“Commissioning a Patient-led NHS”

A local response from the Isle of Wight

20 September 2005

1. Purpose of the paper

This paper sets out the issues and options raised for the Isle of Wight health and social care community by the recently published national guidance, *Commissioning a Patient-Led NHS* and is intended to serve as the collective response of the partner organisations.

The document is mindful of and consistent with; the Islands integration plans; the national policy context for health and social care included in policy documents *Creating a Patient led NHS, Choosing Health, Independence Well Being and Choice*, and the progression of Local Area Agreements (LAAs).

Versions 1 and 2 of this paper have already been widely circulated and discussed at several fora including:

Version 1

16th August Joint Management Team (PCT/IWHCT)
16th August Operational Board (IWHCT)
17th August PEC (PCT)
25th August Joint Board Seminar (PCT/Trust)

Version 2

1st September Social Services SMG
1st September Directors Group (Council)
5th September Transition Steering Group –TSG- (Health /LA Officers)
7th September Shadow Joint Staff Consultative Forum
8th September Commissioning Board

This updated Version 3 including the proposed way forward is for consideration at the 15th September Transition Steering Board meeting. It will be subsequently finalised and recommended for approval to each of the constituent organisations as the Island Response to *Commissioning a Patient-Led NHS*. It is intended to submit the final paper to the Strategic Health Authority early in October in order that this can be taken into account in the Hampshire and Isle of Wight submission to the Department of Health.

2. Island Context [where are we now]

The Islands geography and demography creates some unique challenges and opportunities for innovative models of health and social care commissioning and provision. It has the largest population of any off shore UK Island [Resident population 134,000 with visitor numbers doubling this figure at peak holiday periods] Population growth is projected together with an increasingly ageing population profile. The transport links to the mainland all entail significant travel time and cost. Public Sector organisations consequently have some unique challenges in maintaining safe accessible and sustainable services.

As a response to these challenges a long standing aim of the Local Authority and Local Strategic Partnership is to move to a single integrated public sector organisation and the health organisations and Local Authority have shared a firm vision to maintain a local

base for commissioning and service provision. The health model on the Island is already unique in that the current Healthcare NHS Trust manages the Ambulance Services Mental Health and some Community Services as well as Acute Services

The Island's health organisations and Local Authority proposals to create ground breaking organisational arrangements for the commissioning and provision of all health and adult social care is continuing to develop. A range of options have been considered including:

- Retaining the existing three statutory organisations –with enhanced partnership working but no formal organisational change
- Linking some current commissioning or provision functions with mainland partners
- Joining the Islands NHS Organisations but excluding adult social care
- A Care Trust bringing together health and adult social care but excluding the hospital based services
- A Partnership Trust based on the Care Trust model

The Care Trust model has to date been favoured as it was seen to meet the Islands needs, providing:

- A legal framework
- Maximum possibility to deliver the transformational changes we are seeking
- Maximising integration and synergy across health and social care
- Consistency with national policy direction
- Opportunities to enhance community involvement ownership and accountability

The proposals are driven by a vision that in five to ten years time the model of health and care will look very different to now .This vision is for the development of more locally focussed services with an emphasis on promotion of health and well being, preventative care, independence/choice (of how and where care is delivered) rehabilitation and self management; all seeking to lessen health dependency and in particular reliance on secondary hospital care. An extended range of care outside of Hospital/Closer to home options which could be delivered through contestability are crucial to this. The vision provides for the development of Localities –as an organisational sub division for the planning development procurement and provision of care services. The final shape of the organisation has deliberately been kept fluid to enable full consideration of the national guidance –which is now partly provided by *Commissioning a Patient led NHS* and other national documents referred to earlier. There is also an expectation that the forthcoming White Paper – informed by the listening events as part of *Your Health, Your Care, Your Say* -will further develop the national policy direction and will need to be reflected in the Island proposals. The designation of the Island as a second wave pilot for Local Area Agreements gives added potential to align, integrate and prioritise health and well being goals.

3. Benefits perceived from the single organisational model

The single organisational model has been favoured in the Island context as:

- Management costs and complexity would be minimised-one Board /management team replacing three and transactional costs reduced

- Integrated /localised model of health and social care can be most effectively planned and delivered under unified leadership and direction
- Assets including estate and support services can be shared and utilised most cost effectively
- The local population will have improved access to an appropriate range of care and support –at the right time and in the right place –and better co-ordinated.
- The single organisation given its enhanced scale will be better placed to be an exemplar organisation –offering effective staff development recruitment and retention and overall expertise
- Multi disciplinary team working can be further enhanced
- Simpler administrative and management arrangements with faster decision making

4. Issues Raised by Commissioning a Patient led NHS

The document builds on earlier health and social care policy and predominantly focuses on creating a step change in the way health services are commissioned within an overall context of improving the health of the whole population.

It has potentially significant ramifications for the local plans to integrate health and social care on the Island as it signals a national review of:

- PCT Configuration and where appropriate Care Trusts-the former are likely to significantly reduce in number nationally from the current total of just over 300
- SHAs and their fitness for purpose-with an expectation of a significant reduction of numbers from the existing 28
- Ambulance Service configuration-with an expectation of a significant reduction in the number of Ambulance Trusts

It also assumes PCTs will ensure full implementation of Practice Based Commissioning [PBC] by December 2006 and confirms the intent that all NHS Trusts prepare to move to Foundation Trust status by April 2008.

A major underlying driver is an intention to achieve a 15% reduction in management and administrative costs

Key issues Island Partners have addressed and reached collective consensus on are:

- The preferred island option for PCT configuration/ commissioning services-mindful of the wider agendas including the mandate to introduce Practice Based Commissioning
- The associated issue of whether the commissioning and provision functions can sit within the same organisation – given the national policy mandates seeking to detach health commissioning from provision and the requirements for choice, contestability and plurality of provision
- The range of service provision that should sit in the new organisation – in particular should the concept of a single provider of health and care services remain or are there options in particular around secondary healthcare/Ambulance services
- The view on Foundation status for part or all of the islands Health and Social care provision

5. Commissioning Options

The future proposals for PCT/Health Commissioning will be assessed against the criteria outlined in *Commissioning a Patient-Led NHS* to:

- Secure high quality safe services
- Improve health and reduce inequalities
- Improve engagement of GPs and roll out of Practice Based Commissioning
- Improve public involvement
- Improving commissioning and effective use of resources
- Manage financial balance and risk
- Improve coordination with social services through greater congruence of PCT and Local Government boundaries
- Deliver at least 15% reduction in management and administrative costs.

It is clear nationally that the number of PCTs will significantly reduce and the average size as measured by GP Practice populations will significantly increase. Even in areas of co-terminosity with small unitary authorities there will be questions raised about the viability /capacity of existing organisations. What is also clear however is that integrated health and social care commissioning and provision and effective local partnership working is increasingly recognised as crucial to effectively delivering health improvement and well being. PBC and contracting consortia may over time enable PCTs to assume a much more devolved approach to commissioning. However in the short term PBC is in its infancy and there is a hands on job to help it develop and flourish – requiring a close relationship between Practices and the PCT. The Island model is also assuming a Locality approach sub dividing or clustering the Island geographically into four communities. The proposed locality clusters (level 1) are:

- North East Wight
- Bay area
- West Wight
- Central Wight.

Levels of commissioning are still to be finalised but illustratively level one commissioning could include Acute secondary care/Intermediate care/Prescribing/ General Medical/ Direct access diagnostic services and a range of specialist nursing and therapy provision.

Level two could be those services commissioned on a whole Island health services basis such as Maternity/ Ambulance/ Out of Hours/ ICU/ NICU/ Continuing Care.

Level three services could be jointly commissioned with the Local Authority and whilst this would be a dynamic list might initially include those areas where integrated planning and delivery is essential (e.g. Learning Disabilities/Mental Health/Children)

Level four commissioning could be specialist health services that need to be planned on a sub regional/pan county scale.

The organisational options considered for the hosting of commissioning health care on the Isle of Wight assumes level one to three type functions and has included:

Option 1

A stand alone Island PCT

This would be an Island based independent statutory organisation to commission health services with remaining provider functions transferred out.

Pros - This would be the least change option. The PCT would continue as an independent statutory organisation. It would ensure a clear separation of commissioning and provision and the organisation would have a clear and unambiguous core function of service commissioning.

Cons - Whilst being the least change option it would be a small organisation and would have questionable capacity /viability to economically deliver the anticipated agenda. It would mean the anticipated reduction of Island organisations and associated management overhead costs would not be achieved and the maximum potential of Joint Commissioning may not be realised

Option 2

Island based Single Care Trust hosting Provision and commissioning of Health and Adult Social Care

This has been the model assumed in recent months. The Care Trust would both commission and provide services and governance arrangements would establish a clear separation between the two functions to ensure a rigorous and objective approach could be demonstrated to Contestability and Choice.

Sub variants of this model reflecting differing joint commissioning arrangements have been considered. These include:

Option 2a – full inclusion of health and social care commissioning within the Care Trust
Option 2b – delegation of health commissioning to the local authority or
Option 2c – a variant of the two models that enables the Care Trust to commission health services/oversee Practice Based commissioning and leaves social care commissioning with the Local Authority but provides the opportunity to use Health Act flexibilities/ the Local Area Agreement and the emerging concept of a Public Service Board to increasingly develop joint Commissioning approaches aligning the health and well being agendas.

Pros - Option 2a -This option would minimise organisational duplication and overheads and offer maximum potential for integration. Whilst it would be unique it should be possible to successfully argue the case for this model given the Island context

Cons - It does not organisationally separate commissioning and provision and would for that reason generate a fundamental problem should the new organisation want or be expected to become a Foundation Trust. As it would require relaxation of national policy its deliverability is not guaranteed

Pros – Option 2b – This option also minimises organisational duplication and overheads and takes the separation of commissioning and provision further through use of health act flexibilities.

Cons –under current legislation and guidenance health commissioning responsibilities could not be entirely transferred from health bodies and there would anyway be a wish to ensure an NHS accountability for health expenditure .

Pros – Option 2c – This model offers flexibility to progressively develop innovative joint commissioning approaches whilst enabling both the health organisations and Local Authority to retain control of services and expenditure for which they are directly accountable.

Cons – The option will need detailed exposition as it is capable of differing interpretation. It is anyway likely to be an organic model, not a static end point position.

Option 3.

Island based Joint Commissioning Care Trust

Separate Organisations would commission and provide integrated health and social care

Pros - This option would ensure the formal separation of Commissioning and Provision, retain Island based management, deal effectively with contestability /choice agendas enable both integrated health and social care commissioning and provision leave open the Foundation Trust route for the Provider Care Trust and enable a clear and unambiguous leadership role for the Director of Adult Social Services.

Cons - Whilst some reduction in management costs should be achievable in comparison to the current three organisational model it would still entail two separate organisations and therefore would have higher management costs than the single organisational model.

Option 4

Mainland /Island PCT

This assumes a PCT with a coverage spanning the mainland and Island. A variety of configurations could be theoretically possible (i.e. linkage to a mainland Unitary PCT, either Southampton or Portsmouth, or linkage to a Hampshire County PCT(s)). The PCT may or may not have an Island based Commissioning presence.

Pros - This model could offer economies of scale but as there are a wide range of potential variants it is difficult to be clear about the extent of this.

Cons - There would be question marks about the focus of an off Island based organisation and the added complexity of linking to more than one Local Authority. Integrated health and social care would appear more difficult to guarantee in this model.

6. Service Provision

Healthcare Trust

The Isle of Wight Healthcare NHS Trust was created in 1997 following a merger between St Mary's Hospital NHS Trust, the previous provider of acute services, and the Isle of Wight Community Healthcare Trust, which provided community, mental health and ambulance services. It is a unique provider within the UK in terms of the breadth of its service provision and the Isle of Wight health community believes that there has been many service benefits associated with integration within the one organisation. Indeed this has influenced the general direction of travel in seeking even greater integration as outlined further in this document.

Commissioning a Patient-Led NHS does not require the SHA to put forward future organisational configurations for Acute Trusts or Mental Health Trusts. The Island health and social care community believe that acute services and mental health services should continue to be provided as part of an integrated provider based on the Isle of Wight, which continues to develop links to mainland clinical services which can provide benefits to patients.

PCT Service Provision

The Isle of Wight Primary Care Trust commenced in April 2001, and, in view of the existing integrated Healthcare Trust has only ever taken on a modest service provision role. The service provision element of the PCT includes District Nursing, Podiatry, Personal Dental Services, Primary Care Mental Health services, GP out-of-hours services and various specialist practitioner roles (e.g. diabetes, continence and Parkinson's specialist nurses). A total of 160 WTE staff are employed within direct service provision with the budget for service provision as approximately £7 million. The Primary Care Trust has developed services in collaboration with independent primary care practitioners, such as Primary Care Mental Health Services and District Nursing with GP practices and Personal Dental Services with GDPs.

The direction of travel for health and social care on the Isle of Wight has been to develop a single integrated provider of services which would include the service provision elements of the PCT. Indeed the direction of travel on the Island predated the direction in *Commissioning a Patient-led NHS* whereby PCTs "will become patient-led and commissioning-led organisations with their role in provision reduced to a minimum".

Although the community services currently provided would become part of a larger integrated provider, it is acknowledged that national policy will be seeking some contestability. There is recent precedent for this on the Isle of Wight with Primary Care Dentistry, Prison Medical Services, and Out-of-hours Dental Service all recently procured from new providers following a review of service needs. Once the commissioning model is clear further consideration can be given to contestability of specific community services, albeit within a general direction of the majority of services being a part of the larger integrated provider.

Ambulance Service

The Isle of Wight Ambulance Service is unique in that it is the only English Ambulance Service that is integrated into a Healthcare Trust that also provides acute and mental health services, and being that it is situated on an island it shares co-terminus borders with the PCT, Local Authority and other agencies.

The national review of Ambulance Services published on 30th June, *Taking Healthcare to the Patient,* outlined various improvements to the service and a reduction of at least 50% in the number of Ambulance Trusts. Recommendations included reviewing scale of organisations, partnership working arrangements, effectiveness of clinical networks, use of IT and collaborative working. *Commissioning a Patient-Led NHS* requires SHAs to review configuration within their boundaries, so the question will inevitably be raised whether the current configuration is the best one for the service and its patients. Previous reviews of mainland Ambulance Services have not concluded that the Isle of Wight service would be better provided from a larger mainland Ambulance Trust, and indeed there has been some national interest in the integrated model currently in place on the Island.

Although the Ambulance Service is above average on national reference costs this is mainly due to the requirement for a basic level of ambulance provision across a small resident population, with a significant influx of tourists during the summer months, and no opportunity (except in handling a major incident) to benefit from cross-county boundary flows than mainland services. Although there could be some benefit in terms of economies of scale for the service to be part of a larger mainland based Trust the service already benefits from shared core services within the Healthcare Trust, such as HR, Finance, Occupational Health, Risk Management and Governance. It has also developed collaborative working and regular communication on relevant joint issues with Hampshire Ambulance Services Trust.

The performance of the Ambulance Service on the Isle of Wight has been comparatively excellent and has resulted in the top level 3 Star Rating from the Government performance ratings for the last two years.

The benefits of integration of the Ambulance Service on the Isle of Wight into the wider whole health system fit extremely well with the ethos of *Taking Healthcare to the Patient.* The Isle of Wight Ambulance Service is currently developing Emergency Care Practitioners (ECPs) to enable the treatment and care of patients to take place in the right place at the right time. This approach will inevitably result in the reduction of patients being admitted through the Emergency Department, assist in meeting the 4-hour A&E target and reduce hospital costs. At present there is good joint working between the Ambulance Service and the GP out-of-hours service, but the vision, from the ambulance service perspective on the island, is to deal with all unscheduled care initially through a whole system Communication Centre. The Communications Centre would be an integrated call centre that could potentially incorporate:

- Ambulance 999 calls including telephone advice.
- Ambulance routine calls
- GP Out of Hours
- NHS Direct type call system that provides greater value for money through skill mix and software
- Appropriate local Authority call centre functions
- Bed management.

Although this is a longer term vision and requires formal approval from partners this arrangement would introduce greater efficiencies and ensure that the patient is directed to the most appropriate professional to deal with their condition.

The recent national review stresses the need for the ambulance service to become more integrated with the wider health and social care system. As has been recognised there are potential tensions between the demand and capacity of ambulance services and the delivery of their operational targets with the demand and capacity for acute services and the delivery of their operational targets. The existence of both ambulance and acute services within the same Healthcare Trust on the Isle of Wight has ensured that a careful balance is struck between the pressures on each of the respective services, which has ultimately benefited patients.

Social Care

The Isle of Wight Council is a Unitary authority which has existed since 1995. Adult Services on the Island (formerly called Social Services) are a division of the Adult and Community Services Directorate of the Council. The Directorate also contains housing culture leisure services and safer communities. The areas which are most closely associated with the new organisation are adult services and some elements of housing. Adult services division has a gross budget of £45m and comprises in house registered direct service provision, care management functions and commissioning, procurement and contracting functions. The housing division has a gross budget of just over £11m and is comprised of OT, ICES, Supporting People, Homelessness [including Housing Register] housing renewal and Pan Neighbourhood project.

The direction of travel on the Isle of Wight has been for the development of a Health and Social Care Trust. The areas of provision currently assumed to be transferring to the new organisation are registered service provision and care management functions, OT, ICES and Supporting People.

Integration

A Transition Project Team was established at the end of 2004 with a view to developing a Care Trust following a debate on organisational configuration between the PCT, Healthcare Trust, and Council on the Isle of Wight as well as the SHA. There are already good examples of integration between health and social care, such as joint commissioning of services, joint appointments, co-location of services and integrated provision for adult mental health care. The health care strategy for the Isle of Wight published in response to the SHA's HealthFit initiative outlined a service strategy for a transfer of care from acute hospital provision to "closer to home" settings.

Much national policy encourages greater integration and joint working between health and social care at a local level. This makes even greater sense on the Isle of Wight with its relatively high elderly population, co-terminosity of health and social care boundaries and relatively small-sized organisations. The Isle of Wight health and social care community remain of the view that a broad integrated provider of health and social care is the right way forward. This would enable maximum viability for the provider organisation based on the Isle of Wight, which becomes all the more important in view of the national policies of contestability and choice which will potentially impact upon the

size and breadth of service provision within this organisation. The Care Trust model would appear to offer the most viable solution to the objective of the larger integrated provider.

7. Foundation Status

The stated intention of the Government is that all NHS Trusts should become Foundation organisations by 2008. *Commissioning a Patient-Led NHS* describes a rigorous development programme for organisations aspiring to foundation status which will be rolled out across the country by the end of 2006.

Acute Trusts, Mental Health Trusts and, as recently announced, Ambulance Trusts can all apply for foundation status. It is understood that the Department of Health is currently considering how to roll out foundation status to Care Trusts. A key assumption that we have made is that in aspiring to become a Care Trust this organisation will be able to secure the benefits of foundation status. In the Island context it is attractive for the larger integrated provider to consider the potential for provision of a wider range of services, including those traditionally provided by Primary Care, as is being developed by Foundation Trusts elsewhere in the UK. This adds to the potential plurality of provision in the Island context which over time is likely to lead to a blurring of boundaries between primary and secondary care and a plurality of provision from traditional NHS providers, independent practitioners, such as GPs, dentists, pharmacists, etc, the not-for-profit sector who will have an interest in certain community services and new private providers.

Whilst still an early stage idea the notion of "Foundation Communities"-embracing integrated provision of a range of public services has been mooted both nationally and in an Island context.The Island Partners are keen to be involved in leading edge change that can benefit the local community and effectivelty address the needs and opportunities resulting fron unique geographic situation. The direction of travel would be to develop the large integrated provider as a Care Trust in the first instance, by April 2007, with a view to gaining foundation status by April 2008. In view of the integrated nature of the provider Trust this would be a significant step towards establishing a "foundation community".

8. Summary

Discussions on provision have been unanimously supportive of the integration of health and social care within the single organisational model. The imperatives of choice and contestability are also recognised and it is therefore intended to develop the Island model for service commissioning in a way that ensures this is demonstrably delivered.

Consideration has been given to the potential pros and cons of relocating some services outside of the single organisation. Ambulance Services in particular will be further debated as part of the SHA response to *Taking Healthcare to the Patient*. However the current Island Service is generally acknowledged to be effective and high achieving and already delivering an effective integrated emergency response service.

The various models for commissioning have been extensively debated refined and developed through the recent consultation process. A crude scoring exercise has also been completed on the commissioning options by a small group of representatives from

the three statutory organisations the outcome from which has affirmed the preferred option

The stand alone PCT (option 1) has received little support as it is recognised that it would be both relatively expensive and unlikely to have the capacity to effectively deliver the anticipated agenda.

Equally the off Island option (option 4) has been discounted as potentially remote and insufficiently focussed on the particular circumstances and needs of the Island population.

The two Care Trusts option (option 3) whilst effectively addressing the need for separation of commissioning and provision is felt in the Island context to be an unnecessary organisational duplication – adding both transactional complexity and management and administrative overheads.

The preference has therefore concentrated on the option 2 variants with option 2c emerging as local partners proposed way forward. It enables the Local Authority to include social care commissioning in its developing Local Area Agreement and provides the flexibility for relevant health care commissioning to be included in future. It also enables the single organisation option for health with control of commissioning within the Care Trust.

Given that it would result in health commissioning and provision sitting in the same organisation it is recognised that the governance arrangements would need to demonstrate a clear separation of functions alongside an organisational strategy to deliver contestability ,choice and plurality of provision.

Governance arrangements would therefore include

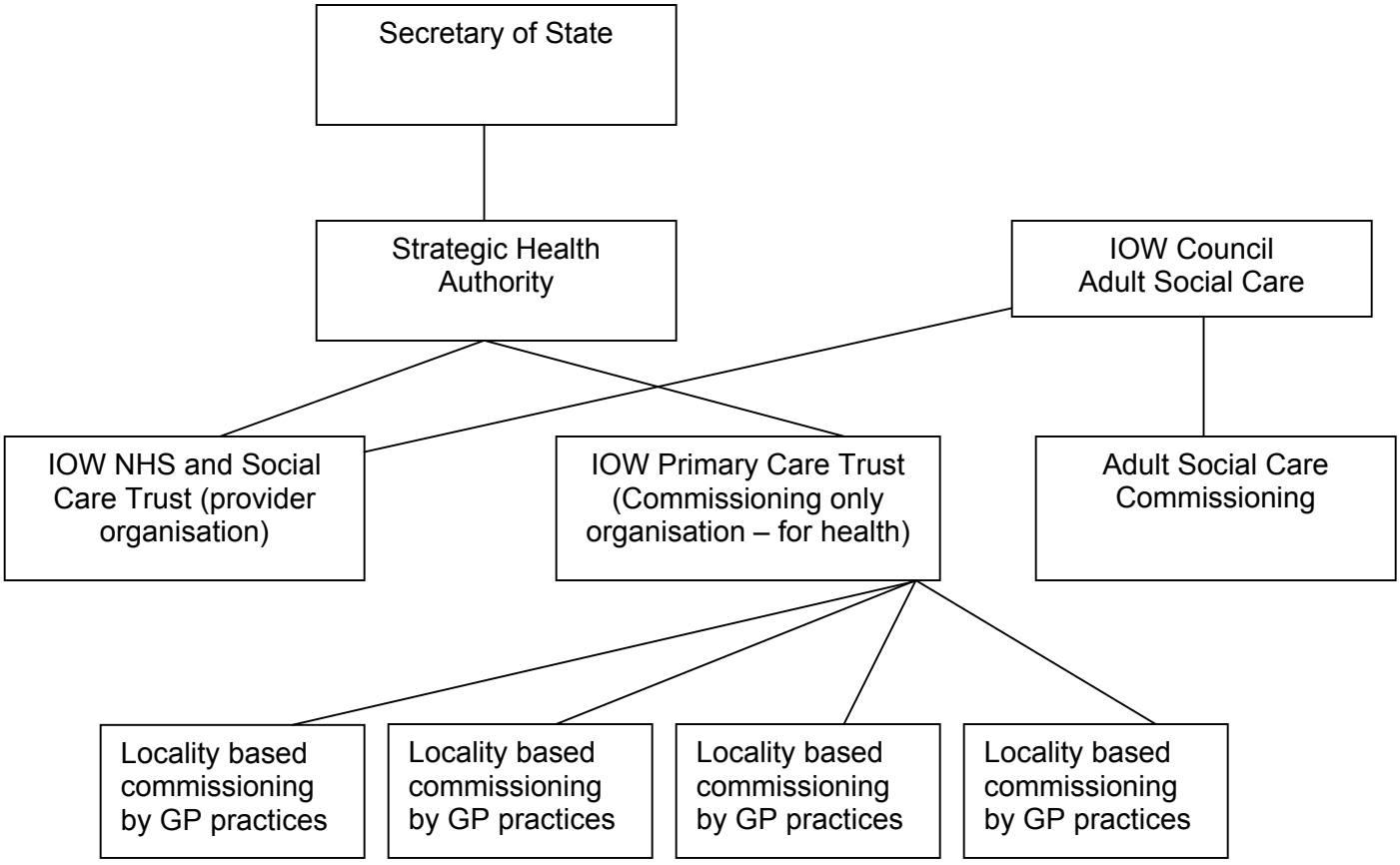
- Exploring options for separately managing commissioning and provision, designating non Executive Board members as either Commissioners or Providers
- Establishing internal and external audit standards for the separation of functions and duties including separate accounting for commissioning and provision and explicit rules to prevent cross subsidisation –cognicent of the over riding statutory duties
- The Executive Committee operating as the designated commissioning Board and the Commissioning function headed by an Executive Director of Commissioning mirrored by a Provision Board and Executive Director, of Operations.Although precise Board membership and details are yet to be determined there would be minimal cross representation between these two Boards
- Service level agreements [SLAs]based on PBR/Foundation Trust model contract principles will be used in so far as is relevant to provide transparency
- Benchmarking and market testing will be routinely used to ensure best value and contestability
- Commissioning through PBC and joint partnering wherever this can be shown to add rigour and transparency

At its meeting on 15th September the Transitional Steering Board for the Project confirmed partners support for option 2c.

APPENDIX 1

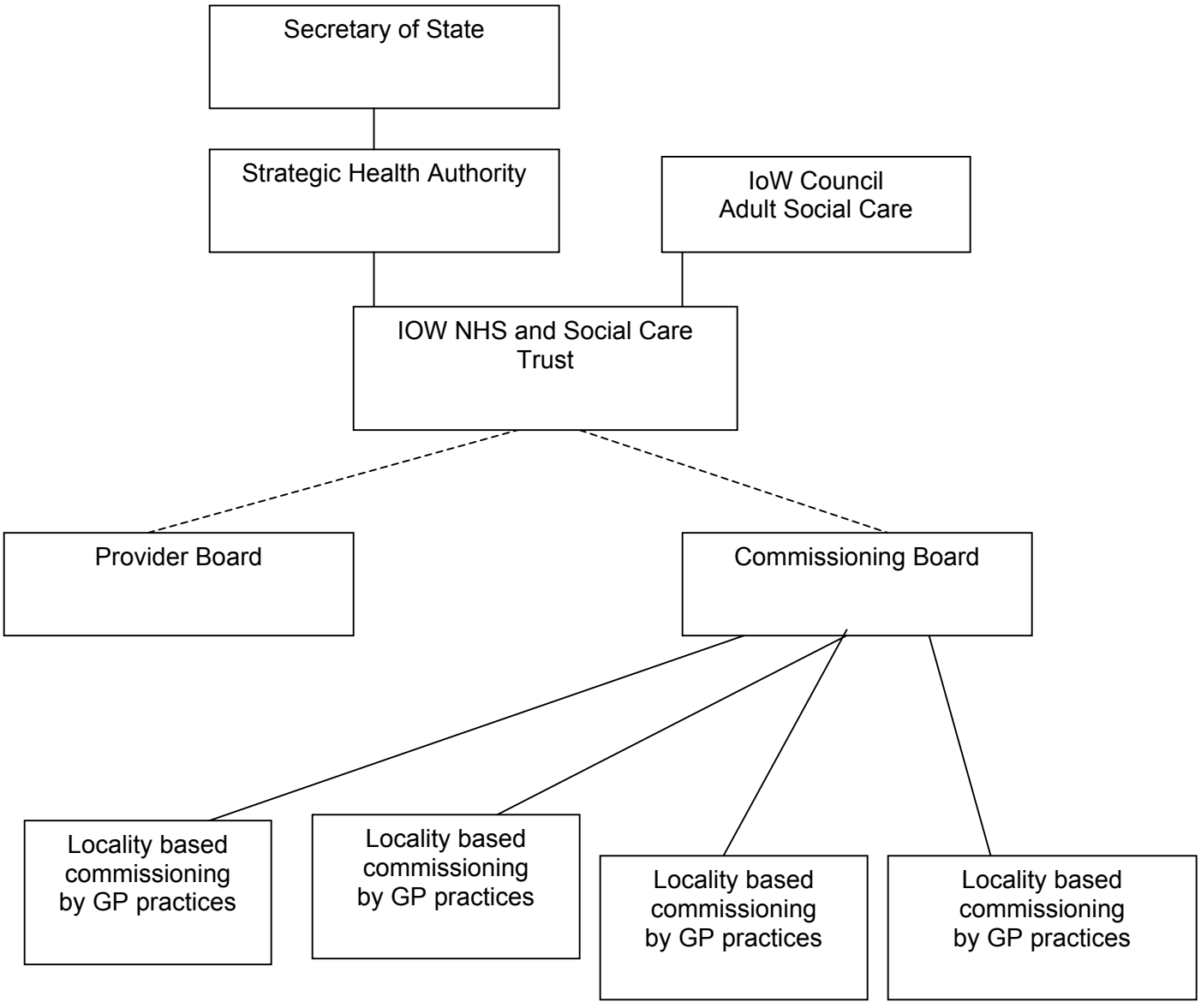
Option 1

A standalone Island PCT with Provider Care Trust



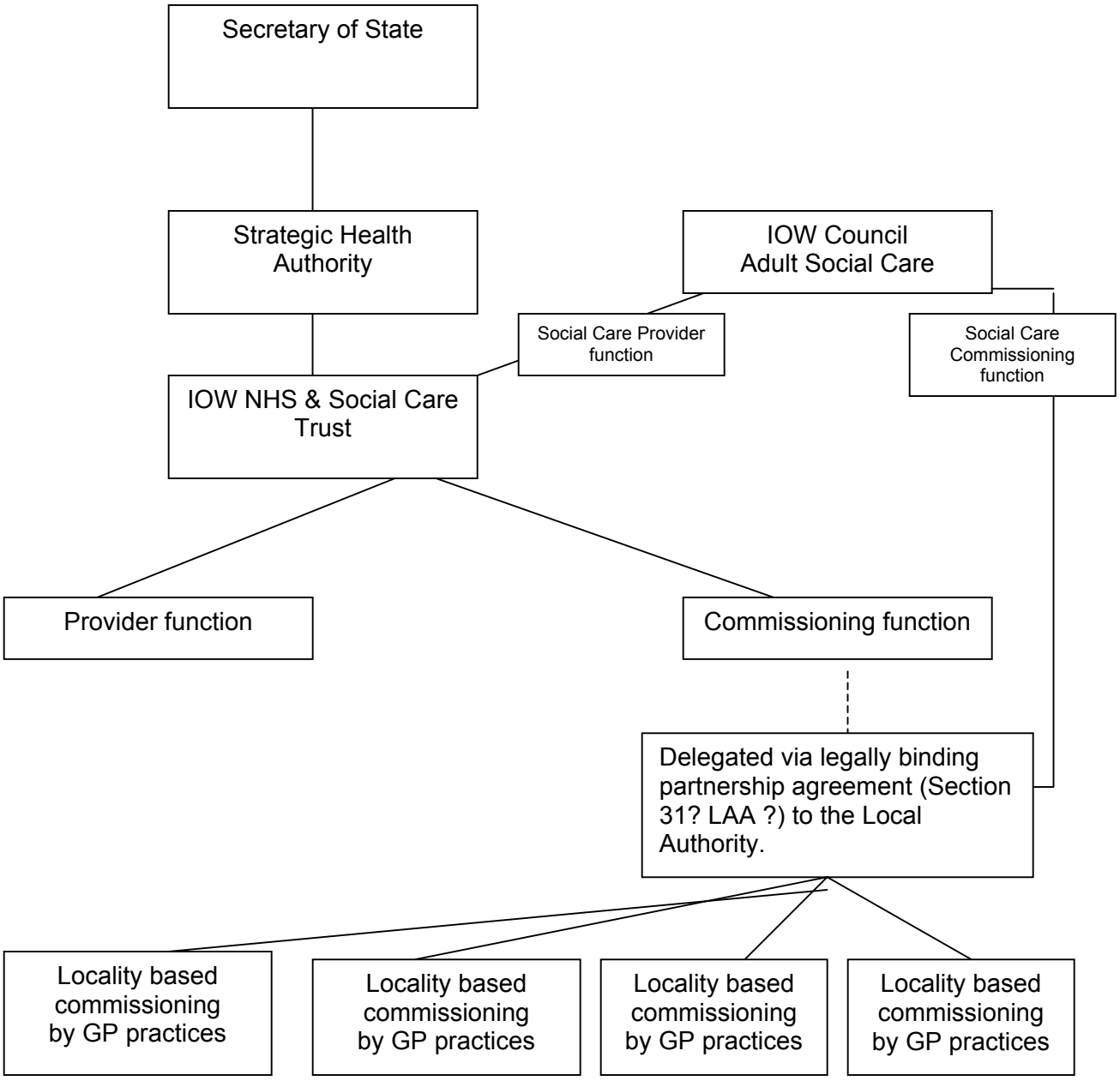
Option 2a

Island based Single Care Trust



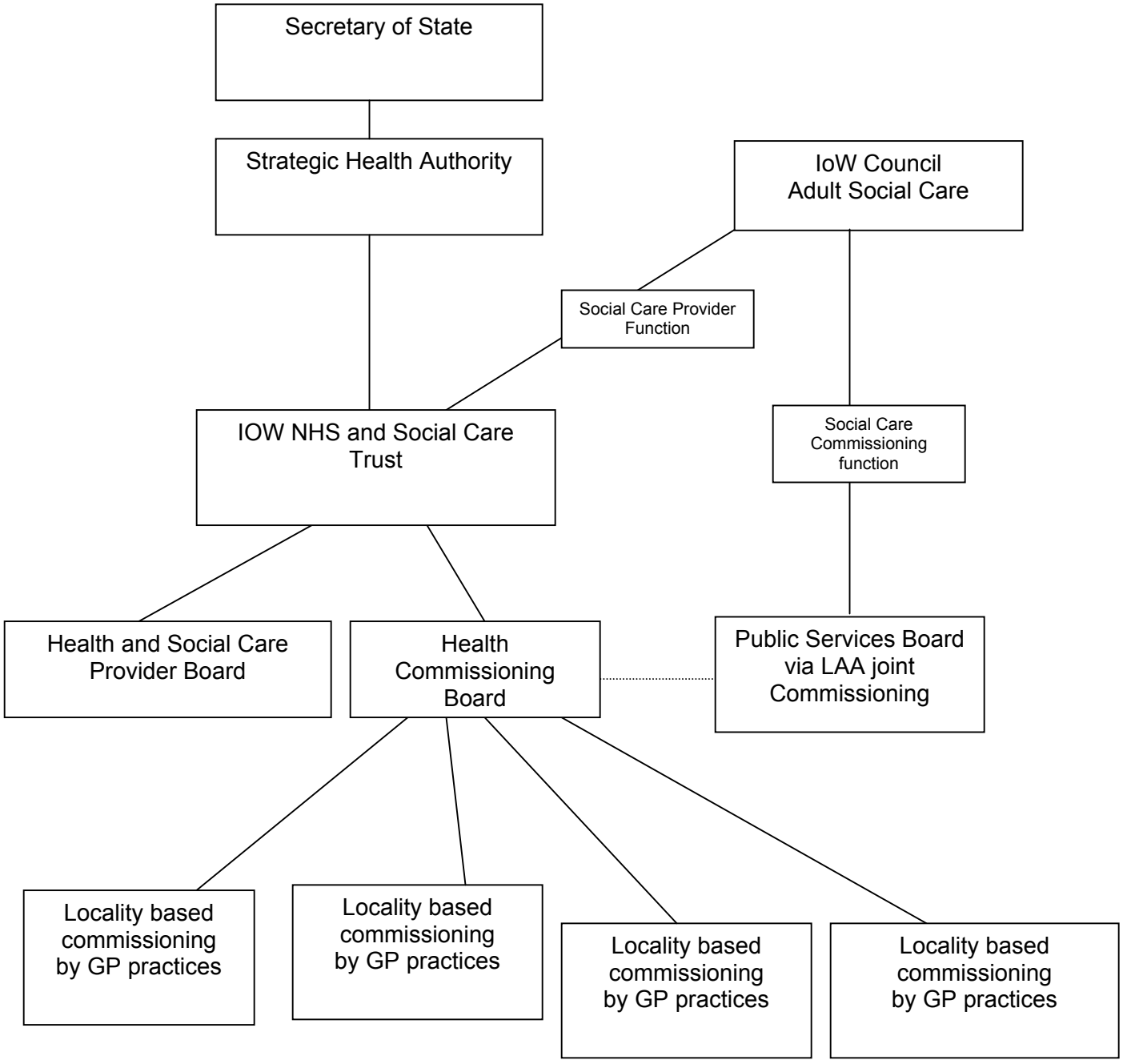
Option 2b

Island based Single Care Trust



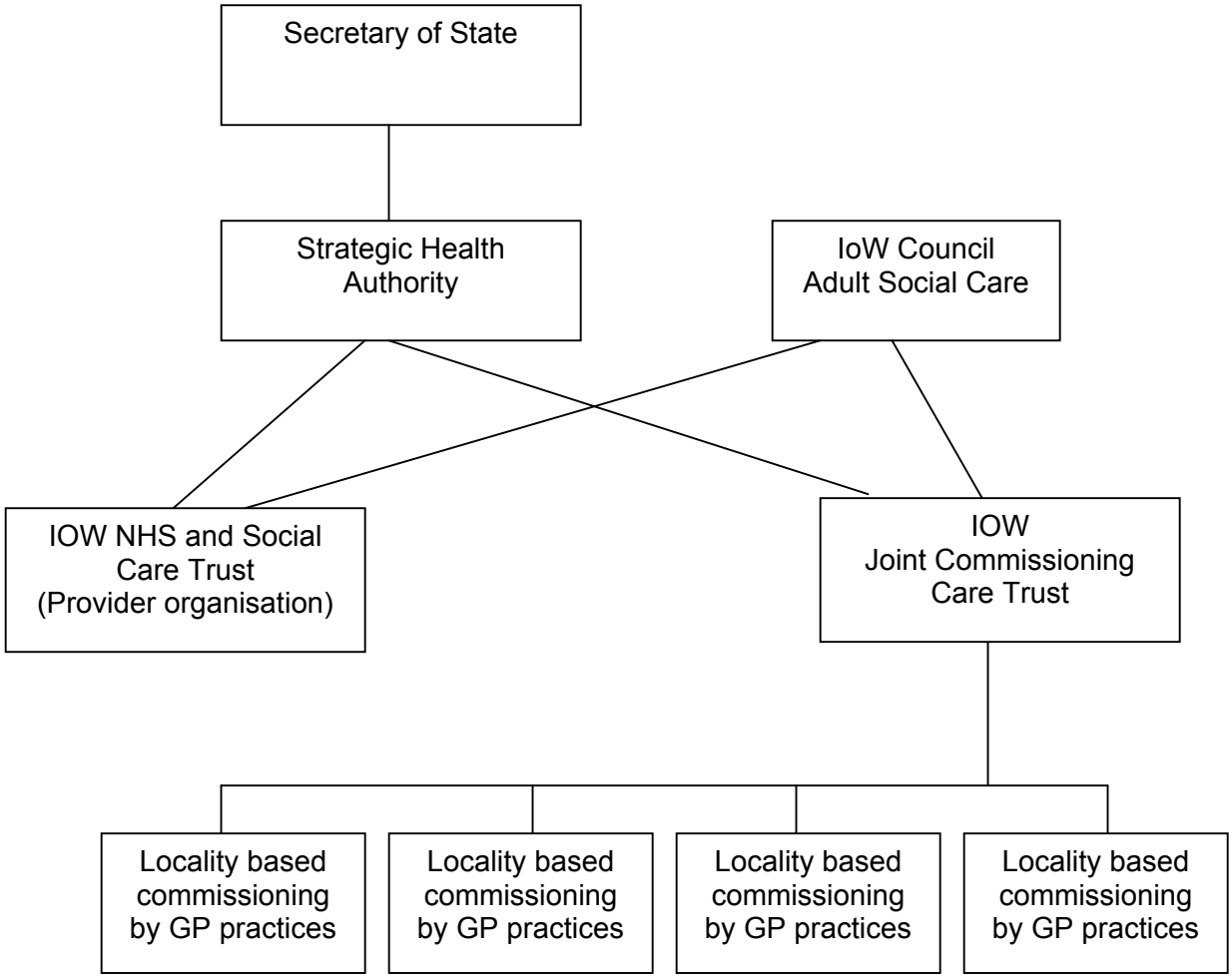
Option 2c

Island based Single Care Trust



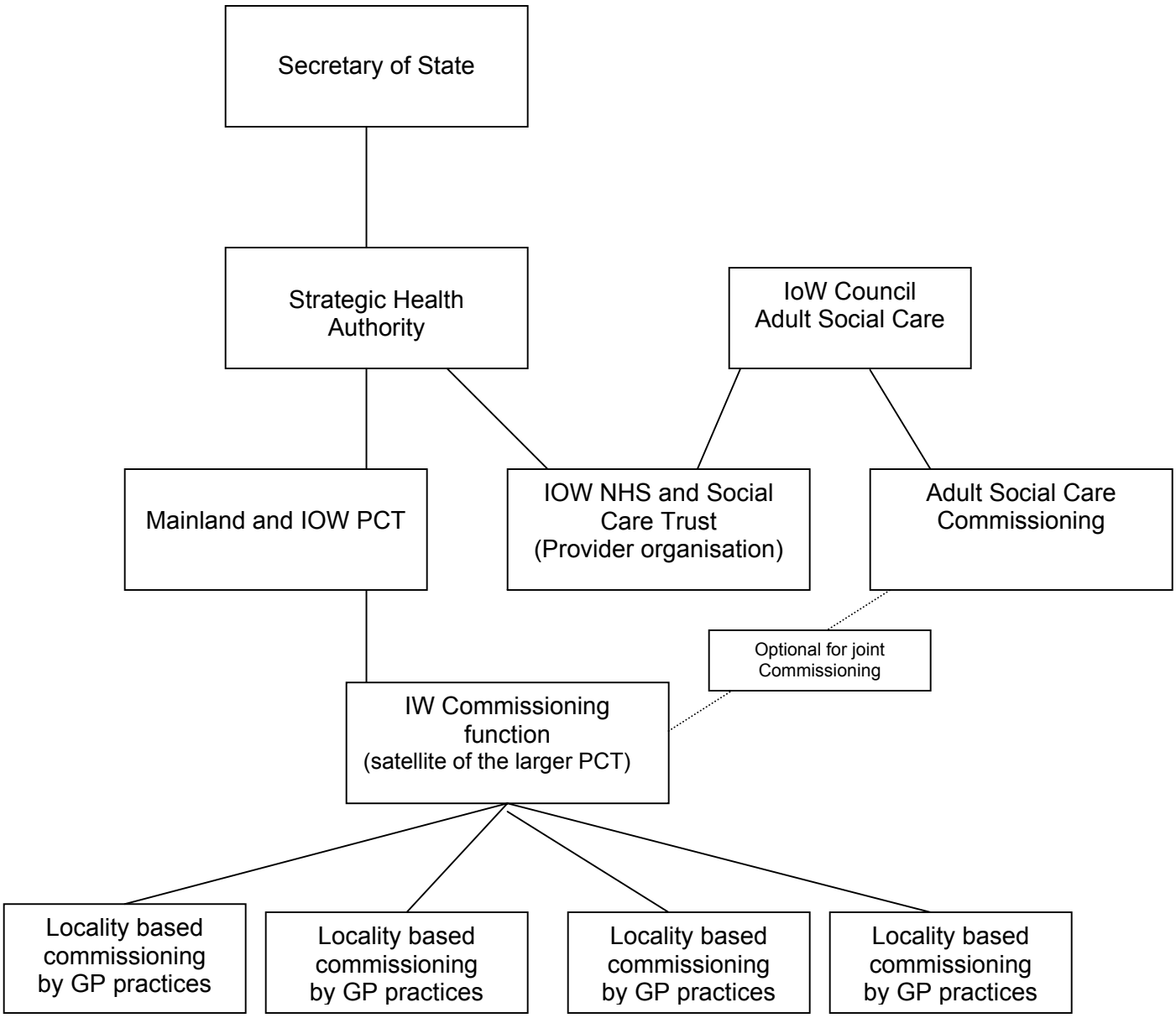
Option 3

Separate Island based Joint Commissioning and Provider Care Trusts



Option 4

Mainland/Island PCT with Provider Care Trust



APPENDIX 2

Options Scoring

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	1	2a	2b	2c	3	4
Secure high quality safe services	3	3	3	3	4	4
Improve Health/reduce inequalities	4	4	5	5	4	2
Improve GP Engagement/roll out of PBC	4	2	2	3	4	2
Improve public involvement	3	2	5	4	4	1
Improve commissioning	3	2	4	4	4	1
and effective use of resources	2	3	4	4	5	2
Manage financial balance/risk	3	4	4	4	3	4
Improve co-ordination with Soc Services through greater congruence of PCT/LA boundaries	3	3	4	4	4	1
Deliver at least 15% reduction in management and admin costs	3	4	5	5	2	5
	28	**27**	**36**	**36**	**34**	**22**

N.B. The criteria are as specified in *Commissioning a Patient-Led NHS*
Scores attained from 1 – 5 (1 low, 5 high, 3 as current baseline)