KIRKLEES METROPOLITAN COUNCIL
Ad hoc scrutiny panel: Ensuring a patient-led NHS

The Overview and Scrutiny Office
Huddersfield Town Hall
Ramsden Street
Huddersfield
HD1 2TA

Telephone: 01484 221908
Web site: www.kirklees.gov.uk/scrutiny

March 2006

Contents

	Page
Membership of the committee	4
Terms of reference and working arrangements	4
Background and context to the review	5
Evidence, findings and conclusions	6

MEMBERSHIP OF THE COMMITTEE

The committee members were:

- Cllr Ann Raistrick
- Cllr Elizabeth Smaje
- Cllr Julie Stewart-Turner
- Cllr Molly Walton (Chair)

TERMS OF REFERENCE AND WORKING ARRANGEMENTS

The terms of reference for the review were:

To prepare and submit a formal response to the West Yorkshire Strategic Health Authority to the 'Ensuring a patient-led NHS' consultation on new strategic health authority arrangements in Yorkshire and the Humber and new primary care trust arrangements in West Yorkshire in accordance with the Local Authority (Overview and Scrutiny Committees Health and Scrutiny Functions) Regulations and subsequent Directions.

Members will seek to identify whether or not the proposals are in the best interests of the local population and make any recommendations as appropriate, focusing on the implications of the proposals for local communities and their likely impact on patient experience. Implications for health inequalities, in its broadest sense, will be a cross cutting theme in the review.

The review will take into account the views of patients, public and service users; relevant professionals; and other stakeholders including local authority services.

At the conclusion of the review the members will produce a written report and recommendations which will include:

- An explanation of the matter reviewed or scrutinised
- A summary of the evidence considered
- A list of the participants involved ; and
- Any recommendations on the matter reviewed or scrutinised.

The process will seek to reach a consensus view and the final report will reflect the views of all the panel members.

The 'Ensuring a patient-led NHS consultation' is not a formal 'statutory' scrutiny consultation under Section 11 of the Health and Social Care Act. This means that the panel does not have any formal powers of referral to the secretary of state.

The panel held three meetings during February and March 2006 to receive information and evidence from a range of individuals and organisations.

- 23/02/06 - the panel received an overview of the proposals from a representative of West Yorkshire Strategic Health Authority

- 02/03/06 - the panel received evidence from the current Primary Care Trusts (PCTs), acute trusts and South West Yorkshire Mental Health Trust.

- 08/03/06 - the panel received evidence from council services, portfolio holders and area committees.

Written evidence was also invited from the Public and Patient Involvement Forums (PPIFs) and Voluntary Action Kirklees.

The work of the panel was supported by John Heneghan (Overview and Scrutiny Team Leader)

The panel is grateful to the individuals and organisations who have contributed to this review.

BACKGROUND AND CONTEXT TO THE REVIEW

In July 2005 the Department of Health published the document 'Commissioning a patient-led NHS' which set out an agenda for reform of the health service by 2008. In response to this document West Yorkshire Strategic Health Authority agreed proposals to change health services in our area by reconfiguring strategic health authorities and primary care trusts (PCTs).

The proposals are to create a strategic health authority for Yorkshire and the Humber co-terminous with Government Office boundaries and to reconfigure PCTs in line with local authority areas. This means reducing the number of PCTs from 15 to 5 in West Yorkshire. For Kirklees this means reducing the number of PCTs from three to one. Changes to the roles of the organisations are also proposed.

These changes are intended to complement the major national policies of Choice of Provider, Payment by Results, Practice-based Commissioning and the development of the NHS Foundation Trusts Programme:

<u>Choice of Provider</u>

'Choice of Provider' aims to provide patients with more choice about when, where and how their healthcare needs are met. It is based on the results of a national patient consultation on Choice, Responsiveness and Equity in the NHS, carried out in late 2003 by the Department of Health, and involves offering a choice of treatment at alternative hospitals, improving the flexibility of public services, and making the NHS more patient-centred.

Payment by Results

In the past commissioning has largely been conducted through high level planning and block (fixed cost) contracts between purchasers and providers of health care. This is now changing. Under the new financial system of payment by results, hospitals will be paid a standard fee for the patients they treat and money will follow the patient.

Practice-based commissioning

Since April 2005 GPs have been able to become more involved with commissioning through an approach known as 'practice-based commissioning'. The aim is to have universal coverage of practice-based commissioning by the end of 2006.

Under practice-based commissioning GPs and practice staff will have access to a commissioning budget and will lead developments to produce more responsive local services. Practices will pay the national tariff for most hospital services, but crucially only for those services their patients use. Practice-based commissioning will allow GPs and primary care professionals to develop and fund innovative community services as an alternative to hospital for some patients. GPs will have a much greater say in the services to be provided to their patients.

NHS Foundation Trusts Programme

NHS Foundation Trusts are a new type of NHS organisation that have been given more freedom by the Government. The Government has stated that it is committed to providing all NHS Trusts with the opportunity to apply for NHS Foundation Trust status within the next three years, although the decision on when to apply remains one to be taken locally.

EVIDENCE, FINDINGS AND CONCLUSIONS

Strategic Health Authority proposals

Strategic health authorities are currently responsible for:

- Developing plans and improving health services in their local area;
- Making sure local health services are of a high quality and are performing well;
- Increasing the capacity of local health services; and
- Making sure national priorities - for example, programmes for improving cancer services - are integrated into local health service plans

Currently there are three strategic health authorities in Yorkshire and the Humber, and the proposal is that these three authorities should come together to form one strategic health authority for the region.

The focus of the new strategic health authority would be building the new system of commissioning and then maintaining a strategic overview of the NHS and its performance in the area. It would be responsible for ensuring that the organisations commissioning and providing local services are doing so in a way which meets the key national objectives of a healthier nation and care services which are high quality, safe and fair and responsive to changing circumstances. The detailed role of the proposed new strategic health authorities is described in the consultation document as:

- Maintain a strategic overview of the NHS and its needs in their area;
- Improve and protect the health of the population they serve by having a robust public health delivery system including emergency planning;
- Provide leadership and performance management for effective delivery of government policy for health and health protection through NHS commissioned services;
- Provide leadership for engagement of health interests in the development of strategic partnerships across the public sector (working with Government Offices of the Regions, Regional Assemblies, Skills Councils and Regional Development Agencies) to secure delivery of government policy;
- Build strong commissioning processes, organisations and systems;
- Ensure NHS trusts are in a position to apply for foundation trust status by 2008/09;
- Work with regulators and external inspectorates to develop the local health community, including ensuring choice and plurality of provision and managing the consequences of clinical performance failure and patient safety breaches;
- Promote better health and ensure that the NHS contribution to the wider economy is recognised and utilised at regional level;
- Lead the NHS on emergency and resilience planning and management;
- Work closely with the Department of Health to inform and support policy development and implementation and handle routine Parliamentary, Ministerial and the Department of Health business;
- Improvement of research and development, strategic development and delivery in each health economy in conjunction with the Healthcare Commission and UK Clinical Research Network; and
- Provide an effective communications link with the Department of Health, facilitating clear and consistent messages.

All acute trusts are intended to become Foundation Trusts by 2008. Unlike ordinary NHS Trusts (which are accountable to strategic health authorities), Foundation Trusts are accountable to an organisation called ‘Monitor’ (a non-departmental public body established under the Health and Social Care Act 2003, responsible for authorising, monitoring and regulating NHS Foundation Trusts). Therefore strategic health authorities’ performance management role will become increasingly focused on commissioners as they become responsible for fewer NHS Trusts.

However, while the new strategic health authorities will still have a performance management role, they will also have a broader, developmental agenda. The panel heard that the proposed merged strategic health authority will be coterminous with Government Office and the Regional Development Agencies which should better enable this more strategic, developmental role including taking forward bigger tasks which are better dealt with at a regional level (such as emergency planning and health protection). Members were informed that this better would enable it to see the 'bigger picture' in relation to services which span larger geographical areas - e.g. services coordinated through clinical networks.

The evidence received by the panel was overwhelmingly supportive of the proposal to create a single strategic health authority for the region.

CONCLUSIONS:

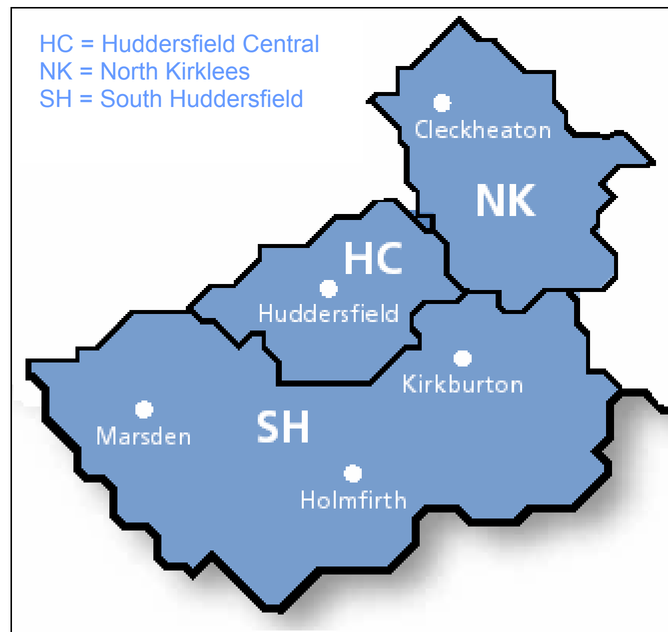
Given the change in functions of the new strategic health authority and the perceived advantages in aligning with regional government boundaries, the panel are supportive of the proposal to create a single strategic health authority for the Yorkshire and Humber region.

The panel considers that the proposed changes will lead to greater coherence and will increase the scope for public sector coordination on a wide range of health matters across the region.

Primary Care Trust proposals

There are currently 15 primary care trusts (PCTs) in West Yorkshire, 3 of which are in Kirklees. Following an independent review by the Audit Commission in 2003, South Huddersfield and Huddersfield Central Primary Care Trusts have established joint management arrangements, with one Chief Executive and a joint management team working across both organisations.

Currently, PCTs commission health care for their local populations from hospitals, GPs, ambulance trusts, and other providers. PCTs are now directly responsible for spending approximately 80% of the NHS budget. In addition to this commissioning role, some PCTs are responsible for directly providing community health services, including district nursing and health visiting. PCTs also have important statutory functions in respect of public health, including improving the health of their local communities and tackling health inequalities.



'Ensuring a patient-led NHS' proposes the creation of one primary care trust for Kirklees. Importantly, it also proposes significant changes to the role of new PCTs. Central to this will be the roll-out of practice-based commissioning with PCTs playing a lead role in supporting GPs and practices as they step into their new commissioning functions, and in managing new relationships with a wider range of providers. The detailed role of the proposed new PCT is described in the consultation document as:

- Improve and protect the health of the population they serve by assessing need and having a robust public health delivery system including emergency planning;
- Secure, through effective commissioning, a range of safe and effective primary, community, secondary and specialised services (some specialised services will be commissioned nationally, others by groups of primary care trusts) which offer high quality, choice, and value for money;
- Reduce health inequalities and ensure that the role of individuals is recognised and utilised at local level;
- Develop and sustain strong relationships with GPs and their practices and implement a system of practice-based commissioning;
- Work closely with local authority partners and other commissioners to ensure integrated commissioning of health and social care, including emergency planning;
- Ensure that nurses, midwives and allied health professionals play a key role in improving the health of local populations;
- Stimulate the development of a range of nursing, midwifery and allied health professional providers;
- Provide appropriate clinical leadership in a system of diverse providers;
- Develop robust communication and involvement systems to manage relationships and engage with their local residents and communities; and

- Ensure that a range of services are provided for their communities in ways that most appropriately meet their local needs.

The consultation document suggests that this proposal would bring a number of benefits for local people, including more joined up services between health and social care, leading to a reduction in inequalities of health services available to people living in different areas of West Yorkshire and significant financial savings which will be reinvested into NHS services. It suggests that the proposals will bring about improved purchasing of NHS services, as expertise, experience and learning is shared across larger organisations.

The consultation document sets out a number of benefits these changes are required to bring to local services, including:

- Securing high quality and safe services;
- Improved health and reduced inequalities;
- Improved engagement of GPs and roll out of practice-based commissioning;
- Improved public involvement;
- Improved commissioning and effective use of resources;
- Better management of financial balance and risk;
- Improved coordination with social services through similar boundaries;
- A 15% reduction in management and administrative costs (approx. £10.7million across West Yorkshire, PCTs) to reinvest into local services.

A note about 'commissioning'…

…Although 'commissioning' involves purchasing of services, it is much broader in scope than purchasing. Commissioning incorporates a number of activities, from assessing, planning and anticipating need for services through to contracting for services and managing the subsequent arrangements. It also involves monitoring and evaluating services to ensure they are fit for purpose and meeting population needs in an effective way.

Irrespective of the configuration of PCTs in Kirklees, there is a requirement on all PCTs to deliver practice-based commissioning by December 2006. In West Yorkshire, the local NHS has agreed that it will deliver it from April 2006 in a shadow form. Potentially, a single GP practice could take on the practice-based commissioning role, although it is more likely that groups of practices will come together as practice-based commissioning groups.

Primary care trusts will support and manage the operation of practice-based commissioning. They will, on behalf of their practices, provide practice budgets, clinical and financial information to help GPs and negotiate contracts for the services required. Primary care trusts will play a crucial role in working with their practices to design, plan and develop better services for patients. They will conduct needs assessments of their local communities and work closely with local authorities so that the wider health and care needs of local communities are addressed.

While practice-based commissioning gives 'freedoms' to practices or groups of practices to determine what services they would like, this has to be within the strategic commissioning context set by the PCT. Accountability for commissioning still rests with the PCT - not with practice-based commissioning groups. PCTs will also retain the commissioning responsibilities for specialist and larger services.

The financial arrangements for PCTs mean that practice-based commissioning groups have to balance their books over a 3 year cycle, whereas the PCT has to balance its books on a 1 year cycle. Any financial 'savings' made by practice-based commissioning groups would have to be redirected into other services in their local communities.

A number of local stakeholders support the notion that a single, larger PCT would be better placed to implement the delivery of practice-based commissioning in a coordinated and consistent way. However, members have noted that all 3 PCTs have a commitment to develop practice-based commissioning in a consistent manner regardless of their configuration.

Practice-based commissioning is taking place in the context of a broader shift by PCTs, the local authority and other partners towards managing services at a locality level. This is recognition of the fact that it is at a locality level that many of the joint working initiatives are most effective and where services can effectively respond to communities and individuals needs. In Kirklees this is happening in the context of the Local Area Agreement (LAA) which reflects the priorities and ambitions of key partners. The four strands of the LAA ('safer stronger communities', 'children and young people', 'adults and healthy communities' and 'economy and enterprise') all have a strong locality dimension, and four Local Public Service Boards (LPSBs) have been established as part of the Local Strategic Partnership to drive forward the shared objectives expressed in the LAA.

The development of locality working in Kirklees has focused around 7 areas defined by the councils Local Area Committees (LAC) boundaries. The panel have been informed that, regardless of whether the PCTs merge or not, there is an intention to align, wherever possible, practice-based commissioning consortia with the 7 locality boundaries. Such alignment is likely in the 3 North Kirklees areas, in Huddersfield North and in Huddersfield South. However it is likely that there will be a single consortium covering the 2 LACs in the Valleys and Denby Dale, Kirkburton & Mirfield Areas.

Another important consideration in relation to commissioning is the proposed move towards greater separation of PCTs commissioning and provider functions. The '*Commissioning a patient-led NHS'* document published in 2005 proposed that PCTs should divest all their direct service provision by 2008. Under '*Ensuring a patient-led NHS*', this requirement has now been dropped, but the new PCT, if approved, may still opt to divest itself of its provider functions. There will need to be in the future a clearer separation of commissioner and provider functions within PCTs, and the panel have been informed that the PCTs expect that it will be necessary to have separate

management support to oversee the provider function (although the final structure of this has not yet been determined).

This is in part linked to a proposed new role for PCTs to 'manage the market', encouraging competition and a greater choice of providers. The rationale behind this part of the proposals is that by encouraging alternative providers, including private and voluntary organisations, quality will be improved and costs will be reduced as a variety of different providers compete to win NHS contracts.

The panel received evidence from a variety of local stakeholders and there were conflicting perspectives about some aspects of the proposals. It was generally agreed that achieving coterminosity between the PCT and the local authority should help to strengthen strategic planning and commissioning. However, there were differing opinions about whether a larger PCT would remain sufficiently sensitive to local needs and be able to provide a sufficiently local focus.

The boards of both Huddersfield PCTs have both expressed their support for the concept of a single PCT for Kirklees. Historically, there has been a strong sense of feeling in the area currently covered by South Huddersfield PCT about the need for a local focus, an issue which was discussed at length when the current configuration of PCTs was consulted on 3-4 years ago. The panel have heard that this strength of feeling still exists in south Huddersfield, but the board are satisfied that, in the context of the proposed changes to the role of any new PCT, the continued emphasis on locality working and the introduction of practice-based commissioning that this local focus will be retained.

North Kirklees PCTs board has not, at the time of writing, made a formal decision on the proposals. However, the panel have been informed that the board have reservations about the proposals. This includes a perception that a single PCT for Kirklees would be dominated by Huddersfield with staff, headquarters and decision-making all happening in Huddersfield.

Reservations were also expressed by the health portfolio lead for the Spen Valley Area Committee who is concerned that a single PCT for Kirklees may:

- Lack the awareness of, and ability to provide for, the specific needs of north Kirklees residents; and
- Reduce the ability for targeted strategic interventions at a north Kirklees level

These concerns were rooted in the perception that there are clear differences in health needs between north and south Kirklees and that a single PCT would not be responsive enough to these differing needs. Examples of where there are differences in health needs were reported as: dental health (a recent survey of the dental health of 5 year old children ranked north Kirklees the second worst in the UK), asthma, coronary heart disease and strokes. A number of the wards in north Kirklees are in the bottom 25% in relation to the

‘index of multiple deprivation’. The panel were informed that there are clear links between the relatively high levels of deprivation in north Kirklees and inequalities in health. For example, information from the Director of Public Health in north Kirklees has shown that the infant mortality rate in north Kirklees is almost double the rate for south Kirklees.

However, the panel have also been informed that differences in health inequalities and health needs exist as much within PCT areas as between them. There are also significant health and deprivation issues which are common to more than one PCT (for example, the health needs of minority ethnic communities in Huddersfield Central and North Kirklees PCTs and rural deprivation in South Huddersfield and North Kirklees PCTs). It is for this very reason, the panel were informed, that the existing PCTs are all committed to locality working, so that there can be a focus on the very specific needs of towns or communities. There is no level of population grouping where people’s needs are homogenous.

Concerns have also been expressed about the financial implications of the proposals, with some stakeholders concerned about the implications of merging and others concerned about the implications of not merging.

It is a requirement on PCTs to deliver 15% savings over the next 3 years. If the current configuration is retained then there is clearly less opportunity to meet the required efficiencies from managerial and administrative savings and therefore more risk that savings would impact on the operational side.

However, from a north Kirklees perspective concerns have been expressed regarding the current financial deficit associated with the Huddersfield PCTs. The current and projected year end financial position of the 3 PCTs has been clarified as:

PCT	Current	Projected Year End	Notes
North Kirklees	Breakeven	Breakeven	Main NHS acute trust in debt
South Huddersfield	£2.5m deficit	£2.5m deficit	Main NHS acute trust in balance
Huddersfield Central	£1.7m deficit	£3.3m deficit *	Main NHS acute trust in balance

*Increase due to a land sale which will now be completed after year end, but will result in a receipt of £1.6m in the new financial year

Panel members have been informed that any current deficit in the existing PCTs would need to be balanced on a Kirklees-wide basis. Different opinions were expressed about the potential impact this might have. On one hand, a view that an inherited deficit would unfairly disadvantage north Kirklees residents. Conversely, a view that the deficit sitting in the PCTs has to be seen in a whole-systems context, and specifically in the context of the current deficit in the main acute trust providing for north Kirklees.

Key to the successful implementation of practice-based commissioning and locality working will be the fair allocation of resources. This has a number of strands:

- Clarity about which resources are best devolved and controlled at a locality level and which need to be maintained centrally;
- Fairness of allocation of resources

A new Kirklees-wide PCT, if approved, will need to ensure that it provides fairly for both north and south Kirklees. One of the requirements of practice-based commissioning will be to achieve 'weighted capitation'. Initially, practice-based commissioning budgets will be based on historic usage of health services, but will be required to move towards a 'weighted capitation' or fair shares allocation. This allocation is based on a national formula that reflects deprivation, ethnicity, age, sex and a range of other factors. Therefore, regardless of the respective financial positions of the PCTs, practice-based commissioning groups will be moved to a point where they receive their fair allocation of resources (although the pace of change is yet to be determined).

The panel has been informed that it is the intention that the anticipated financial savings from the strategic health authority and PCT reconfigurations in West Yorkshire (estimated at £13.2m) will be reinvested into cancer and palliative care services. There is currently a shortfall in palliative care. This type of care needs to be delivered locally (e.g. through hospices, community chemotherapy services etc.) as distinct from more specialist cancer care which needs to be delivered at specialist centres to which all the populations have access. The proposals therefore enable the financial benefits from the reconfigurations in West Yorkshire to be redistributed for all the areas in West Yorkshire fairly.

One issue of potential concern is that the PCTs have already pre-committed money towards the new cancer centre and oncology wing at Leeds. It needs to be ensured that any savings from the reconfiguration process can be counted against this pre-commitment.

Another issue explored by panel members was whether greater devolution of resources and responsibilities to practices could lead to inconsistencies or gaps in provision. The panel were informed that the new PCT would continue to have a performance management function in relation to GPs. GPs are now part of a quality framework system and go through a formal appraisal system. The panel were informed that one of the benefits of groups of practices coming together as commissioning groups would be the introduction of some peer challenge to practice specific inconsistencies, and that this should help to reduce variation between practices. If the proposals are approved, PCTs will still be responsible for GPs, dentistry, opticians contracts and for taking over failing services.

The panel were also keen to explore the potential impact of the proposed reconfigurations on PCTs' public health role. Evidence provided to the

parliamentary select committee in December 2005 noted that there may be advantages to introducing larger PCTs aligned with local authority boundaries, as this could strengthen joint working and could lead to shared public health teams with Local Authorities. However, potential risks were also reported - if PCTs end up solely as commissioners of health services, the public health function, which includes health improvement, health protection and health services, could end up being fragmented.

With any reorganisation the period of transition is potentially challenging. There will be a need to ensure smooth transitional arrangements to ensure that skill and capability are not lost from the local health family and that there is continuity of systems and no disruption from a service user perspective. If the proposals are approved, it will be important to ensure that the new PCT is able to draw on what worked well from all of its predecessor organisations.

CONCLUSIONS:

The panel consider that a single PCT, coterminous with the council's boundaries would assist in strengthening arrangements for strategic planning and commissioning. It would also ensure a consistent approach in implementing practice-based commissioning and locality working.

A single PCT for Kirklees may also be better placed to ensure a strong and effective relationship with the proposed new strategic health authority.

The panel note that merging the current PCTs provides an opportunity to realise savings in management and administrative costs, and that if the proposal for a single PCT for Kirklees is not implemented then there is a greater likelihood of savings having to be met from the operational side.

The panel recognise that there are concerns about whether a single PCT would be sufficiently sensitive to local needs and be able to provide a sufficiently local focus. Support for the proposed changes is therefore CONDITIONAL on the new PCT s commitment to developing effective and robust arrangements for locality working, preferably coterminous with the council's area committee boundaries.

The panel RECOMMENDS that PCTs (regardless of their final configuration) continue to involve and engage Overview and Scrutiny in Kirklees around future developments for locality working and the implementation of practice-based commissioning.

The panel wish to emphasise that a single PCT for Kirklees must be able to enhance the delivery of locality working, including closer integration of front line services at a neighbourhood level.

The panel RECOMMENDS that locality arrangements must be sufficiently flexible to ensure that resources are allocated fairly, and note in relation to practice-based commissioning that the requirement to move towards weighted capitation will achieve this.

The panel wish to emphasise the importance of ensuring the effective targeting of resources to tackle inequalities in accessing health services and inequalities in health outcomes among our local populations.

While it is recognised that there are potential benefits in encouraging a greater choice of providers in primary care, the panel are concerned that there are also risks associated with contestability and that this could lead to fragmentation; increased complexity or gaps in provision. The panel would like assurances that the new PCT, if approved, will ensure that in 'managing the market', it maintains the ability to strategically plan and deliver workforce development and training, and to ensure there is no lack of cohesiveness in local service delivery.

If a single PCT for Kirklees is approved the panel RECOMMENDS that it is sensitive to the perceptions of residents and community leaders in both north and south Kirklees.

It will be important to ensure that the new organisation is able to draw on what worked well from all of its predecessor organisations.