Chorley
Borough Council

Report of	Meeting	Date
Head of Leisure and Cultural Services (Introduced at Executive Cabinet by the Executive Member for Life and Leisure, Councillor Cath Hoyle)	Customer Overview and Scrutiny Panel Overview and Scrutiny Committee Executive Cabinet	1 March 2006 2 March 2006 9 March 2006

CONSULTATION ON CHANGES TO THE STRATEGIC HEALTH AUTHORITY, PRIMARY CARE TRUSTS AND AMBULANCE SERVICE NHS TRUSTS IN LANCASHIRE AND CUMBRIA

PURPOSE OF REPORT

1. To consider a response to the consultation on changes to the Strategic Health Authority (SHA), Primary Care Trusts (PCT) and Ambulance Service NHS Trusts in Cumbria and Lancashire.

CORPORATE PRIORITIES

2. Tackling health inequalities in the Borough is a priority area of work in the Community Strategy.

RISK ISSUES

3. The issue raised and recommendations made in this report involve risk considerations in the following categories:

Strategy	√	Information	
Reputation		Regulatory/Legal	
Financial		Operational	
People		Other	

As mentioned above, tackling health inequalities in the Borough is a priority area of work in the Community Strategy. The existing arrangements, in particular with a PCT covering Chorley and South Ribble, have identified health inequalities in the Borough and are local enough to make a difference. There is a risk that the focus on the Borough's inequalities could be diluted if they were hidden amongst other inequalities across a larger area.

BACKGROUND

4. In recent years the NHS has seen significant investment and reform. These reforms have concentrated on the provision of services, for example providing patients with more choice and developments such as NHS Foundation Trusts.

5. In July 2005, proposals were announced to improve commissioning of services by PCTs and to ensure local health services are working effectively for patients. SHAs were asked to develop proposals for consultation which:

- strengthen commissioning of health services, including putting more control of decisions about local health services in the hands of front-line health professionals such as GPs;
- improve health, particularly the health of disadvantaged communities; and
- achieve savings in management costs of £250m nationally to be re-invested in health care.

6. Strategic Health Authorities, known as the local headquarters of the NHS, are accountable for the performance of NHS Trusts (except NHS Foundation Trusts) and PCTs in their area. Other responsibilities include ensuring there is a coherent strategy for health across the SHA area, co-ordinating the NHS response to major incidents, developing the capacity and capability of NHS Trusts and ensuring the implementation of national policies and initiatives by NHS Trusts and PCTs.

7. In future, SHAs will be directly accountable for fewer NHS organisations. More NHS Trusts are expected to achieve Foundation status and if the proposals under consultation for PCTs are accepted, there will be a reduction in PCTs.

8. SHAs will have a strategic overview, ensuring the NHS in its area is performing well and delivering high quality health care for patients.

9. In July 2005, the Government published Taking Healthcare to the Patient: transforming NHS Ambulance Services. This document made 70 recommendations for improving NHS ambulance services, including strengthening management capacity and capability through fewer and larger NHS Ambulance Trusts.

10. Each of the three consultations are taken in turn. The bold text highlights the Council's proposed response to each consultation.

STRATEGIC HEALTH AUTHORITY ARRANGEMENTS

11. Cumbria and Lancashire SHA is one of three SHAs in the north west. The proposal is to create a single SHA for the north west by merging Cheshire and Merseyside, Cumbria and Lancashire and Greater Manchester SHAs.

12. As health reform policies continue to develop there may be additional roles and functions identified for SHAs. An initial view of the new SHA role is as follows:

- 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.

13. The system of management of the health system will continue to develop and change as Payment by Results and patient choice are fully implemented and moves are made towards a greater number of providers through NHS Foundation Trusts and greater independent sector involvement.

14. The Department of Health has a significant programme of policy development work on the future regulation and management of the health system overall. Further guidance in 2006 will set out the implications of this work for SHAs, PCTs and other NHS bodies.

15. The consultation document argues that SHAs will be better equipped for these challenges through their:

- Numbers: There is likely to be a smaller number of more streamlined SHAs. This is because they will be responsible for a reduced number of larger PCTs, and a smaller number of NHS Trusts as more gain Foundation status.

- Boundaries: Their boundaries will largely match those of Government Offices for the Regions, helping SHAs to work more closely and strategically with public sector partners to streamline services.

- Role: The focus for SHAs will be on building the new system of commissioning and then maintaining a strategic overview of the NHS and its performance in their area. They will 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.

16. The existing three SHAs considered whether the current SHA configuration was best suited to deliver the new functions outlined above. In particular they took into consideration the development of NHS Foundation Trusts, and the proposed reduction in the number of PCTs from 42 to between 21 – 23 across the north west which, subject to the outcome of consultation, will require the three SHAs to relate to significantly fewer organisations.

17. SHAs have a duty to streamline management costs in order to contribute towards the Government's manifesto commitment to save £250 million for reinvestment in patient care.

18. The SHAs believe that the best way to deliver the new roles is to dissolve the existing three SHAs and create a new single Strategic Health Authority for the north west. This would share the same boundary as the Government Office for the North West. It is proposed that the new SHA is called the North West Strategic Health Authority. It is envisaged that the proposal will make a contribution of £8.5 million to the national savings target of £250 million. If the consultation supports the establishment of a new single North West Strategic Health Authority, it is envisaged that the new SHA would be established during the period 1 July 2006 and 31 March 2007.

19. The SHAs did consider whether the current configuration of three separate SHAs could successfully deliver the new functions required; it was their view that only the proposed new SHA would meet the national criteria and achieve the management costs savings. Therefore no other option is being proposed.

20. In terms of the consultation, there is one question – do you support the proposal for dissolving the existing three SHAs and to create a new North West Strategic Health Authority covering the area of the existing three SHAs and the government regional office boundary? **In the absence of any alternative options that meet the criteria and financial targets it is difficult to suggest alternatives. Members may choose to say yes or not comment. Members may wish officers to comment on the appropriateness of a consultation exercise that is presented as a fait accompli.**

AMBULANCE TRUSTS

21. There are currently four ambulance trusts in the north west: Cumbria, Lancashire, Mersey Region and Greater Manchester. The proposal is to replace the four trusts with one new trust covering the north west.

22. The Department of Health, in their consultation document, claim that the benefits of this proposal are:

- more investment in front-line services
- more opportunities for staff
- improved planning for, and ability to handle, chemical, biological, radiological or nuclear incidents, terrorist attacks or natural disasters
- better equipped and trained workforce and the ability to adopt best practice quickly and consistently
- better use of resources to support high performance in all trusts
- greater capacity to carry out research and check that patient care is of the highest standard
- greater influence in planning and developing better patient services, both regionally and nationally
- greater financial flexibility and resilience, ability to plan and make longer-term investment decisions
- financial savings achieved through greater purchasing power and economies of scale
- improved contingency planning to make sure that the control room (where the 999 calls are received and the ambulances are dispatched) will stay fully operational regardless of any information technology or service disruption
- improved human resource management, organisation and leadership development
- increased investment in new technologies.

23. The Department of Health go on to say that services should also be able to deliver locally: If these proposed trusts are established, they would need to ensure that current good performance and practice is maintained and that good practice is spread across the proposed new trusts' areas for the benefit of all patients. They would also need clear local management and operational structures that reflect the different communities they service. This would be a key consideration for the proposed new trusts (if established) when determining new management and operational arrangements and would need to be agreed with PCTs, as commissioners of ambulance services for their populations and discussed with other stakeholders.

24. As with the Strategic Health Authority consultation, there is only one option to be considered. **Members may have concerns that a regional service will be less**

responsive to local needs, than a county service. As mentioned, in the previous paragraph, ambulance services are commissioned by the local Primary Care Trust (PCT). This will be an issue to remember in the next section regarding proposals to reconfigure PCTs. **Based on initial discussions with colleagues and partners, there have been concerns that local performance – specifically around response times, especially in rural areas – could be less of a priority for the trust with the focus being given to aggregate performance. Although the Department of Health have stated that they intend to raise standards to the highest levels; members may wish to comment on the need to have local performance information, including response times at district council level, reported on a regular basis.**

PCT RECONFIGURATION

25. There are currently thirteen PCTs covering Lancashire and Cumbria; Chorley and South Ribble PCT being the PCT covering Chorley Borough.

26. There are three options being consulted on:

Option 1 :

- Retain a Blackpool PCT
- Retain a Blackburn with Darwen PCT
- Establish a PCT co-terminous with Cumbria County Council boundaries
- Establish a PCT co-terminous with Lancashire County Council boundaries.

Option 2 :

- Retain a Blackpool PCT
- Retain a Blackburn with Darwen PCT
- Retain a Morecambe Bay PCT
- Establish a North Cumbria PCT
- Establish a Lancashire-wide Trust, minus the Lancaster City Council area.

Option 3 :

- Retain a Blackpool PCT
- Retain a Blackburn with Darwen PCT
- Establish a PCT co-terminous with Cumbria County Council boundaries
- Establish three PCTs co-terminous with the local authority boundaries of:
  - Lancaster, Wyre, Fylde;
  - Burnley, Rossendale, Pendle, Hyndburn, Ribble Valley
  - West Lancashire, South Ribble, Chorley, Preston.

27. The Department of Health identified a set of criteria against which they would consider submissions from Strategic Health Authorities on options for the future configuration of primary Care Trusts.

- Secure high quality, safe services sensitive to changing population needs
- Improve commissioning and effective use of resources
- Improve co-ordination with social services through greater congruence of PCT and Local Authority boundaries
- Improve health and reduce inequalities by influencing County and District Council
- Improve the role of the public in influencing planning, delivery and assessment of local health and healthcare provision
- Improve the role of the public in influencing planning, delivery and assessment of local health and healthcare provision
- Manage financial balance and risk in the context of Payment by Results and practice based commissioning
- Improve engagement of GPs and roll out of practice based commissioning
- Deliver at least 15% reduction in PCT management and administrative costs
- Develop clear and prospective commissioning frameworks consistent with addressing need.

28. PCTs are responsible for commissioning health services for local people. Through commissioning, PCTs seek to ensure services are accessible, high quality and achieve improvements in the health of people living in their area.

29. Our proposals aim to strengthen commissioning by merging some PCTs, putting more decision-making power and funding for local health services under the control of GP practices (known as Practice-Based Commissioning) and ensuring closer links with local authorities.

30. PCTs need to be the focal point for planning, designing and shaping local health services, working closely with others who can help deliver health improvement.

31. Fewer PCTs should lead to an increase in management capability and capacity, closer working with local authorities and ensure value for money from the resources allocated to them.

32. The following paragraphs set out the Council's suggested response to the PCT consultation. There has been consultation with Chorley and South Ribble Primary Care Trust and The Chorley Partnership, prior to preparing this response. The PCT's views, which were shared with us, were informed by detailed discussions with their directors, board, Professional Executive Committee members, staff and Patient and Public Involvement Forum.

33. In Chorley, the existing arrangements with Chorley and South Ribble PCT work very well. The local consensus is that the existing arrangement, with some adaptation, could meet the criteria set out in 'commissioning a Patient-led NHS'. It is recognised that achieving a 15% saving in management costs would be a significant challenge. Larger PCTs will make it more difficult to satisfy some of the criteria, in particular those relating to public health/inequalities, clinical engagement and patient and public involvement. Whilst it is recognised that change is inevitable, it is vital that existing good practice and effective working

relationships are not lost in the process. Any solution must preserve the things that are working well whilst addressing the things that could be improved.

34. The Council is also concerned that, although coterminosity with local authority boundaries is seen as important, this reorganisation is taking place in isolation from any review of local government, which may commence later in the year.

35. The Council accepts the importance of coterminosity and therefore the proposal to retain the two PCTs for Blackpool and Blackburn with Darwen. Morecambe Bay PCT straddles the boundaries of Cumbria and Lancashire County Councils and therefore Option 2, which includes the retention of Morecambe Bay PCT does not meet the principle of coterminosity with social services authorities. We believe Option 2 should be ruled out on this basis.

36. We are of the view that smaller PCTs have an advantage over larger PCTs in securing high quality, safe services because senior management is much closer to what is happening locally. Also, an important element of our ability to secure high quality, safe services is the rapid feedback, through effective clinical engagement, of issues that give cause for concern and the mechanisms in place to address these through established relationships with local providers. This would be more difficult with larger PCTs.

37. Arrangements for appraisal and revalidation of GPs will be central to ensuring high quality, safe primary care services. Local ownership by GPs will be important in establishing and maintaining effective arrangements. New General Medical Council proposals for revalidation are likely to rely on local knowledge of doctors' performance, conduct and health. Local knowledge is also important in identifying and addressing specific issues of poor performance. There is a real danger that local knowledge and local ownership will be lost in moving to a very large PCT.

38. In addition, smaller PCTs are more likely to be sensitive to changing population needs and inequalities at a local level, which are likely to be 'swamped' by bigger issues in a very large PCT.

39. There is the potential for new service developments and the ability to ensure services are sensitive to suit local circumstances to be compromised by centralised decision making structures in a larger PCT.

40. It is recognised that larger PCTs will have the potential for greater influence in securing services and for greater consistency in the application of national guidance and standards.

41. In the light of the above, we believe that three PCTs for the LCC area will provide an appropriate balance between local knowledge and sensitivity and greater influence and consistency.

42. Lancashire County Council has found it necessary to develop locality arrangements in order to manage both provision and commissioning of services and, although recent improvements have been acknowledged, still finds itself subject to criticism about lack of responsiveness and local sensitivity. It is likely that a single PCT would need to develop similar locality arrangements, which would impact upon management costs, and be subject to the same criticisms.

43. **The proposed three PCTs for Lancashire match the County Council's three localities for adult and older people's social services and the Council's five localities for Children's services map onto the proposed PCTs. A reduction in the number of PCTs relating to the County Council from eight to three would mean significantly greater congruence and allow for much improved co-ordination with social services.**

44. **The PCTs have a crucial role to play in delivering against the five outcomes in Every Child Matters. Option 3 would be the most effective fit with the footprints established for Children's Trusts arrangements covering Chorley, South Ribble and West Lancashire and a second for Preston.**

45. **Local knowledge and a local focus are essential in order to improve health and address inequalities and these are more likely to be maintained in smaller rather than larger PCTs. There is a danger that a very large PCT would focus on the biggest and most obvious areas of deprivation and relatively affluent areas would lose out even thought they compare unfavourably on a national basis. There is also a potential for smaller pockets of deprivation to be overlooked.**

46. **The relationship between PCTs and district councils is extremely important, particularly in relation to public health issues and patient and public involvement. Current relationships operate at all levels across the PCT and the Council. It is essential that these relationships are monitored in order to deliver the public health agenda. We believe this is manageable with three PCTs but that it would be impossible for a single PCT to relate to twelve district councils in this way.**

47. **Patient and public involvement is currently secured through a variety of mechanisms including representation on Local Implementation Teams and other service specific groups, local Health Improvement Teams and the PCT's Patient and Public Involvement Committee, liaison with the Patient and Public Involvement Forum and work with district councils and other partners through Local Strategic Partnerships.**

48. **Patients and the public usually have experience of local services and want to get involved in influencing the development of those local services and decisions about local priorities. Representation on a countywide basis is not likely to be regarded as local or sensitive enough. It is difficult to envisage how this would work without some supporting substructure but there would then be a risk of local views being diluted by the time they fed into the 'top tier' and individualities being masked in an attempt to get a countywide consensus. There is also a danger that patients and the public would be less willing to get involved if the results of their involvement were less obvious.**

49. **The Council believe that one PCT for the whole of the area covered by Lancashire County Council, with a population in excess of 1.1 million is too big. It would create a significant imbalance in the size of PCTs across Cumbria and Lancashire and potentially across the wider area to be covered by a single Health Authority in the future. We believe that this would make collaboration and joint working across PCTs difficult.**

50. **Our main concern, however, is that such a large PCT would not be responsive enough to local views and issues or sensitive enough to local needs.**

51. NB The consultation document clearly states that they are only consulting on the three options. However, the initial consultation was clear what was and was not up for consultation, yet a Morecambe Bay PCT figured following the initial consultation. Given the possibility of local government reorganisation in the future, Members may wish to express an opinion that is not covered by the three options available.

COMMENTS OF THE HEAD OF HUMAN RESOURCES

52. There are no human resource issues arising from this report.

COMMENTS OF THE DIRECTOR OF FINANCE

53. There are no finance issues arising from this report.

RECOMMENDATION(S)

54. That the comments shown in bold in paragraphs 20, 24 and 33 to 50 form the Council's response to the respective consultations. Members may chose to suggest an alternative option, as per paragraph 51.

REASONS FOR RECOMMENDATION(S)

55. To take an active involvement in the consultation exercises so that the best outcomes for the Borough, in our endeavours to tackle health inequalities, are achieved.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

56. Not to respond to the consultation exercises.

JAMIE CARSON
HEAD OF LEISURE AND CULTURAL SERVICES

Background Papers			
Document	**Date**	**File**	**Place of Inspection**
Consultation on New Primary Care Trust Arrangements for the Cumbria and Lancashire SHA Area Consultation on new Strategic Health Authority arrangements in the north west of England Configuration of NHS Ambulance Trusts in England	Dec 2005	LEA/HA/CON	Head of Leisure and Cultural Services Offices, Gillibrand Street

Report Author	Ext	Date	Doc ID
Jamie Carson	5815	13/02/2006	ADMINREP/REPORT