Scrutiny - Cooperative Scrutiny Reviews

Tuesday 3 March 2015

PRESENT:

Councillor Mrs Aspinall, in the Chair.
Councillor James, Vice Chair.
Councillors Mrs Aspinall, Mrs Bridgeman, James, Dr. Mahony, Mrs Nelder and Dr. Salter.

Also in attendance: Carole Burgoyne, Strategic Director, Plymouth City Council; Jerry Clough, Chief Operating Officer of CCG and Managing Director, Western Locality, NEW Devon CCG; Ann James, Chief Executive, Plymouth NHS Hospitals Trust; Kelechi Nnoaham, Director of Public, Plymouth City Council; Steve Waite, Chief Executive, Plymouth Community Healthcare, Ross Jago, Lead Officer and Amelia Boulter, Democratic Support Officer.

The meeting started at 2.00 pm and finished at 3.45 pm.

Note: At a future meeting, the committee will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

1. **DECLARATIONS OF INTEREST**

There were no declarations of interest made.

2. **CHAIR'S URGENT BUSINESS**

There were no items of Chair's Urgent Business.

3. **Representatives of the health economy in Plymouth will attend the panel to give oral evidence and discuss the future for the health and social care economy in the city.**

The Chair welcomed everyone to meeting and thanked Jerry Clough, Carole Burgoyne, Ann James, Steve Waite and Kelechi Nnoaham to the meeting today to help the Panel to understand the underlying issues effecting the health and social care service today. The Chair also invited NHS England to the meeting under the regulations pertaining to this committee. NHS England sent their apologies and therefore would not be attending the meeting today and we will investigate this.

This review on Plymouth's Health Economy results from the significant pressure that was present in the health and social care system. This was the first opportunity to have the major organisations together and to have that public discussion on how the system could be improved.

The review hopes to address some of the following –

- NHS England allocations and related impact on Plymouth;
- Market forces factor and national tariffs;
- Public Health settlement;
- Regulatory bodies.

The Chair invited each of the health representatives to share with the Panel their main funding streams, challenges and recommendations on what could be done to improve the system.

Kelechi Nnoaham, Director of Public Health, Plymouth City Council.

Kelechi reported that Plymouth currently receives £47 per head compared to Portsmouth who receive £77 per head. The target figure for Plymouth would be £58 per head. The poor settlement Plymouth receives results from a poor baseline allocation and formula. The Department of Health uses the standard mortality rates for the under 75s as a basis for allocating funds and there was a strong case to rethink the use of this formula for allocating funding. In addition to this Plymouth has poorly invested in public health services in relation to other cities in the country.

Kelechi stated that a strong case should be made when looking at prevention, when it comes to allocating funds we do not invest appropriately in this area. The integration of health and social care was a huge opportunity to address the commissioning of health and social care services from prevention to wellbeing.

Carole Burgoyne, Strategic Director for People, Plymouth City Council

Carole reported that she has responsibility for a budget of £121m which included a projected overspend of £4.5m. This overspend was due to pressures in the system, such as children coming into care and the cost of high level need for residential and secure placements and the demands on domiciliary care.

It was also reported that from the 1 April 2015, the Integrated Health and Wellbeing, delivering "One System, One Budget" would be in place. This system would ensure that individuals would receive the right care, at the right time in the right place as well as meeting the financial challenges and demands in health and social care over the next 3 to 5 years.

Jerry Clough, Chief Operating Officer of CCG and Managing Director, Western Locality, NEW Devon CCG

Jerry reported that NEW Devon CCG's budget was £1.1bn, for Plymouth this was £320m and for Derriford Hospital was £420m. The CCG's deficit for 2014-15 was £24.7m, this overspend would get carried forward into next year. The CCG would commence the year with an accumulated deficit of £41.3m, this equate to 2% of the CCG's very large budget. In order to balance the books the CCG need to make savings of 5.5%.

Last year the CCG was identified as a challenged health economy and received external support. It was also highlighted that NEW Devon CCG were not the worse overspending CCG but it was still significant because of size and the difficult position the CCG faces. It was further reported that the western locality was in balance for the in-year financial position.

There was inequity on how the money was spent and to put this into context the CCG was the payment system for all healthcare services, 130 GPs, 3 acute hospitals, as well as the number of treatments carried out. The CCG need to resolve how they move to a more equitable position and to ensure that the people of Plymouth receive the right healthcare. A lot of progress had been made on integration and the move towards sustainability and spending money where people need it most. Integration doesn't mean stopping what we do but instead working as a whole system when commissioning and providing services.

Ann James, Chief Executive, Plymouth NHS Hospitals Trust

Ann reported that the Hospital Trust receives funding from different 4 funding streams –

- 3 CGGs
- NHS England
- Military Hospital
- Funding for medical education

The hospital in total receives an income of £429m with £200m received NEW Devon CCG.

The Hospital Trust was experiencing unprecedented levels of activity and pressure on the emergency department. This has resulted in a number of operations being cancelled; these cancelled operations have to be rescheduled. It was also reported that the system needs to keep pace with the population changes as well as supporting people to live longer, with the right type of services moving away from a hospital setting.

The Hospital Trust work in partnership with the Growth Board, Plymouth Ask and Plymouth Plan to pave the way on what the city would look like in the future. The Hospital Trust also works in partnership with Plymouth University on research and innovation as well as looking at alternative funding sources. It was highlighted that there were issues around education and training and how this was funded.

The Hospital Trust for a number of years faced a significant financial problem and currently has a £13m deficit. This leads to a number of significant challenges for the Hospital Trust with the ageing population with more complex needs and major rehabilitation. Structural funding issues, capitation funding and fair shares which is quite complex and there is a material issue on where the money is allocated. The material issue not being able to keep pace of needs of community services and how we address this and in what time scale is of real importance. The more we can focus locally to make those changes we will see a lot of improvement to make that transformation.

To have the right baseline funding for Plymouth was important given the ageing and deprivation issues within the city. Fair shares and looking at the year of death and there were a high proportion of people dying prematurely. How we attract resources for emergency care to what it actually costs, there was a 50% – 60% gap through emergency care and this had to be addressed. The market forces factor and the system on how the formula was designed, this was the lowest region in the country with a difference of between £12m – £17m depending on how you calculate the formula. The equity of the formula needs to be understood.

Steve Waite, Chief Executive, Plymouth Community Healthcare (PCH)

Steve reported that they recently undertook a Community Assessment Hub pilot which consisted of working with 29 people that would have been admitted into hospital. Out of the 29 people, 2 had overnight stay, 3 transferred to the emergency department and the remainder seen by a number of medical professionals prior to going home with the appropriate package of care and support with a social worker. The atmosphere and feedback to the pilot has been phenomenal and this was part of the future, making sure people are kept safe.

Steve was responsible for a £90m budget and works with 9 commissioners. PCH has a key role to play in how they support the health economy and was a major employer in the city. There were a number of challenges, such as the national requirement for waiting list targets for mental health services, district nursing was high and the packages of care being provided and to allow people to die in a place of their choosing was significant.

Another challenge for PCH was recruitment of staff into primary care, GPs, care of the elderly and children was very low. It was reported that PCH had experienced difficulty in appointing senior posts. Speciality commissioning and the CCG tier 4 unit was used very little by PCH, they had used the outreach unit and do like to keep children at home, placing people leads to delays in the system and this needs to be addressed. On a positive note moving forward PCH had a clear understanding of what people's needs were than previously.

In response to questions raised, it was reported that -

(a) the integration programme would address the lack of funding for Plymouth;

(b) the people of Plymouth were already feeling the impact of the financial situation with the number of operations being cancelled. The system cannot deal with the number of complex people coming through the system. Structural funding unfairness to be addressed as well as the distribution of resources and we have to do things together and for a plan to be built up and not entirely in our gift;

(c) the impact of the poor funding scenario and looking at where we disinvest to invest, for example, breastfeeding which is absolutely important to the life of a child, breastfeeding figures were poor but women accessing the services the rates of those women were higher than those not accessing that particular service. We do not have the money, we have fewer resources and the issue of low funding that we receive for the city and this was having an impact on people. We have to look at how we join our resources together to get the best for the people of Plymouth;

(d) the Plymouth Primary Care Trust (PCT) for Plymouth was under the fair shares scheme and was always in surplus or break even and the spend on public health was in line with allocations expected. Since the merging of the 3 PCTs into the new system everything moved around in terms of finances with a bigger pot shared several ways and now hard to make the comparisons;

(e) a vote was taken by practitioners to have one CCG and at an earlier point in the conversation they did look at Plymouth. For clarity the CCG needs to takes a firm and difficult decision to protect the population budget in Plymouth. The only way to get rid of the contracting systems and look at a capitation base underpinned by the 5 year forward view with more money being given directly to the provider and the CCG supporting the provider. There was a need for more people to access healthcare when they need it and for this to happen the whole system has to come together;

(f) the structural funding issues was fundamentally unfair for the people for Plymouth. The Hospital Trust has regular meetings with the Advisory Committee on Resource Allocation (ACRA) and Ann personally briefs the local MPs on the issues that have been shared today in hope that this issue is taken forward. Carole also briefs the local MPs and the Department of Health and advised them of the healthcare changes. Steve has put his view across to Dr Dan Poulter MP when he recently visited the south west;

(g) there was an initial understanding of the city based on statistics and elected members have good knowledge of the city. Public Health can produce a lot of data and can also work with elected member in greater partnership. This was a huge opportunity for elected members to take on more leadership on public health;

(h) there was a cohort of clinicians coming up for retirement and GPs were now looking at part-time roles rather than full-time positions. There were issues in attracting permanent members of staff and how we can attract high quality candidates and retain them;

(i) it was highlighted that some staff could earn more money within the retail sector. It was highlighted that staff were undertaking amazing work at the Hospital Trust. Staff, however, were choosing agency work as a career rather than taking on a more permanent role;

(j) integration of health and adult social care would commence from 1 April 2015;

(k) Plymouth Community Healthcare's overall budget was £90m and they currently had a £3m surplus. This surplus money would be reinvested back into the PCH and the community;

(l) there needs to be greater clarity on the real debt and if the market forces were addressed, the hospital's debt would not be as high. The debt was structural and the Hospital Trust was a high performing hospital and this debt does reflect this;

(m) was a huge public campaign underway, 'your own bed is the best'. The campaign is about stopping people going into hospital unless appropriate. There was a lot of willingness to try out new ways to support people actively at home and the benefits of staying at home;

(n) they were looking at primary care support closer to where people live and to think more strategically to allow visiting to happen throughout the day. The CCG were looking at different models of care for the future;

(o) they were taking advantage of every opportunity to make a case to change the formulas with regard to structural and market forces to ensure a fair allocation for Plymouth;

(p) Plymouth was striving to become a centre of excellence/innovation. Clinical research and trials taking place at the hospital in partnership with the university and the medical school. They were currently developing an app that checks for the early signs of dementia.

4. SUMMARY AND REVIEW

There are a number of issues which have contributed to the current financial crisis within the Devon health economy. **The review has agreed** that "Plymouth Health Deal" will be developed by council officers and partners which will reflects the following –

Structural Funding Issues

National Tariffs for Emergency Care

- Recognition that the current Tariff system, in failing to fund Emergency Departments appropriately, risks destabilising acute trusts.
- National Tariffs for Emergency Care should reflect actual costs, and cost effectiveness, of providing high quality emergency care.

Market Forces Factor

- Reform of the Market Forces Factor within health service funding allocations is required to address the significant underfunding of health services on the Peninsula.

Public Health Settlement

The NHS is becoming increasingly aligned to local priorities and stakeholders and Health and Social Care integration in Plymouth is testament to that. As such NHS resource allocation will need to be seen within the whole system with alongside the other public funding which contributes to health and wellbeing.

- A formula-based approach, based on a Standardised Mortality Ratio, will not help determine the overall scale of resources needed to improve health inequality. This formula has led to a systematic under-funding within the local authority. If the allocation system is a tool for achieving wider policy goals a fundamental review of the formula to is required to reflect local need.

Recruitment, retention and agency staff

NHS is undergoing enormous change and is experiencing considerable pressure with increasing demands in the working environment. Whilst there will always be a need for external agency staffing to cover short-term absences that occur there is a significant cost to using external agency staff and the amount spent in 2013-14 on contract and agency staff by NHS trusts was £1.2billion.

The panel was concerned that reliance on external agency staff is placing a considerable burden on NHS trusts. **The review agreed** that the Department of Health should consider a cap on commission rates for external agencies providing medical staff to the NHS.

In addition **the review agreed** that the development of "nurse pool" which offers guaranteed shifts and provides the opportunity to work throughout the health service should be considered as employment gateway to provider organisations on the Peninsula. In addition a casual nurse bank for the Peninsula should be developed.

The panel has noted that Peninsula Postgraduate Medical Education is performs well but feels that a review of fill rates may be in order to understand the underlying reasons why 8 Health Education South West training programmes are below 90% subscribed. The panel remains particularly concerned with low fill rates within Geriatric Medicine and General Practice. **The review agreed** that a recruitment marketing campaign to attract graduates to clinical positions in Plymouth and the Peninsula.

Education campaign

The review agreed of the opinion that increasing demand across the system can only be abated by significant investment in public health interventions.

Whilst the Thrive Plymouth initiative provides a starting point, a conversation with the public should be initiated at a national level to highlight the risks of, for example, undergoing surgical treatments when at BMI 35 or above.

At a national level the general public must be made aware that, by looking after their own health, they play a part in improving the health and sustainability of the NHS into the future.

Fair Distribution of Funding

The review was not assured that the allocation of funding across the CCG area was fair. **The review agreed** that the Caring Plymouth scrutiny panel consider this issue in detail in the new municipal year.

Primary and Specialist Care Commissioning

The review agreed to the consideration of the inclusion of specialist care commissioning within the section 75 regulations and supports the Government's move to include Primary Care commissioning with section 75 regulations.

5. **EXEMPT BUSINESS**

There were no items of exempt business.