HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 1 August 2012.

PRESENT: Councillor Dryden (Chair), Councillors Cole, Junier, Mrs H Pearson and P Purvis.

PRESENT BY INVITATION: Councillor Brunton (Chair of Overview and Scrutiny Board).

ALSO IN ATTENDANCE: M F Graham, Deputy Director of Planning, South Tees Hospitals NHS Foundation Trust.

OFFICERS: J Bennington, E Kunonga, J Ord and S Perkin.

APOLOGIES FOR ABSENCE were submitted on behalf of Councillors Biswas, Harvey, S Khan and Mawston.

DECLARATIONS OF INTERESTS

There were no declarations of interest made at this point of the meeting.

MINUTES - HEALTH SCRUTINY PANEL - 12 JULY 2012

The minutes of the meeting of the Health Scrutiny Panel held on 12 July 2012 were submitted and approved as a correct record.

PRIVATE PATIENT UNITS - SOUTH TEES HOSPITALS NHS FOUNDATION TRUST

The Scrutiny Support Officer presented a report the purpose of which was to introduce representation from South Tees Hospitals NHS Foundation Trust (STHFT) who provided a briefing on the concept of Private Patient Units and potential impact on local NHS hospital services.

The Chair welcomed Mr M. Graham, Deputy Director of Planning, STHFT who highlighted the key points outlined in a briefing paper, Appendix 1 of the report submitted which covered aspects referred to in a series of questions previously forwarded to the STHFT.

By way of background information reference was made to the NHS White Paper' Equity and Excellence: Liberating the NHS' and the resulting Health and Social Care Act 2012 which included a strong theme on competition and privatisation in the NHS, and a debate about the ability to treat private patients.

In 2009, £5bn had been spent on private healthcare in the UK of which £2.8bn had been paid to private healthcare providers (£1.7bn to consultants and other clinicians and £0.5bn to NHS private patient units). Regionally, the North East had the lowest level of private medical insurance in the UK at 9.7%, compared to a UK average of 16% and the highest level in the South East of 22.3%.

Whilst data in respect of local markets for healthcare was difficult to obtain as such information was not collected or published nationally like NHS services it was pointed out that within 25 miles of James Cook University Hospital (JCUH) there were seven facilities offering private health services, in addition to other NHS hospitals offering private services and not including private mental health providers. The Panel was advised that STHFT only captured a small proportion of the local market since the Trust had not focussed on private patients and did not provide any dedicated or differentiated facilities unlike elsewhere.

The amount of the Trust's private patient income was currently reported as 0.36% (£1.63m of total income of £450.44m for 2010/2011) and 0.29% (£1.48m of £509.76m for 2011/2012). In terms of patient numbers this equated to 5,368 outpatient appointments in 2010/2011and 5,671 in 2011/2012 and 375 patients spells in 2010/2011and 355 in 2011/2012. The Panel was advised that private activity was performed around the margins of NHS activity for

instance by adding a private patient to the end of an existing operating theatre list and utilising a 'spare' bed on a ward. Reference was made however to facilities provided on a commercial basis to a privately provided skin service.

It was reported that whilst there was some private patient activity in many of the Trust's specialties most of the current patient activity was in cardiothoracic services, radiology and women and children's services. Although general surgery and orthopaedics were major areas of private activity nationally, they were not major services currently provided by the Trust. It was pointed out that whilst private cosmetic surgery was one of the other major areas of private activity nationally it was not currently provided by the Trust at all.

It was confirmed that the Health and Social Care Act 2012 effectively removed the cap on private activity for Foundation Trusts stating that, 'the principal purpose of a foundation trust is not fulfilled unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes'.

The Panel was advised that this would mean that no more than 49% of a foundation trust's income could come from outside the NHS in England. If a Trust wanted to increase the proportion of its total income earned from outside the NHS in England by more than 5% it must include this in its forward plan which must be approved by the Trust's governors. In terms of STHFT it would mean increasing the patient activity to more than 5% of the total income or more than £25m.

Given the current minimal level of activity in relation to private patient income the Trust was actively investigating the potential to increase such income and the resources that would be required. It was considered that the Trust had the potential to offer the more complex services which private hospitals were not able to provide and also to build on the quality of current NHS services and strengthen the expertise of medical staff and the co-location of all specialties and diagnostics on one site. It was felt that there was scope to expand all specialties in particular current general surgery and orthopaedic services and develop private cosmetic surgery services. It was pointed out that even if the level of activity in respect of private patient income significantly increased it would still be a small proportion in comparison with NHS services.

An assurance was given that as an organisation the Trust was strongly committed to providing NHS healthcare services and that private patient activity was seen as providing a business opportunity offering high quality services for private patients and to generate a significant and much needed financial profit to be utilised by the Trust for the benefit of NHS services. Although such a possibility was still being investigated research had shown that profit margins of 20% or more had been achieved elsewhere.

The Panel was advised that any resources used to deliver private activity, whether beds, operating theatre time or staff time would be in addition to resources required to deliver NHS activity and would be funded out of the private income. Given the current level of NHS activity it was noted that there were current difficulties in finding space for additional beds or finding unused theatre time which could be allocated to private patients at the JCUH. It was reported, however, that the Trust had an ambitious transformation programme with the aim of increasing efficiency, removing waste, and improving patient pathways and manage demand which should free capacity, either to reduce costs or to reuse for other services, including private patient services.

Mr M Graham reaffirmed that private patient business would not be pursued unless a significant financial gain could be invested for the benefit of NHS services and it would not impact on the delivery of such services.

In commenting on the development of private patient units Members emphasised the importance of ensuring that it should not be at the detriment of the delivery and development of NHS services. Members referred to statements made within the briefing report regarding challenges facing the Trust in terms of finding space for additional beds or finding unused theatre time for private patients given the current level of NHS activity. In response, Mr Graham confirmed that major work was currently being undertaken in order to achieve

efficiencies in delivering services including improvements to NHS patient pathways which could result in freeing up space within existing buildings and the availability of resources to invest in developing private patient units. It was confirmed that other options being examined included virtual wards. In terms of concerns expressed around possible detrimental affects on NHS services it was indicated that there was potentially less risk if there were dedicated facilities for private patients but it was reiterated that this would not be undertaken unless there was sufficient income generated to be re-invested into NHS services. Should private patient facilities be developed it was considered that the Trust would be in a better position to compete in the market with other providers and had the potential to offer more complex services.

In response to a Members' query it was confirmed that a relatively small number of people had been assigned by the Trust to undertake work around the development of private patient units and a decision around the possible need to seek additional resources externally in terms of appointing a temporary project manager was being considered. Whilst such work was being funded by the Trust the aim was to generate a larger return in order to provide facilities for private patients and ultimately re-invest into improving NHS services.

Following Members' requests for further details in relation to such areas as the forward plan, direction of travel and the extent to which private patient units would be developed it was indicated that the concept was still being researched and it was too early in the overall process to have firm proposals on such matters. The forward plan provided details on financial sustainability and how services would be developed for the benefit of patients. It was suggested that the Trust would be in a better position in probably six months' time to provide more detailed information for the Panel.

In commenting on overall reporting arrangements with the Trust's Governors and publication of the forward plan an assurance was given that the Governors would be kept informed on a regular basis in terms of developing private patient units regardless of the statutory requirement for them to be informed if it was intended to increase the proportion of the Trust's total income earned from outside the NHS in England by more than 5%. It was confirmed that further details on this matter could be provided.

Members reiterated the importance of having appropriate procedures in place to ensure that the possible development of private patient units did not have a detrimental affect on local NHS hospital services.

Members agreed that whilst recognising that the Trust's current work in respect of the possible development of private patient units was in its initial stages it was considered useful if a briefing report could be prepared on the Panel's observations at this stage of the process. In particular, Members were keen to seek assurances in terms of ensuring appropriate governance and reporting arrangements in addition to the statutory requirements and how income generated from the private patient units would be utilised.

AGREED as follows:-

1. That Mr Graham be thanked for the information provided.

2. That the South Tees Hospitals NHS Foundation Trust be requested to provide a progress report in approximately six months' time on the possible development of private patient units.

3. That the Scrutiny Support Officer in consultation with the Chair and Vice-Chair compile a briefing report on the Panel's observations as outlined and including recommendations for consideration by the Health Scrutiny Panel.

HEALTHY LIVES, HEALTHY PEOPLE - UPDATE ON PUBLIC HEALTH FUNDING

In a report of the Scrutiny Support Officer Members were reminded of the main points raised at the meeting of the Panel held on 12 July 2012 with regard to evidence received in relation to current Department of Health proposals as outlined in a consultation document on Public Health funding.

By way of background information the Director of Public Health reported upon the NHS Reforms in particular the public health functions which would become the statutory responsibility of local authorities with effect from 1 April 2013. An indication was given of such functions which centred on three main categories.

The Department of Health proposed that the key determinant that would establish levels of funding would be on the premise of a standard mortality rate of 75. As indicated at the last meeting a view had been expressed that by opting for such on approach there was a risk of insufficient attention being given to levels of deprivation in a given area and for areas such as Middlesbrough there would be reduced funding for discretionary, locally driven work.

The Panel had been advised that the Department of Health had assured local authorities taking on public health responsibilities in April 2013 that funding for 2013/2014 would not be less than current funding levels but there was uncertainty in respect of 2013/2014.

In order to determine the level of funding from PCT's to local authorities the Department of Health had undertaken a mapping exercise in 2010/2011 and a baseline structure was published in February 2012 prior to the publication of proposals on a new public health funding formula. The baseline estimate for 2010/2011 was reported as £14.8m which reduced to £14.1m taking into account those public health functions which would not be the responsibility of local authorities. Public health funding would be ring-fenced but there would be flexibility to supplement with other sources of funding. It was confirmed that whilst the Authority had public health statutory functions (approximately £7m) there would be certain flexibility on utilisation of remaining resources (£1.3m) on health related activities as long as there was evidence of a health outcome.

It was noted that formal responses on the proposed public health formulae needed to be submitted to the Department of Health by 14 August 2012. A report had been considered by the Overview and Scrutiny Board at its meeting held on 24 July 2012. It was intended that a formal response would be compiled for consideration by the Executive prior to submission to the Department of Health. The Panel was advised of aspects which would be covered in the Council's formal response which included the level of allocations which historically had been significantly higher than other areas and concerns highlighted as to the impact on the work already undertaken should such levels be drastically reduced.

AGREED as follows:-

1. That the Officers be thanked for the information provided.

2. That the Scrutiny Support Officer liaises with the Director of Public Health with regard to the Health Scrutiny Panel's observations for inclusion within the Council's draft formal response on the Department of Health's consultation document on public health funding to be considered by the Executive.