A MEETING OF THE OVERVIEW AND SCRUTINY COMMITTEE

WAS HELD ON 8 OCTOBER 2012

Councillors Farr, Forder (Chairman) (P), Foster-Reed (P), Geddes (P), Gill (P), Hazel (P), Hylands (P), Jacobs (P), Jessop (P), Kimber (P), Scard (P) and Mrs Searle (P).

19. APOLOGIES

An apology for inability to attend the meeting was submitted on behalf of Councillor Farr.

20. DECLARATIONS OF INTEREST

There were no declarations of interest.

21. FAREHAM AND GOSPORT CLINICAL COMMISSIONING GROUP (CCG)

The Chairman introduced Dr David Chilvers and Richard Samuel, Chair and Chief Officer (Designate) of the CCG respectively.

A presentation was made by the Chair and Chief Officer of the CCG which provided Members with the opportunity to ask questions regarding their role and responsibilities and progress to date in establishing the organisation. A copy of the presentation as affixed as Appendix A to these minutes.

Mr Samuel advised that the creation of the CCG revolved around the Health and Social Care Act 2012. Organisationally the implications of the Act were the dissolution of Primary Care Trusts (PCTs) and Strategic Health Authorities. Some of the functions carried out by the local PCT would be transferred to Hampshire County, especially in regard to public health, promotion, prevention and health visiting.

Some functions were being transferred to Public Health England such as screening and some areas of protection, particularly communicable disease control. Also created, together with the CCGs, was a National Commissioning Board. Gosport would fall under the Fareham and Gosport CCG which would be taking on its commissioning role from April 2013. The population of the area was around 200,000 and the CCG would comprise 21 member practices. The 2012/13 budget was currently £291 million.

The CCG would be commissioning health care including the purchase of secondary (hospital) care. Some specialised areas would remain with the National Commissioning Board.

The mission of the CCG was for clinicians, managers and communities to work together on behalf of patients and the public to transform health experiences and reduce inequalities whilst keeping within an agreed financial envelope.

The message coming across was that public use of health services in Fareham and Gosport had been comparatively low which was somewhat surprising given the need identified, particularly in Gosport. The system was very lean and with an average outcome. There were inequalities in Gosport, for example the average life expectancy of men which was due to a number of factors including lifestyle.

It appeared that, in Gosport, people often attended the accident and emergency unit or minor injuries clinic as a proxy for visiting their general practitioner.

Key achievements of the CCG were:

- Improved waiting times
- Care closer to home: ENT, cardiology, gynaecology and diagnostics
- Cancer appointments
- Integrated older persons community service fully delivered
- Negotiation and management of provider contracts
- 111 and out of hours service re-commissioned
- New community diabetes service
- Building up of the use of the Gosport War Memorial Hospital

A variety of customers and providers had been observed and listened to with patients being at the centre of the process.

There would be an emphasis on the preventative aspect of the CCG's work with quality the main driving force. The greatest threat was a continued growth in demand for conventional unscheduled care.

The question of usage of the system was raised and whether, if more were to be spent in one area of service, another would suffer. The Committee was advised that there had been no confirmation as yet on the final allocation of financial resources although it was understood it would be based on practice, population and profile. The pace of change was slow but there was flexibility in the use of financial resources within the allocation.

Concerns were raised regarding the possibility of private providers tendering at low prices but "cherry picking" work. The Committee was advised that a uniform price was paid for a uniform service but there was room for negotiation on quality. There was a risk that some private providers may not wish to take on work involving more complex patients.

There were no block contracts for acute care - payment was made per patient per treatment. Patients had a choice of location for planned care provided through the CCG. There were sufficient providers in the Fareham and Gosport area which would give patients some choice.

Concerns were raised regarding the recent discussions between the Southampton and Queen Alexandra Hospitals over vascular surgery services. The Committee was advised that vascular surgical services were specialist in nature and so would not be commissioned by the CCG in future. It was, however, important how services were delivered. The Hampshire Primary Care Trust covered 1.2 million people. CCGs were local in nature and did not have the final say in some areas of work but would have to work hard to collaborate and exert influence. For vascular surgery the CCG had put forward a set of conditions to the hospital. Next year there would be five CCGs in the Hampshire area and they would have to try to ensure that vascular surgery reflected the needs of that area. Southampton and Portsmouth could be different but the role of CCGs was to identify local needs.

There could still be an adversarial atmosphere between the two providers but good ties had been developed between senior leaders. A meeting was to be held on 7 November which, it was hoped, would help shape the future.

With regard to changes to vascular surgery which the National Commissioning Body may propose, it was confirmed that consultation would have to take place.

The question was raised regarding members of the armed forces and their families. The Committee was advised that the process for the electronic transfer of patients was not yet underway and that it was a large, complex task. A key priority of the CCG was to support veterans and Mr Samuel undertook to provide the Chairman with a briefing note to be forwarded to the Committee members.

Concerns were raised that the Health and Social Care Act 2012 was a means to assist in the break up of the National Health Service with budgets becoming ever tighter. There were already providers seeking contracts. The Committee was advised that savings had to be made and CCGs would have to look at how to achieve better for less outlay. For example, the home oxygen service had cut out considerable wastage. Savings could be made without damaging patient care. With regard to “cherry picking”, the CCG had a responsibility to ensure that all work was to the benefit of patients.

Mr Samuel advised that policy was set by central government and it was the responsibility of the CCGs to interpret and apply the policy locally. He stated that he would not wish to see a fragmentation of the National Health Service and did not interpret the policy as such. The areas of market development were not impacting on the provision of critical 24/7 services such as accident and emergency.

With regard to a question about the service provided to armed services personnel, it was advised that they were covered by the military and their families by their local general practitioner.

The Committee was advised that customer choice, whilst applying in many areas of work, would not always be appropriate, for example, emergency treatment. Some treatments may be available abroad but not in the UK if required treatments were both appropriate and not available in the UK although such occurrences were very infrequent.

With regard to prices for work, the Committee was advised that these were set nationally. However, a market forces factor could apply if treatment were to be carried out in London. Different ways of buying care were looked at and, where long term care was needed, a long term package could be purchased.

The “choose and book” system was explained and it was emphasised that appointment time spans were given on information available the night before. The patient would be given a telephone number to call. Due to the historical nature of the information, the time spans may be subject to change.

The Committee was advised that private providers were keen to do a good job but the CCG would only want this at a good price. The future would depend on the provision of strong medical services and working with patients and communities to achieve what would be most effective.

Concerns were raised regarding the fitness of the CCG and Hampshire County Council to undertake its responsibilities following the Health and Social Care Act 2012 bearing in mind many hospitals had failed. Mr Samuel advised that, broadly speaking, the role of the Primary Care Trust with regards to public health had been transferred to Hampshire County Council, who had a strong track record in such an area. CCG fitness for purpose would be assessed by way of 119 indicators. There would be a large number of representatives from other organisations involved in the assessment and the CCG would have six months to prove its fitness. If successful, the CCG would then be established but not authorised. This authorisation would rest with the National Commissioning Body to whom the CCG would be directly accountable.

There would be representation for the local population via the local authority. There would also be accountability through the member practices which had voting powers. There was also extensive engagement, involvement, consultation and reporting to the public.

With regard to those leaving the armed forces with mental health problems, the Committee was advised that extensive work had been carried out by Hampshire Primary Care Trust. There would be some changes after the dissolution of primary care trusts but the CCG would wish to draw on existing expertise.

The question of mental health patients having to travel to Havant following the closure of The Meadows was raised. Dr Chilvers advised that concentrating the service in Havant was an example of achieving more for less and this was a planned operation where consultation had taken place. The ability to deliver in the community was being assessed.

Dr Pennells, who had been advising the Gosport Medical Scrutiny Working Group, raised the issue of the lack of local general practitioners who may be willing to be involved with the CCG. Dr Chilvers confirmed that he was more optimistic and a number of general practitioners were retiring or cutting their working hours. Of these a number could be interested, particularly if the CCG were seen to be doing a good job.

Dr Chilvers advised that the out of hours service had gone live on 2 October 2012. The previous provider had been Solent Health Care but, following the tender process, the service was now provided by Care UK, Southern Health and PHL. Dr Chilvers explained the workings of the system and stated that there had been some difficulties due to problems encountered by British Telecom. The system involved a significant change in ideology.

Dr Chilvers advised that there were significant challenges, particularly of a financial nature. There were targets to be met and Queen Alexandra Hospital needed to achieve foundation trust status.

The Chairman advised that the Chief Executive would be submitting a formal report to the next meeting of the Council regarding its representation on the CCG.

The Chairman thanked Dr Chilvers and Mr Samuel for their presentation and response to questions.

22. OTHER BUSINESS

There was no other business to discuss.

The meeting ended at 7.35 pm.

CHAIRMAN