HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 13 September 2012.

PRESENT: Councillors Dryden (Chair), Biswas, Harvey, Junier, Mawston and P Purvis.

PRESENT AS OBSERVERS: Councillor Brunton (Chair of Overview and Scrutiny Board).

OFFICERS: J Bennington, E Kunonga, J Ord and K Warnock.

APOLOGIES FOR ABSENCE were submitted on behalf of Councillors Cole, S Khan and Mrs H Pearson.

DECLARATIONS OF INTERESTS

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

1 **MINUTES - HEALTH SCRUTINY PANEL**

The minutes of the meeting of the Health Scrutiny Panel held on 20 August 2012 were submitted and approved as a correct record.

2 **DRAFT HEALTH AND WELL BEING STRATEGY**

The Scrutiny Support Officer submitted an introductory report on the development of Middlesbrough's first Joint Health and Well Being Strategy 2012-2022 which set out the long - term vision of the Middlesbrough Health and Well Being Board and how through collaborative working would respond to priorities identified in the Joint Strategic Needs Assessment.

The Strategy provided the overarching vision and strategic framework for improving health and well being and tackling health inequalities in Middlesbrough. The Strategy was underpinned by a number of national and local policies, strategies and action plans as set out in the draft document.

The Director of Public Health gave a presentation which included a Middlesbrough Health Transformation Programme update, progress on improving health and well being challenges and the emerging Joint Health and Well Being Strategy framework.

Specific reference was made to ongoing discussions regarding the most appropriate model to be established for the local Health Watch which would be supported by national Health Watch. The preferred option was to allow sufficient time for a Local Health Watch to develop expertise over the next few years and then consideration given to adopting a south tees approach as in the case of existing Foundation Trusts.

In response to clarification sought concerning the involvement of the MVDA with regard to representation on the Health and Well Being Board the Panel was advised that the organisation was facilitating the identification of the most appropriate voluntary sector representation on the Board.

In discussing the importance for community engagement to be at the right level, Members requested further information on such mechanisms and with particular regard to the BME community. Reference was made to evidence which had been obtained from local health representatives which had demonstrated problems of access and take up by members of the BME community to certain health services. Whilst reference was made to the supporting structures including the Task and Finish Groups of the Health and Well Being Board the Panel was keen to ascertain more detailed information on which group and persons would be responsible for that area of work.

In terms of the current health picture in Middlesbrough the Panel's attention was first drawn to improving trends.

Statistical information was provided which showed that male life expectancy rates were increasing although still below the rate for Tees and the English average. It was noted that there was a similar pattern in respect of female life expectancy.

Middlesbrough had continued to make progress in improving health outcomes for the local population over recent years but an increased rate of improvement was required to narrow the gap with the England trend.

Specific reference was made to deaths from cardiovascular diseases which had fallen faster in Middlesbrough compared to England falling by 66% between 1995 and 2010. It was acknowledged that this had been achieved not only by improvements in primary and secondary care but contributions from a whole system approach including early diagnosis, preventative measures and early screening.

Graphical information was also provided which demonstrated the gradient of social inequalities in health life expectancy which reduced by two years for every mile from the suburb to the Town Centre. One of the challenges was to focus on reducing the life expectancy gap even further between Middlesbrough and England.

Through consultation with key partners and reflecting on the findings of the JSNA, the Health and Well Being Board had identified four strategic aims as follows:-

- Ensure children and young people have the best health and well being.
- Reduce preventable ill-health and early deaths.
- Ensure high quality, sustainable and joined up health, social care and well being services.
- Tackle social causes of poor health and well being.

Such themes would form the basis of the Board's annual work programme and focus on implementing actions and ways of working, over and above existing activity under each of the themes. The draft Strategy document provided details on the current picture, strategic priorities for the Board to focus on and high level outcomes.

Targets within the Strategy would be monitored against the JSNA priorities and the public health outcomes framework.

In terms of the proposed timetable it was noted that the Strategy was to be considered and agreed by the Health and Well Being Board in October 2012.

The Panel noted that as part of its remit the Health and Well Being Board was responsible for promoting integrated and partnership working between the NHS, social care, public health and other local services. Whilst Members acknowledged the statement made that the Board would influence partner agencies and strategic forums to ensure social causes of poor health and well being were being addressed it was considered that there should be more explicit reference to how issues such as the impact of average household income and access to affordable sport and leisure facilities would be advocated in the existing and emerging structures.

RECOMMENDED as follows:-

1. That in consultation with the Chair and Vice-Chair of the Panel a briefing note be compiled outlining the Panel's views on the matters raised with regard to the Health and Well Being Board.

2. That further information be provided on the mechanisms for providing appropriate representation from the voluntary sector on the Health and Well Being Board and its supporting structures and specifically the engagement with the BME community.

3. That further clarification be provided as to the areas within the existing and emerging structures which would focus on the influencing social factors, explicitly the impact of average household income and affordable access to sport and leisure facilities.

3 **HEALTH SCRUTINY PANEL FINAL REPORT - DEVELOPMENT OF PRIVATE PATIENT UNITS**

The Panel considered a draft Final Report on the outcome of the Panel's consideration of the topic of Private Patient Units and possible conclusions and recommendations which had been prepared in draft and circulated at the meeting as follows:-

Conclusions:

(i) The Panel considers that it is almost inevitable that given the challenging financial climate facing the NHS and the prevailing Government policy that actively encourages it, NHS organisations such as South Tees Hospitals NHS Foundation Trust, will seek to supplement their income by exploring private sources of income. the critical matter is how that process, provision of services and income stream is managed.

(ii) That Panel heard that the Trust would seek to establish a separate private patients unit, where all treatment would be undertaken and the patients would be accommodated. On balance, the Panel thinks that this is probably the correct decision, as this will at least lessen the likelihood of private work impacting on the provision of NHS work.

(iii) The Panel is clear that although there may be separate private and NHS units, all housed on the same JCUH site, it should be mandatory that any contracted partner in the provision of private healthcare services, should be bound to operate according to NHS clinical governance standards. The Panel thinks that this should be a non-negotiable aspect of any contract. It would not be acceptable for a Foundation Trust to argue that clinical governance and clinical standards are a matter for the contracted partner. This is important for reputation management, as well as patient safety and clinical quality.

(iv) The Panel feels that the governance arrangements established to monitor (and ultimately approve) the percentage of Trust turnover attributable to private income are too weak and too easy to evade, Governance arrangements stipulate that if the Trust wants to increase its private patient activity by 5% of turnover, in any one year, it must seek authorisation through the Foundation Trust governors process. The Panel is concerned that, hypothetically, a Trust could increase its activity by 4.9% of turnover each year and it would not need to satisfy any formal process of validation/approval. The Panel considers this unacceptable and would suggest that any increase in private patient activity should be presented to the governors for authorisation. If the NHS aspect of the Trust would benefit from that additional income, it is difficult to envisage a scenario when governors would object.

(v) The Panel notes that the South Tees FT has stated that the Tees area does not have as sizeable a private healthcare market as other areas. This may be the case, although the Panel would be interested to see whether the creation of private facilities at JCUH would stimulate demand and encourage a bigger market to develop. If so, the points raised become more important. This may well be the case if the NHS financial reality begins to impact on the quality of service provision.

(vi) Having made the points above, the Panel would point out that if a private healthcare market does exist on Teesside, it is surely a positive that the local NHS facilities may benefit financially from that. It may even help to recruit and retain key staff. Still, the Panel is clear that the Foundation Trust should be able to clearly articulate, on an annual basis, how much private income it has received and specifically what areas of NHS service provision have benefitted as a result.

Recommendations

(i) The Trust's governance arrangements should be tightened to ensure that any percentage increase in the Trust's turnover, attributable to private health care work, should be presented to and verified by, the Trust's Governors, Local Overview and Scrutiny Committees should also be informed.

(ii) That, in such event that a private healthcare provider contracts to deliver services on the Foundation Trust's property, the Trust ensures that the clinical governance standards in force are of the same rigour as NHS clinical standards. This should be a non-negotiable element of the contract signed.

(iii) That the appropriate local Health Scrutiny function receives a retrospective annual report of private activity each year, the money it generated and how that money has developed NHS services. The Foundation Trust should also publish a forward work programme of areas of clinical practice that it is considering providing or contracting to provide, a private healthcare equivalent.

(iv) That the Trust commits to a position statement which emphasises its status as an NHS organisation, that will fundamentally only provide private healthcare services to support and develop the provision of NHS services. That position should also make it clear that in such an event as the Trust's private work not providing adequate financial contribution to then operation of the Trust, it should cease in the provision of that private service. The Trust should never find itself in the position that the provision or contracting for the provision, of private healthcare work leaves the Trust out of pocket.

AGREED as follows:-

1.That the draft Final report in relation to Private Patient Units be approved subject to recommendations 2 and 4 being revised to reflect the following:-

(i) that in respect of recommendation 2, the provision of private patient units should not impact or detract from the NHS provision and that the quality of the physical environment of such areas should be retained;

(ii) that recommendation 4 be more explicit in that the Trust should provide an assurance that in the event of private patient units being developed such provision would only be provided if there were sufficient resources to do so without impacting on the NHS provision.

2. That the revised Final Report be forwarded to the Chair and Vice-Chair prior to submission to the Overview and Scrutiny Board.

4 **OVERVIEW AND SCRUTINY BOARD 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 21 August 2012.