Executive

NHS London Strengthening Commissioning Programme - future implications

Item no: 5

Report by:	Dick Sorabji	**Job title:**	Corporate Director, Policy and Public Affairs
Date:	27 April 2009		
Contact Officer:	Dick Sorabji		
Telephone:	020 7934 9761	**Email:**	Dick.Sorabji@londoncouncils.gov.uk

Summary

This report updates the Executive on the development of NHS London commissioning plans during 2008/9. Describes the impact this had had on existing London Councils policy and makes recommendations for more proactive engagement to ensure that borough level commissioning of health care is enhanced within the Strengthening Commissioning Programme of NHS London.

Recommendations

The Executive is asked to:

- Note and agree the direction of travel described in the report.
- Encourage all boroughs to develop proposals for borough level commissioning.
- Agree that London Councils investigate the potential for pan-London support to boroughs developing borough level health commissioning proposals.
- Note that creation of common information analysis system will be an early priority for investigation.

NHS London Strengthening Commissioning Programme – future implications

Overview

1. London Councils has previously defined core principles guiding the response to NHS London plans for commissioning and related changes in health care delivery. Recent developments suggest that more proactive engagement by London boroughs may now be required to maintain these core principles.

2. This report describes the increasing pace of developments in NHS London's Strengthening Commissioning Programme and the actions of London Councils and London local government in response. This recent experience suggests that London Councils policy of supporting borough level commissioning and coterminous PCTs will require London local government to influence future policy by making proposals for local commissioning rather than waiting to respond to NHS plans.

3. To this end a range of approaches to borough commissioning is described that are consistent with policies on health care in London agreed by the Executive and Leaders Committees of London Councils. The report makes related recommendations on how London Councils might support all London boroughs to more effectively influence the emerging design of health care commissioning, ensuring strong links between PCTs and local government at borough level.

4. The Executive is asked to consider the direction of travel described by the report and to agree the proposals for future action.

Previous Policy Decisions

5. Over time London Councils has developed wide ranging policy on health care in London. Policy reflects both general principles on local democratic control and also responses to NHS plans including Healthcare for London that followed the Darzi review and the Strengthening Commissioning programme. The decisions of the Executive Committee on 6th October 2008 and Leaders' Committee on the 8th July 2008 are especially relevant to recent developments in NHS Commissioning policy. London Councils principles include:
    - The retention of coterminous PCT and borough boundaries is essential for high quality health care in London. It underpins partnership working with the NHS,

democratic accountability and statutory accountability for LAAs, JSNA and the coming CAA.

- In the medium term local government in London should exercise stronger local democratic influence over commissioning health care and this should include devolution of PCT commissioning budgets within guidelines protecting national policy.
- London local government recognises the sub-regional and pan-London implications of the current weaknesses in the commissioning of acute care in London and that, within the context of coterminous PCTs; this will lead to discussion of strategies to improve outcomes for patients through collaboration between PCTs.
- Partnership working and joint commissioning between PCTs and local government is a vital contribution to ensuring that Londoners get the best quality health services.
- Delivery partnerships between boroughs and PCTs are an important contribution to high quality care. They should be fostered and not undermined simply to meet administrative requirements.

6. London Councils has also made clear its view that the process of change and development in NHS provision must be open, transparent and inclusive. Early warning of future plans is a necessary condition for ensuring constructive joint working.

NHS London - Implementing Strengthened Commissioning

7. Since the summer of 2008 the pace of change in NHS London commissioning and delivery has accelerated. This is the result both of the Strengthening Commissioning Programme gathering momentum and also of wider pressures on NHS London to drive up health care standards more swiftly. Developments include:
   - The first World Class Commissioning Assessments were conducted between June 2008 and March 2009. The process has accentuated the urgency of NHS London's drive to raise commissioning standards.
   - On 8th December 2008 the Health Secretary announced PCT budgets for the next two years. The majority of London PCTs received the lowest level of increase of all PCTs in England at 10.6% over two years compared to an average rise of 11.3%. Changes to the funding formula mean that finance will become tighter after the end of 2010/11.
   - In December 2008 NHS London approved the business plan for the London Clinical & Business Support Agency (LCBSA) a pan-London service designed with PCTs to support individual PCTs health improvement plans.

- Consultation on major trauma and stroke services began in January 2009 and will close on 8th May.
- On 24th March the appointment of six Sector Chief Executives was announced to work at sub-regional level across PCTs. They will lead the creation of larger commissioning entities for acute care and be responsible for performance management issues in acute care. These officers will continue in their roles as chief executives of individual PCTs.
- Five Polyclinics are planned to open in London by April 2009.
- National government has required the NHS to separate out internal provider services from PCTs by April 2009.

Local Government Response

8. London Councils has responded to these initiatives as they arise making clear local government's concern that stronger commissioning should be borough led. Following both the Leaders Committee of July 2008 and the Executive Committee in October 2008 London Councils arranged discussions with NHS London at political level. These discussions have been underpinned by ongoing work at officer level which has engaged chief executives from London boroughs. There is now a network of ongoing officer level discussion between local government and NHS London.

9. However, three types of pressure are increasing the importance of more proactive engagement by London local government in order to maintain and then advance existing policy on health care. These are:
    - The pace of NHS decisions on commissioning is increasing and it is more important to shape these decisions before they are made, rather than to respond to them.
    - Individual boroughs are already engaged in detailed discussions.
    - Long term concerns about the cost and quality of health care unless devolution can be delivered.

10. NHS initiatives during the last nine months have often had implications for London Councils policy supporting coterminous PCTs. Some of the developments described above have caused concerns about centralisation, the relative priority given to borough level and sub-regional or pan-London commissioning capacity and about the time available to discuss the implications of change. In retrospect it appears that local government could have had more influence if it had been in a position to offer its own

proposals for the design of borough level commissioning, rather than responding to NHS plans.

11. During recent months many individual boroughs working individually and in groups have entered detailed discussions on the Strengthening Commissioning programme. This work has highlighted the importance of joint working between PCTs and London local government to strengthen borough level commissioning and improve patient outcomes. The process has led to the emergence of differing policy initiatives in different parts of London. During 2009/10 borough level commissioning is programmed as a priority within NHS London and so the opportunity to shape and enhance NHS policy by proposing specific health commissioning plans at borough level will increase.

12. In the long term the success of NHS London policy depends on being able to devolve health care to a more local level. The Darzi report revealed both the need to raise health care standards in London and also the high cost of low standards. The report forecast NHS costs would reach to £14.5 billion by 2016; £1.4 billion more than is funded on current plans.

13. In response *Healthcare for London* proposed closing the £1.4 billion shortfall and increasing patient activity by 57% through a shift of most health services to a more local level. By 2016 many aspects of health care in London's major hospitals would be devolved closer to communities:
    - In-patient work would be 59% devolved: 29% delivered in local hospitals, 20% at elective centres, and 8% with GPs and polyclinics and 2% no longer needed.
    - A&E work would be 80% devolved: 20% at local hospitals, 50% at polyclinics and 10% no longer needed.
    - Outpatient work would be 87% devolved: 13% at local hospitals, 13% at elective centres, 41% at polyclinics and 20% no longer needed.

14. It will be a challenge for the NHS to deliver this level of devolution by 2016. More proactive support by London boroughs could increase the chance of success and ensure that London local government's policy concerns are at the heart of future discussion.

Strengthening Local Influence on Health Commissioning

15. Officers from London Councils and London local government held a preliminary discussion with political Group Leaders and relevant Portfolio holders of London Councils to consider how to ensure that local government maintains influence on the future shape of health care commissioning. At the heart of the discussion was the need to raise the quality of health care for Londoners and to ensure local responsiveness through a strong link between coterminous PCTs and individual boroughs.

16. As a result it is proposed that London Councils should encourage as many London local authorities as possible to develop proposals for shaping health care commissioning in their borough. Different approaches will be required in different boroughs. Some common forms of support will be needed by all participating boroughs and should be provided on a pan-London basis. This should be facilitated by London Councils.

17. When considering what models for borough commissioning might be effective in a specific case there are a range of relevant issues:
    - What types of model are available and how fully have they been tested?
    - What factors affect the likely success of different models in different circumstances?
    - What types of pan-London support might be offered?

18. Possible approaches to borough commissioning cover a wide spectrum. However, it is possible to single out three distinct points on that spectrum:
    - Full integration of the management of both PCT and local authority and greater integration of governance structures between the local authority Cabinet and the PCT Board.
    - Integrated action through joint commissioning units, or allocation of lead commissioners between PCT and local authority, across a wide range of non-acute services for example older people, disabilities, learning disabilities, mental health, children, substance misuse and community care. This is often supported with joint appointments of specific staff such as Directors of Public Health. To have significant impact the system would need to deliver joint needs assessment, policy development, planning and public engagement.
    - Integrated information creating a common method for assessing and analysing need shared across PCT and local authority and defining need in terms of places and people, not professions and institutions. These systems will be easier to deliver and

yet offer a strong foundation for the development of joint analysis, the development of common strategies and vision for the area. This in turn will provide direct support for JSNA, CAA LAAs and WCC assessment of PCTs.

- Examples of these approaches are provided in appendices 1-3 of this report.

19. There is no one best approach. There are recent examples of attempts at joint working that look coherent in theory, but have not been sustainable in practise. Different places will need different approaches. When developing approaches for a particular place a range of competing pressures will need to be considered including:
    - The depth and quality of existing relationships and the extent of a common vision and common language for discussing policy solutions will be important in designing solutions.
    - A tension between ambition for quick results and the risk of policies that are too ambitious to succeed.
    - There will be trade offs between ideal solutions and those which can be developed within the time constraints on both boroughs and PCTs.
    - The financial stability of PCT and local authority

20. The more boroughs that put forward proposals, the greater the chance of influencing NHS London as a whole to protect and enhance borough level commissioning. NHS London works across six “sectors” or sub-regions. London local government will increase its ability to shape final outcomes if there are significant and positive interventions in each of these sectors.

21. In order to ensure that the largest possible number of boroughs adopt a proactive approach to NHS commissioning plans it is proposed that London Councils should investigate the resources that would be useful and could be marshalled to support individual boroughs when developing joint commissioning proposals.

22. A common approach to information analysis is especially important. It is recommended that this should be a priority area when considering possible forms of pan-London support.

Recommendations

23. To take forward existing London Councils policy in the light of the developments described in this report the Executive is asked to:
    - Note and agree the direction of travel described in the report.
    - Encourage all boroughs to develop proposals for borough level commissioning.
    - Agree that London Councils investigate the potential for pan-London support to boroughs developing borough level health commissioning proposals.
    - Note that creation of common information analysis system will be an early priority for investigation.

Financial Implications for London Councils

24. There are no financial implications for London Councils.

Legal Implications for London Councils

25. There are no legal implications for London Councils.

Equalities Implications for London Councils

26. There are no equalities implications for London Councils.

Appendices

Appendix one
A unified Executive team (Hammersmith and Fulham)

The proposal
In Hammersmith and Fulham, a proposal has been agreed to create a unified executive team for the London Borough of Hammersmith and Fulham (LBHF) and NHS Hammersmith and Fulham (NHS H&F).

The proposed approach is for:

- a unified management team to support the two continuing statutory bodies;
- a single Chief Executive for both LBHF and NHS H&F;
- a unified executive management team, consisting of the existing 5 directors of LBHF and a new post at NHS H&F of Managing Director Health;
- both the NHS H&F Board and the LBHF Cabinet continuing, with minor changes to membership; and
- the NHS H&F Board and LBHF Cabinet to meet twice a year to discuss shared agendas.

Context
Both organisations have a history of working together successfully. This proposal has come about as a result of agreement by the executive leadership of both organisations that the challenges they face can best be tackled through working together even more closely. A recent joint strategic needs assessment provided a clear picture of the health and well being needs of residents. It was evident that meeting these needs would require more than a traditional health service and would necessitate all partners working together. The new Local Area Agreement and Comprehensive Area Assessment with its focus on the area rather than the actions of individual statutory bodies also supported the need for the two bodies to reconsider how they work together for the benefit of residents. In the NHS, the emphasis on strengthening commissioning has required the NHS to look closely at how it commissions services locally. The context of constrained public sector growth in the future, combined with future cost pressures, is also a factor.

Expected benefits
It is considered that implementing a unified executive team can:

- improve resident and customer satisfaction with public services in H & F;
- deliver high quality, timely, effective services with best value for money;
- deliver real early benefits that will make a difference to residents;
- support both organisations to achieve and maintain excellence in delivering their functions: and
- over the long term, reduce inequalities and regenerate neighbourhoods

Organisational and governance arrangements
The Council Cabinet and the PCT board will be supported by a unified executive team. The Joint chief executive will be the head of paid service and principal adviser to the council and the accountable officer for NHS H&F for PCT functions. In addition to the existing directors from LBHF, a new post of Managing Director Health will be created which will report to the Joint Chief Executive. All directors who are part of the integrated management team will act on behalf of both organisations.

LBHF and NHS H&F will continue as separate legal entities. The Cabinet and NHS H&F Board will remain the key accountable bodies for local government and the NHS respectively. The proposal has recommended two changes to the membership of the NHS H&F Board:

- That the Managing Director Health is a member of the Board as well as the Chief Executive; and

- That the lead Councillor for Community and Children's services becomes an Associate Member of the Board to facilitate joint governance.

In the event of disagreement between the two bodies, the continued legal separation of the two entities will allow transparency with both bodies about their respective roles. The joint chief executive will be conscious of his respective legal responsibilities to both organisations. The chief executive also has authority, as now, to prevent certain actions being taken by the Cabinet if necessary.

Appendix Two

Borough based commissioning

In South West London[1], a partnership approach to borough based commissioning has been proposed. The approach was originally developed at a workshop attended by borough representatives, with input from chief executives, directors of children's services and directors of adult social services and based on work commissioned by the South West London boroughs to strengthen commissioning. It was refined further through a meeting between Chief Executives and senior officers of the councils and PCTs in January 2009.

It is considered that this proposal could achieve the following benefits:

- Commissioning led organisations that secure improved health and social care outcomes for their population;
- Horizontal integration of health and social care;
- Local borough focus;
- Harnessing capacity and capability;
- Accountability and democratic scrutiny of commissioning decisions;
- Optimising economies of scale; and
- Performance improvement.

There are a number of principles underpinning this approach:

- Changes in the manner that health care commissioning ordered and organised will inevitably have an impact on what is possible at a borough level: health care commissioning is interdependent and intertwined with the commissioning that local authorities undertake;
- It is recognised that commissioning for certain clinical pathways, health specialities and tertiary services needs to be done on a broader geographical basis to improve health outcomes, ensure cost effective procurement and contracting and achieve value for money;
- However, it is acknowledged that much acute commissioning has care pathways that begin and end in localities and that to develop effective care commissioning involves the input of local authorities; and
- The contribution of local authorities can be direct in terms of prevention or post hospital discharge but also indirectly through a council's well being agenda or work to promote health improvement. It also considered that links with GP and practice based commissioning can be maximised at a borough level.

[1] South west London covers the boroughs of Croydon, Merton, Kingston, Richmond, Sutton and Wandsworth.

The following working arrangements are proposed:

- Boroughs and PCTs to establish joint commissioning units (to undertake joint needs assessment, public engagement, policy development and planning and determining local investment priorities at borough level, as well as examine scope for integration of some business support functions).

- Boroughs and PCTs jointly to promote the career prospects and benefits for health commissioning staff based at borough level.

- Public health leadership and delivery to remain at borough level, with greater integration between borough and PCT health and health inequalities work.

- The scope of joint commissioning a borough level to be: older people, people with disabilities, people with learning disabilities, children's services, substance misuse and community services.

- Commissioning community health services will take place on a borough basis and be the responsibility of an integrated borough/PCT leadership.

- Boroughs are fully included in the examination of options for PCT's new provider arrangements post 2010, including the potential for integrated provider development of council and PCT provision within borough boundaries.

- Children's trusts to include representation from both commissioning and providing health functions to ensure specialist expertise continues to inform the commissioning agenda going forward.

The following approach to investment is proposed:

- Boroughs and PCTs will develop a protocol for sharing the dividend from more effective acute commissioning processes and from savings to acute services from strengthened prevention programmes and community services.

- PCTs as statutory bodies will retain decision making on investment. PCTs and Councils will establish mechanisms to discuss all their investment decisions in advance.

It is proposed that PCTs and Councils would seek to secure integration at a borough level around:

- Commissioning
- Public engagement
- Provision; and
- Corporate functions.

Appendix Three

An example of joint borough – PCT work to better understand the needs of the population

As a prelude to closer working, local authorities and PCTs may choose to undertake work to better understand the needs of the population they both serve and the opportunities this presents to work together to meet these needs.

As just one example, in Hammersmith and Fulham, a joint strategic needs assessment provided a clear picture of the health and well being needs of residents. This involved the use of customer segmentation work, using MOSAIC, to drill down to a deeper level than the IMD (Index of Multiple Deprivation) map to understand the different population groups that live in the borough and what their corresponding needs are likely to be.

This information was used to assess the impact of each segment on financial metrics for the Council and the PCT, as well as for identifying opportunities for shared access, shared delivery, shared outcomes and shared outreach.