links with and role of LINk representatives was continuing to develop.

An indication was given of the overall financial arrangements including confirmation that a more robust regime was in place, which included requirements, set by Monitor and a five-year Business Plan underpinning actions.

In terms of practice based commissioning an assurance was given that the Trust would continue to engage and develop relationships with partners and agencies to assist in informing the future pathways of care and how it is delivered effectively.

In commenting on recent recommendations on the Panel's Final report on car parking at James Cook University Hospital Mr Pleydell noted the suggestion that the consultative procedures should be more transparent especially with regard to the evidence of engagement with local groups about the ticket pricing structure.

AGREED as follows: -

1. That Mr Pleydell be thanked for the information provided and participation in the subsequent deliberations.

2. That in consultation with the Chair and Vice-Chair the Scrutiny Support Officer write to Mr Pleydell confirming the key issues for the Panel as outlined including the suggestion for an update to be provided to the Panel following a year's operation of the Trust as a Foundation Trust.

OVERVIEW AND SCRUTINY UPDATE

In a report of the Chair of the Health Scrutiny Panel, Members were advised of the key matters considered and action taken arising from the meeting of the Overview and Scrutiny Board held on 28 July 2009.

NOTED

ANY OTHER BUSINESS – REGIONAL HEALTH SCRUTINY

With the approval of all concerned the Scrutiny Support Officer gave an indication of recent discussions regarding the possibility of setting up a Regional Health Scrutiny Forum. Specific reference was made to a regional meeting to be held in Newcastle to discuss this matter further to which Members had been invited to attend.

AGREED as follows: -

1. That the information provided be noted.

2. That a further report be given on the outcome of the above event.