

Ref: 201010-805

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**To: Leaders and Chief Executives of Local Authorities in
NCL, ONEL, SWL and SEL**

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**Cc: Sector Chief Executives and PCT Chief
Executives in NCL, ONEL, SWL and SEL**

4 October 2010

RE: Managing the transition of the NHS in London

Dear Colleagues,

The PCTs in London, the SHA and shared commissioning services will face increasing challenges over the next two years. While continuing to deliver against our obligations in terms of quality, safety, performance and finance, we must also reduce management costs by 54%. At the same time, we must ensure we are fit to move towards the new state which emerges from the consultation on the July 2010 White Paper 'Liberating the NHS'. This shift is likely to include releasing further resource to GP consortia.

We know that we cannot succeed in meeting all three of these challenges at once unless we work closely with our Local Authority partners. This letter is therefore intended to keep you informed of recent developments, and to encourage an open dialogue between the NHS and local government in London so that we can begin to co-design responses to these challenges.

Current challenges faced by London PCTs

PCTs have made significant efforts to develop and strengthen their commissioning capabilities in recent years, but continue to struggle with their operational and financial performance. In recent months an increasing number of patients have had to wait longer than 4 hours to be seen in A&E, a deterioration which has not been seen in the rest of England. As winter sets in, this situation is likely to worsen. Meanwhile, MRSA rates have increased this year, and three trusts have already breached their full year 2010/11 MRSA threshold. The financial situation is also deteriorating. Twelve London PCTs have a cumulative in-year deficit of £34.4 million, and the latest (Month 5) financial returns revealed a £36.5 million adverse variance against plan amongst PCTs and trusts.

In part, these gaps are due to the fragmented nature of London's commissioning system, which has significantly smaller PCTs than elsewhere in the country. Historically, many PCTs have underperformed in national capability assessments, struggled to

London Strategic Health Authority

Interim Chair: Professor Mike Spyer

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recruit high quality leadership, and have consistently had high numbers of vacancies at a senior level. Since the publication of the White Paper, leadership has become even more difficult to recruit and retain. Moreover, the focus of existing leadership has become split between the need to maintain grip and performance today, the need to support the emergence of the new system and understandable worries about personal futures.

PCTs' ability to cope with these challenges is likely to decrease in coming years as PCTs and the SHA lose staff. In particular, achieving the London-wide target of a 54% management cost reduction will require London PCTs lose approximately 3000 of their 6350 employees. As a result, some PCTs will end up as only a fraction of their current size. By 2012/13, London's smallest PCT would be functioning with about 65 staff. It is very unlikely that such a PCT could maintain firm control of finance and performance as it prepares to hand over its legacy to local consortia.

Emerging local solutions

Local solutions to these challenges are already emerging. Two sectors of London – North West (NWL) and Inner North East (INEL) – have come to the conclusion that they must merge their management and staff teams to strengthen their commissioning capabilities, conserve leadership and achieve economies of scale. INEL's PCT Boards will take a final decision on this in early November. If then agreed, both sectors will maintain individual Chairs and Boards; INEL will have a single accountable officer and NWL will become a central body with three accountable officers each representing a cluster of PCTs. Both sectors have received initial support for these moves from their local authorities and are now working up more detailed plans with them and other partners.

NWL and INEL identified several advantages of merged management teams:

- Strengthening commissioning capabilities - the creation of strong, sustainable teams strengthens commissioning capability through the transition and ensures quality is maintained
- Conserving high quality leadership and staff - integrating management teams reduces the number of executives required. This helps retain existing high-quality leaders within the system and maintain grip on finance and performance
- Less expenditure on executive officers - merging management teams means that several PCTs share a single CEO, Finance Director and other executive officers which saves on pay spend. Across London, sharing executive officers in this way could represent annual savings of more than £16 million (assuming six executive teams serving 31 PCTs)
- Increasing financial control - this improves the ability to maintain financial control and pass on a strong financial legacy to GP consortia

We have asked the other four sectors to develop proposals on how they will address the challenges of maintaining financial and operational performance, while also making management cost savings, supporting staff, working with local authorities to develop future health and wellbeing arrangements, and (where possible) offering resources to emerging consortia. In doing so, we expect they will learn from the conclusions of NWL

and INEL that it is very difficult to achieve these goals while maintaining the current fragmented commissioning structure. The sectors have agreed to submit their individual transition plans by 29 October 2010.

In making the changes outlined in this letter, we are keen that all transitional structures are flexible enough to support the development of GP consortia. We are currently investigating the possibility that London may have at least one 'pathfinder' consortium already, which might have a different relationship to its consolidated PCT structure from the start. This potential 'pathfinder' in Bexley, has a history of strong GP engagement which has enabled rapid progress in discussions about GP-led commissioning.

As demonstrated by the differences between the models in NWL, INEL and Bexley - all of which we support - we do not intend to impose a top-down solution or require a single approach to arrangements during this period of transition. Rather, in designing any temporary model, local needs should be considered and variance be expected. We therefore do require that in each area the NHS works closely with Local Authorities and local GPs. In this spirit, we encourage you to engage with your local commissioners (sector and PCT) to open the dialogue if it is not already occurring. We also encourage you to begin talking to your local GPs now about how joint working with emerging GP consortia could happen during and after transition.

In some areas this may also be a useful opportunity to begin a dialogue with PCTs about joint working during transition, including whether the responsibility for some functions (e.g. public health) could shift from PCTs to Local Authorities within the next year. During transition, section 75 agreements could be used to do this. Of course all arrangements will be governed in due course by the forthcoming Public Health White Paper.

I hope that your existing relationships can be a basis for useful discussions on how local needs can best be addressed alongside the challenges facing the NHS in London, and that we can work effectively together with all our partners to co-design a smooth transition.

Yours sincerely,

A handwritten signature in blue ink that reads "Ruth Carnall". The signature is fluid and cursive, with the first name "Ruth" and the last name "Carnall" clearly legible.

Ruth Carnall
Chief Executive