COMMISSIONING A PATIENT-LED NHS – FORMAL CONSULTATION

1 BACKGROUND

1.1 The Council was invited by Essex Strategic Health Authority (SHA) to respond to formal consultations on the reconfiguration of health service structures, including those relating to Primary Care Trusts.

1.2 At the meeting of the Community Overview & Scrutiny Committee on 17 January 2006, the Chief Executive of Castle Point & Rochford PCT outlined the options which are being considered. The report which was made to that Committee is at Appendix 1.

1.3 The Committee resolved that the Essex Strategic Health Authority be informed that this Council's response be:-

"This Council wishes to express its disappointment with the proposals put forward for the future of Primary Care Trusts and considers the restructuring to be premature, given the progress made to date by the Castle Point & Rochford PCT. This Council would prefer to see the retention of a PCT for Castle Point and Rochford, but in view of this option being excluded from the proposals, will support Option 4 as the only local action". (Minute 11/06)

1.4 A response was made to Essex SHA following this resolution. The consultation deadline is 22 March 2006.

2 RECENT DEVELOPMENTS

2.1 Essex County Council has now determined its view on the restructuring of PCTs and is of the view that a two PCT structure – north and south Essex – is the best proposal. The Leader of Essex County Council has written urging the Council to support this proposal.

2.2 The Chief Executives of the PCTs of Harlow, Colchester, Tendring, Basildon, Castle Point & Rochford, Billericay, Brentwood & Wickford and Epping Forest have issued a joint response to the County Council's position statement.

2.3 These documents are appended so Members have all the available information:-

•	Appendix 2	-	Lord Hanningfield's letter
•	Appendix 3	-	Joint letter from the PCT Chief Executives
•	Appendix 4	-	Essex CC explanatory position statement with PCT notes (in bold italics)

•	Appendix 5	-	ECC proposals to achieve locality focus with PCT notes (in bold italics)

2.4 At Council on 23 February 2006 it was agreed that the matter should be referred to this Committee for further consideration.

3 RECOMMENDATION

3.1 Proposed that this Committee **RESOLVES** the response the Council should make to this consultation.

Graham Woolhouse

Head of Housing, Health & Community Care

Background Papers:-

Consultation document from Essex County Council 14 December 2005.

For further information please contact Graham Woolhouse on:-

Tel:- 01702 318044
E-Mail:- graham.woolhouse@rochford.gov.uk

Appendix 1

COMMISSIONING A PATIENT-LED NHS – FORMAL CONSULTATION

1 SUMMARY

1.1 The Council has been invited to respond to formal consultations on the reconfiguration of health service structures relating to

- Primary Care Trust arrangements in Essex
- Strategic Heath Authority arrangements in the East of England
- NHS Ambulance Trusts in England.

2 FORMAL CONSULTATION

2.1 This is the second stage of a consultation process which is being co-ordinated by Essex Strategic Health Authority (SHA). The "informal" consultation was considered at Policy & Finance Committee on 13 September 2005.

2.2 At that time, Members resolved to respond that *"this Council wishes to see the retention of a Primary Care Trust for Castle Point and Rochford (and specifically not a body that includes Southend) to ensure best fit with other local structures, particularly Local Strategic Partnerships, and to ensure effective communication with local people. The Council is concerned that the options appear to preclude the previously established localism agenda and would suggest that any review include partner organisations to facilitate consideration of the possibilities for rationalisation across public services."*

2.3 In summary, views are being sought on the following proposals:

Primary Care Trusts (PCT)

- Option 1 2 PCTs; North Essex/South Essex
- Option 2 3 PCTs; Essex County/Southend/Thurrock
- Option 3 4 PCTs; North Essex/South Essex/Southend/Thurrock
- Option 4 5 PCTs; Mid Essex/North East Essex/South East Essex/ South East Essex/West Essex

Strategic Health Authority (SHA)

- One SHA covering Bedfordshire, Hertfordshire, Essex, Norfolk, Suffolk and Cambridgeshire.

NHS Ambulance Trusts

- One trust mirroring the SHA area set out above

2.4 Castle Point and Rochford Primary Care Trust's Director of Primary Care and Partnerships, Liz McGranahan, will be attending the Committee to brief Members on the proposals.

3 RECOMMENDATION

3.1 It is proposed that the Committee considers the proposals and the response that the Council should make.

Graham Woolhouse

Head of Housing, Health and Community Care

Background Papers:-

Letter and consultation documents from Essex Strategic Health Authority, 14 December 2005.

For further information please contact Graham Woolhouse on:-

Tel:-
E-Mail:- graham.woolhouse@rochford.gov.uk

Appendix 2

Leader of the Council
Essex County Council
PO Box 11, County Hall
Chelmsford
Essex CM1 1LX

To: All District and Borough Councils
Thurrock and Southend Unitaries
All NHS Trusts and Primary Care Trusts
All Local Strategic Partnerships

Our ref: LH/kw/pct2002
Date: 02 February 2006

Dear Colleague

Commissioning a Patient-led NHS – new arrangements for Primary Care Trusts
Explaining the County Council's preferred option

You, like us, have been invited to respond to the Strategic Health Authority's formal consultation on new arrangements for Primary Care Trusts (PCTs). We believe that the decisions that will be taken following this consultation will have far-reaching effects on the people of Essex, Southend and Thurrock.

We are determined that changes to Primary Care Trusts should bring major benefits for the people of Essex, Southend and Thurrock. Our priorities are for better health and well-being of local people with reduced health inequalities across the area and for more joined up health and social care services so that each individual receives a seamless service. Our aim is a genuinely local service operating within an integrated strategic framework.

Across the Strategic Health Authority area our health colleagues spend £1.7bn. In the Essex County Council area alone we spend £400 million (gross) on adult social care and nearly £200 million (gross) on children and families. Add the expenditure of our colleagues in Southend, Thurrock and the District and Borough Councils on people's health and well-being and this all amounts to a major collective annual investment of nearly £2.5bn. It is crucial that this huge investment is properly planned, commissioned and directed.

We support the two PCT option because it is the best organisational structure to deliver stronger integrated commissioning across health and social care at both County-wide level and at local level. Two strong, well-resourced PCTs working closely with us on strategic planning and commissioning means a better chance of meeting the particular needs and aspirations of different localities across Essex. At a local level the resources freed up by the reorganisation of PCTs will enable our

services to work ever more closely with our health partners, local councils and the other local organisations that are part of Local Strategic Partnerships.
We are keen to ensure that there is a full and informed debate on the merits of the proposed options – and for our part we wish to share with you our views so that you can have the opportunity of considering what we have to say and the chance to give us and others your views on our position. Our Cabinet will decide the County Council's formal response to the consultation on 7 March.

We want to encourage full and frank discussion so we invite views on the proposition that:

The two PCT option, when allied to a strong locality presence, is best able to deliver a strong commissioning function integrating health with the social care and children's authorities.

We set out our reasons for supporting the two PCT option in the attached paper.
We hope you will be able to support our position.

If you would like to comment on our proposition and the points we make in this letter we would be pleased to hear from you. Please respond by 28 February to:

Tony Cox, Head of Strategic Commissioning and Policy Development
Adult Social Care
PO Box 297
County Hall
Chelmsford
Essex CM1 1YS
tony.cox@essexcc.gov.uk

You can send also your comments and views to our PCT consultation page on Essex County Council's website www.essexcc.gov.uk where we intend to publish all the responses we receive.

Finally, I do encourage you to enter into the debate. The proposed changes will affect the lives of all of our citizens and our democracy will be strengthened by an open and robust discussion.

Yours sincerely

Lord Hanningfield
Leader, Essex County Council

Appendix 3

Epping Forest NHS
Primary Care Trust

The Laurels
St. Margaret's Hospital
The Plain
Epping
Essex CM16 6TN

Tel: 01279 827856
Fax: 01279 827392

To: All District & Borough Councils
Thurrock & Southend Unitaries
All NHS Trusts and Primary Care Trusts
All Local Strategic Partnerships
Local Members of Parliament
Distribution list as attached

February 13th 2006

Dear Colleague

Re: Commissioning a Patient-led NHS – new arrangements for Primary Care Trusts Explaining the County Council's Preferred Option

I am writing on behalf on the Chief Executives of Harlow, Colchester, Tendring, Basildon, Castle Point & Rochford, Billericay, Brentwood & Wickford and Epping Forest PCTs in response to the letter and accompanying paper you recently received from Lord Hannigfield in which he set out the County's position regards the reconfiguration of PCTs in Essex.

I would like to state very clearly that although we, along with our Boards, are advocating the development of five PCTs for Essex, as close working partners of the County Council, we fully respect that the County has a view and in no way wish to undermine this.

However, as far as Health is concerned we feel that the whole purpose of the *Commissioning a Patient-led NHS* consultation is to focus on the patient and their needs and this, we all firmly believe, can only be achieved if PCT's are nearer to their populations.

As is expected with a consultation of this scale and potential implication, issues and facts do change and, on reviewing the paper, we felt that some of the statements are misleading or inaccurate in their interpretation.

These range from a point made in the covering letter, (health spend £1.9 not £1.7 billion), to more robust facts about the potential savings anticipated by merging to two PCTS being much less than stated in the consultation documentation. A point that Essex Strategic Health Authority now agrees to be correct.

I have attached the papers originally sent which have our points of clarification included as, as Lord Hanningfield rightly identified in his letter, a full and frank discussion is to be encouraged at the Cabinet meeting on March 7th. To this end we felt it important that by giving you the facts as health knows them to be, we could assist in making this a robust discussion as possible.

Along with my Chief Executive colleagues from the organisations listed earlier, I am happy to help with any further information should you require it, please do not hesitate to contact me on the numbers above.

Yours sincerely

Aidan Thomas
Chief Executive

Appendix 4

PCT Clarification on Commissioning a Patient-led NHS – new arrangements for Primary Care Trusts - Explaining the County Council's preferred option

Why are we keen on having two PCTs?

1. The new type of PCT will not just be an amalgamation of the existing organisations. It is not simply a question of altering geographical boundaries and carrying on as before. The new style PCTs will have significantly heavier responsibilities than current PCTs. But at the same time the new style PCTs are not just the old Health Authorities reborn with their old defects. The transfer of power to local GPs as practice-based commissioners and the increasing role of Local Strategic Partnerships together with similar moves within local authorities mean more of a focus on neighbourhoods and localities. The new style PCTs will require significant management capacity to meet these new responsibilities. And the more PCTs the less resources available to undertake these tasks. The two PCT option frees up the most resources to provide this local focus.

2. Stronger strategic commissioning requires responsible bodies able to see the wide picture so that resources are targeted at areas of greatest health need. The new style PCTs will set the framework for practice-based commissioning and will ensure that resources are allocated in a fair and equitable way across localities. Spreading the responsibility for this commissioning framework between 5 PCTs means it will be difficult to ensure consistency across Essex. The 2 PCT option provides the objectivity needed to balance competing pressures.

PCT Clarification:

Consistency across Essex may be gained but at the loss of local sensitivity and the ability to remedy health inequality at a local level.

3. Stronger strategic planning for a seamless community health and care service needs integrated commissioning arrangements across mental health, learning disabilities, services for older people, children and young people and for public health. Achieving this is one of the main drivers for change. Integration here means jointly commissioning health, adult social care and children's services; joint commissioning at specialist strategic level e.g. a single cross County commissioner to lead for both ECC and health on delivering the priority outcomes for children identified in Local Area Agreement and children's plan and a similar role for implementing the recently published community health and care White Paper *Our health, our care, our say*. Similarly joint working is required to underpin Local Area Agreement delivery e.g.

joint public health posts, others covering services for older people, people with physical disabilities etc. We already have excellent experience of jointly commissioned mental health and learning disabilities services on the North Essex: South Essex model. The two PCT option means we can roll out this successful model to the three other services much more easily than if we have to work with a larger number of partners.

PCT Clarification:

Joint working for health with other key local partners such as schools, and District and Borough Councils is more difficult with two PCTs than with five.

To ensure that strategy turns into action and reality, links with District and Borough councils will be significantly more important than linking with the County Council to improve health and reduce health inequalities. This does not belittle the importance of the County Council however their focus is Essex wide and they are reliant on District / Borough Councils to inform how services should be developed locally.

PCTs have developed very successful Local Strategic Partnerships (LSPs) with their respective District Councils. The representation on local LSPs means that key health targets can be prioritised across public sector partners, for example education and leisure services involvement in smoking cessation and reduction in obesity in children.

The establishment of two large remote organisations could result in health not being represented at the appropriate senior level at the LSP and the local focus at a strategic planning level dispersed among other, bigger population groups across Essex.

4. Operating locally, identifying and responding to local needs requires a focus on neighbourhoods and communities. There needs to be local integrated commissioning and planning of health, social care and children's services based on networks of GPs, schools, social care teams and local community organisations at a neighbourhood level. There could easily be over 40 such networks operating across Essex. Empowering, supporting and influencing them will require the resources freed up by PCT reconfiguration. How this would work is set out in Appendix A. Only the two PCT option provides enough resources to do this.

PCT Clarification:

This statement is factually incorrect there is only a marginal cost difference between two and five PCTs with the need for money to be spent on devolved structures in two PCTs which is recognised in the SHA consultation document.

5. The understandable desire to equate a larger number of PCTs with more effective locally based working is misleading. For example, a new Mid Essex PCT would not be able to offer a local service to any of the three localities without some form of structure below the PCT able to engage with the local Councils and the Local Strategic Partnerships. District and Borough Councils naturally want to achieve the most local organisation for their citizens but no solution will provide this without some form of locality working. See Appendix A for details. The two PCT option frees up enough resources to provide such a locality-based structure.

PCT Clarification:

The five PCT option enables the senior and executive elements of the organisation to be local and more locally accountable, whilst still enabling devolved management

6. The ability of the new style PCTs to work in close co-operation with the three children's and social care authorities will be crucial. Whilst other options drive a wedge between Essex, Southend and Thurrock with each authority potentially operating in isolation the 2 PCTs option gives the 3 authorities real incentives to work together with the South Essex PCT on their shared responsibilities whilst in North Essex the new PCT can concentrate on just one relationship.

PCT Clarification:

This is misleading; two new PCTs would have to concentrate on nine important local authority and six local authority relationships, whereas with five the most would be four.

7. It is important to look towards the future: there is to be a White Paper on the future arrangements for local government later this year and creating a number of relatively small PCTs in Essex will result in a organisational geography that lacks consistency or local focus and is in the longer term unsustainable. The two PCT option provides a strong foundation for future development and alignment with local government.

PCT Clarification:

This assumes a configuration of local government in the future which does not conform to government proposals and is uncertain.

8. Finally, our support for the 2 PCT option is consistent with the options being proposed for other large shires; for example Kent and Hertfordshire will have one or two PCTs in their area; Surrey will have just one. Moving to five PCTs across Essex would be extraordinary and difficult to justify. To quote the Audit Commission on the current health and local authority arrangements in our area "This place is too

complex". Moving to a two PCT structure starts the process of making the place simpler to manage – and that, in our view, is an important step on the way to improving the health and well-being of the people of Essex, Southend and Thurrock.

PCT Clarification:

This statement is incorrect ; Some large shires are consulting on few others on more PCTs; for example Hampshire is consulting on 6 PCTs , Devon and Cornwall on 6 PCTs, Gloucestershire and Wiltshire on 7 PCTs, Shropshire and Staffordshire on 5 PCTs, The population and geographical size of two PCTs would be exceptionally large and diverse in its needs.

What else needs to happen?

9. We have referred a number of times to the need for stronger integrated commissioning and for a locality-focus. Clearly we have a responsibility to say how we think these can happen and show how they will improve the health and well-being of local people. In Appendix A we set how we envisage both of these working. Whilst we have put considerable effort into our thinking we recognise that these proposals will benefit from opening them up to wider consideration. We therefore invite comments and views on these proposals in the expectation that they will be improved during the consultation period.

Appendix 5

PCT Clarification on: Commissioning a Patient-led NHS – new arrangements for Primary Care Trusts - Achieving stronger integrated commissioning of health and care services and ensuring a local focus.

Commissioning is about deciding how best to spend public resources to ensure needs of individuals, families, and communities are met as far as possible. It is about identifying needs, procuring and organising services to meet those needs, ensuring quality and value for money and monitoring and evaluating the outcomes.

The White Paper *Our health, our care, our say: a new direction for community services* makes clear that in future there will be much more joint commissioning between Primary Care Trusts and local authorities. At the individual level integrated Personal Health and Social Care Plans, integrated social and health care records and joint health and social care teams will change how services are delivered. Binding these changes together is the challenge for all.

Commissioning a Patient-Led National Health Service and the changes that will mean for the Primary Care Trusts in Essex provide the chance for health and local government to work together to create a coherent integrated approach to the commissioning process for improving the health and lives of children, adults and older people. This has to be done at 3 levels – strategic or new PCT level; local or District/Borough Council level (reflecting existing arrangements such as local strategic partnerships, children and young people partnerships, crime and disorder partnerships, and locality or practice-based commissioning clusters level (reflecting current moves to locality working, such as local delivery groups and neighbourhood policing).

Strategic commissioning – there is close alignment of the new PCT's responsibilities for protecting and improving the health of their communities and achieving joint commissioning of health and social care in their area with the County Council's statutory responsibilities as the Social Care and Children's Authorities for the same area. Both organisations are also responsible for ensuring that that there are resources (people, services and financial) available in the community to meet identified needs. So the new PCTs and the County Council should jointly identify the physical, social and mental health needs of the community, ensure an integrated approach to meeting these needs and jointly develop an approach to market and workforce development across their areas, something we have already begun to achieve in our partnerships for mental health and learning disabilities. This will key into other partners' arrangements such as the police, and the Learning and Skills Council.

Local commissioning – local here means District or Borough Council area. Each new PCT will cover a larger geographic area than its predecessors and it will need to ensure a strong local focus within its area. The County Council also faces this challenge and, in close conjunction with District and Borough

Councils and Local Strategic Partnerships, is developing the concept of 'thinking strategically, acting locally'. Crucial to this approach is the need to strengthen locally based planning capabilities and to align investment decisions with locally identified needs within an overall integrated commissioning framework. The local authority Health Targets in the local Sustainable Community Strategies and the outcomes sought by practice-based commissioning will converge at local strategic partnership level. With regard to children and young people, it is vital to maintain and improve current arrangements of local children's leads across health. At this local level it will provide a structure within which we can work more effectively with partners by becoming proactive participants in LSPs and the other local partnerships as we have begun to do with the development of the Local Area Agreement. The cross cutting nature of the reform agenda within localities, which incorporates better involvement of schools in the local community and service framework, better use of local housing resources in partnership with local Registered Social Landlords, the growing requirement to meet the new demands of a divergent population, a requirement to jointly plan within Local Development Frameworks, a host of sustainability targets and most importantly engaging local people in the decision making process through work with Districts and Town and Parish Councils means that the County and the new PCTs need to be major players within local areas. The new, larger PCTs should undertake joint commissioning with the County Council (as Social Care and Children's Authorities) and with Districts and Borough Councils at this level in order to ensure engagement with GP clusters.

PCT Clarification:

There is an important element to commissioning at the District and Borough council level that is missing from this description – that is the need for strategic commissioning of services to address issues of equity and deprivation and causes of ill health at a locality level. Until the establishment of District based PCTs those parts of Essex with for example the shortest life expectancy or no community mental health services were completely ignored. The County is important for collaborative working with health on providing services, but District and Borough Councils and local schools are more important to the actual delivery of, and improvement in, health development.

The modern NHS is about a 'health' service rather than a 'sick' service thus improving health in the population overall and reducing health inequalities is a vital role for the new PCTs and will require much greater joint working at a local level to achieve this effectively.

Locality Commissioning – locality here means a neighbourhood or community i.e. part of a District or Borough Council area. Whilst the exact definitions are variable and subject to further discussion, there is developing close alignment between many of these, for example, the local delivery groups through children's services and the proposed neighbourhood policing areas. This is very much where the individual comes into contact with services and where an individual service is provided. The key to empowering

patients within the National Health Service is Practice-based Commissioning where clusters of GP practices will be responsible for assessing local needs and for specifying the services to meet those needs. The more we secure close alignment with other locality working arrangements and Practice-based Commissioning, the better value for money and benefit to individuals and communities we are likely to secure. The focus on improving the health of the local community, the more intensive work with identified individuals who would otherwise need more serious (and expensive) interventions and moves to enable patient choice are directly comparable with the direction of our work with children, adults and older people. Bringing together at this local level GP clusters, schools and Local Delivery Groups, youth and children's workers together with adult and older people social care teams, and neighbourhood policing, to provide integrated commissioning for individuals enables local needs to be tackled in a comprehensive manner. As we are cluster our services around communities and neighbourhoods so the health needs of the community should shape the clusters of GPs. Clarification

PCT Clarification

As mentioned previously, this ignores the importance of District and Borough Council housing, leisure services, Public Health, Planning Departments and local Voluntary Coordinators are very important to Health Improvement, and future PCTs will need to be in close contact with these. The NHS Confederation supports our view that that there should be more local control in the NHS and better engagement with front-line staff, something that cannot be achieved with remote planning.

How would this work in practice?

Achieving stronger integrated commissioning

This will require:

- Governance arrangements between the new PCTs and the County Council covering the health and well-being of children, adults and older people, building on current arrangements such as the children and young people strategic partnerships.
- Joint commissioning posts with each PCT at a senior level across the health and social care leading on services to adults and older people and children and young people
- Joint ownership of the Commissioning Frameworks including that within which Practice-based Commissioning will operate
- Integrated strategies for market and workforce development including joint analysis of the impact of initiatives and ventures in procurement, risk-sharing, recruitment and training
- Alignment of budgets to ensure action follows commissioning
- Extending the existing joint commissioning arrangements to other areas of community-based health and social care, perhaps with County Council leading on services for people with long-term conditions and for children's mental health services and health services for looked after children

- Ensuring that locality-based GP clusters and other neighbourhood services operate an integrated person-centred approach

PCT Clarification

All of the above are possible with either configuration of PCTs and much joint work is already happening across organisations.

Ensuring a local focus

The key here is ensuring that the neighbourhood or locality based commissioning operates within a local accountability framework that allows local stakeholders to have a real say in decisions affecting their communities. So a strong local focus will need:

- Governance arrangements covering health and social care based on each Local Strategic Partnership area.
- Alignment of the local Children and Young People's Strategic Planning Partnership and the local Strategic Planning Partnership for Health and Adult Care with the appropriate local sub-groups of each Local Strategic Partnership so enabling increased involvement of voluntary and community sector and local representatives of patients, service users and their carers in planning and commissioning strategies co-operation on analysis of need and the development of local opportunities within the commissioning framework at local and locality levels
- Alignment of budgets to enable local action to drive an enhanced role for preventative services that can avoid expensive in-patient care.
- Extending the successful integration of service delivery in Learning Disabilities and Mental Health to exploit opportunities for further integrated services in Older People, Occupational Therapy, Intermediate Care and Day Hospitals/Day care.
- Maximising the benefits of Practice-based Commissioning by a joint development programme for local people involving GP clusters, the PCTs, District and Borough Councils, the County Council and voluntary and community sector in order to
- The PCT Commissioning Framework for practice-based commissioning should include mandatory requirements to ensure integration of GP clusters with neighbourhood/community/school clusters, local social work teams and the voluntary and community sectors
- A duty on each GP cluster to work with the Local Strategic Partnership

PCT Clarification

All of the above are possible with either configuration of PCTs however responding to local needs effectively can be more easily achieved with more local organisations who know their population and professionals who work with them.