Commissioning a Patient-led NHS in Essex

Formal Consultation

14 December 2005 to 22 March 2006

What people want

- Local services when you need them
- Emergency care when you need it
- No waiting
- The best patient experience
- To have a say, to have a choice
- More emphasis on prevention
- Health and social care working together

8 national criteria

- Improve commissioning
- Improve the engagement of GPs
- Improve co-ordination with social services
- Secure high quality safe services
- Improve health, reduce inequalities
- Improve public involvement
- Manage financial balance and risk
- At least 15% reduction in management costs

What is the best PCT structure?

- **Stronger commissioning**
  - **Improve commissioning**
  - **Improve the engagement of GPs**
  - **Secure high quality safe services**
  - **Improve public involvement**
  - **Manage financial balance and risk**

What is the best PCT structure?

- Closer links with local councils and LSPs
  - Improve co-ordination with social services
  - Improve health, reduce inequalities
- Management cost savings
  - At least 15% reduction in management costs
  - Target for Essex £7.5m (£2m from SHA, £5.5m from PCTs)

Option 1 – 2 PCTs (North Essex and South Essex)

- £3.3 million above current level to strengthen commissioning
- Resources for locality Director and team
- Resources for locality public health budget
- In-house functions or share “back office functions”
- Economies of scale and devolved structure
- HQ remote from local practices
- Deprived areas risk losing out if finances merged

Option 2 – 3 PCTs (Essex County, Southend and Thurrock)

- Coterminous with social care and education– benefits for joint commissioning
- £2.5 million more available than currently to strengthen commissioning…
- …but in Southend and Thurrock only £0.7m and £0.6m in total
- Southend and Thurrock likely to need £1m more each:
  - Potentially £2m away from frontline services
  - Other PCTs would need to make good savings shortfall
- Larger PCT would have economies of scale, but over 1.3 million population

Option 3 – 4 PCTs (North, South, Southend and Thurrock)

- Nth Essex has similar pros/cons as option 1
- 3 sth PCTs could consider shared services
- Southend and Thurrock PCTs have benefits of coterminosity, but same problems with resources as option 2
- South Essex PCT does not match local communities or health arrangements

Option 4 – 5 PCTs (Mid, North East, SE, SW, West)

- Builds on existing arrangements
- Potentially £0.9 million above current level – could be further savings from shared services
- Resources for locality Director and team
- Resources for locality public health budget
- Is management cost sufficient to strengthen commissioning?

Streamlining SHAs

- SHAs responsible for fewer PCTs
- More hospitals becoming independent Foundation Trusts
- Closer match with Government Office
- Strategic overview to meet national objectives

Ambulance reconfiguration

- Range of emergency care expanding - *Taking Healthcare to the Patient*
- Larger organisations - more capacity for new services
- Management cost savings – more money for frontline services
- Local operational structures to serve different communities
- Boundaries to match SHAs, GOs

Your feedback

- What do you think are the pros and cons of each option?
- Documents and feedback forms available
- Deadline 22 March