Annual Report of the Director of Public Health 2005

Health Inequalities In Sutton and Merton
Developing a Platform for Local Action
Executive Summary
Health inequalities are the differences in health within a population due to social or economic circumstances. There is clear evidence of inequalities in death rates, illness, disability, quality of, and access to care and the underlying determinants of health such as housing, education and environment. These relate to where people live; their socio-economic background such as income, employment, education; their age, ethnic group and gender.

Tackling health inequalities is important because inequality is widespread and in many cases this has widened over the last two decades. Unless concerted action is taken, most policies inadvertently widen health inequalities.

This report describes health inequality in Sutton and Merton. The initial chapters give an overview, describe the local population and explain the local context for the two national goals:

- In the long term, up to and beyond 2010 to reduce health inequalities by tackling the wider determinants of health such as poverty, poor housing and education
- To reduce inequalities in health outcomes by 2010 by 10 percent as measured by infant mortality and life expectancy at birth

The chapters follow the five themes of the national Cross Cutting Review, 2002 and describe local inequalities, what works, examples of local good practice, opportunities for action, key messages and then conclude with recommendations. The key messages of these five chapters are shown below.

Tackling the wider determinants of health is central to all chapters but is described in detail in chapter 4.

**Strengthening disadvantaged communities**

Though Sutton and Merton are affluent boroughs overall, the Index of Multiple Deprivation (IMD 2004) shows that some electoral wards and areas smaller than these, are deprived in multiple or single determinants of health (for instance housing). It confirms known areas of deprivation in East Merton, and the Northern wards and Roundshaw Estate in Sutton but also highlights small areas of deprivation outwith wards or areas traditionally recognised as deprived. Sutton and Merton both have up to 11 small areas that are among the most deprived 20% in England on most deprivation indices, and one Sutton area is amongst the most deprived 1% in England for crime deprivation. Chapter 4 describes these in detail and effective action to tackle the underlying determinants of health, such as low educational attainment, poor housing and material disadvantage, which will have some of the greatest long-term impact on health inequalities.

**Improving the health of vulnerable groups through targeted interventions**

There are a range of groups in Sutton and Merton who are particularly at risk of poor physical and mental health. Social isolation, poverty, discrimination and stigma contribute to health inequalities: and access to primary care is a problem for many of these groups. In the long-term, all mainstream services must meet the needs of vulnerable groups but in the short-term targeted action is needed to improve their health and reduce inequalities. Limited information on the size and needs of these groups makes assessment of local need difficult. Chapter 5 gives examples of the inequalities issues experienced by older people; Black and Minority Ethnic groups; people who are homeless; refugees and asylum seekers; people with a learning disability; those who have mental health problems; drug and alcohol users; and those with HIV.

**Breaking the cycle of inequalities**

As shown in Chapter 6, health inequalities persist through generations and tackling child poverty is central to redressing these. Maternal and child health is relatively good in Sutton and Merton but within each borough there are wide variations in the determinants of child health such as low birth weight and child poverty. Low income, deprivation and low educational attainment lead to poorer health in infancy, childhood and later life. There is a strong link between teenage parenthood and the cycle of deprivation; although the average borough teenage conception rates are low, there are large differences within each borough. Local data shows marked socio-economic inequalities in oral health across each borough.
Tackling the Major Killers

There are large differences by social class, gender and ethnic group in the major causes of death – circulatory disease and cancer - and the lifestyle factors contributing to these. Inequalities in smoking rates account for half the difference in death rates in middle-aged men between social class V and I. Chapter 3 shows that although the life expectancy of men and women in Sutton and Merton is as good as or better than the national average, there are socio-economic differences at ward level across both boroughs. Chapter 7 shows similar differences between wards in death rates for circulatory disease and cancer. Tackling behavioural factors – smoking and obesity (including diet and physical activity) – will have a major impact on health inequalities. Addressing the strong social gradient for heart disease and smoking requires action across both boroughs not confined to deprived communities. Effective approaches include interventions at the level of individuals and communities and addressing the wider determinants of health.

Improving Access to Good Quality Services

Chapter 8 describes inequalities in access to, and quality of, health care, in the context of the local acute health care strategy (Better Health Care Closer to Home) and new national policies. Inequality in access to health care contributes to poorer health outcomes and there are opportunities to improve: preventative care and good chronic disease management in primary care; outpatient and elective hospital care; and hospital treatment for cancer and heart disease. The greatest health service contribution to reducing inequalities in health is made by improving the quality of primary care, particularly for patients with chronic diseases, through systematic care, financial incentives and innovative models. The effect of hospital services on inequalities in health is less certain, but overcoming access barriers for some groups is important to ensure equality of care. Some national initiatives such as practice based commissioning risk widening health inequalities. Action from outside the NHS for example improved transport can improve access for disadvantaged groups.

Proposed Priorities for Action

In the final chapter, recommendations based on evidence of need, what works, national policies and local opportunities are summarised. From among the 34 recommendations, proposed priorities for joint action are to:

- Review area based initiatives to ensure that they are appropriately targeted (based on IMD 2004) and that activity takes account of what works.
- Use this report to prioritise action on the inequalities in determinants of health that will have greatest impact on local inequalities in health.
- Develop and implement a tobacco control strategy.
- Develop and implement a childhood obesity strategy.
- Develop a rolling annual programme of structured health needs assessment and appropriate action for vulnerable groups.
- Lead local action to tackle unemployment and improve retention of employees.
- Review progress on the implementation of the recommendations of this report at least every two years.
- Systematically consider and address the impact of changes in local health services, including the implementation of Better Healthcare Closer to Home and practice based commissioning, on inequalities in health.
CHAPTER 1: Introduction
1.1 Introduction

This report has been written to support the multi-agency Local Strategic Partnerships (Sutton and Merton Partnerships), in developing their strategic direction, priorities and action plans to address inequalities in health and the wider determinants of health. It describes important inequalities, using local data where available, effective action to address them and sets out the national and local policy context.

It is the first stage of a high level Health Equity Audit (HEA). HEA is a key tool for tackling health inequalities by: describing health inequalities; comparing service provision and resource allocation to meet need; identifying gaps and priorities for action; and effecting change. The audit cycle is not complete until something changes that is likely to reduce inequalities.  

Action on health inequalities requires leadership from Primary Care Trusts (PCTs), with active support from Local Strategic Partnerships and their constituent organisations and communities. Priorities and actions must be agreed in partnership to ensure sustained changes. Over the last few years partners have developed local mechanisms to agree strategies to address health inequalities. This report makes recommendations and proposes priorities for action for local consideration and implementation.

1.2 Why health inequalities are important

There is clear evidence of inequalities in death rates, illness, disability, quality of, and access to, care and the underlying determinants of health such as housing, education and environment. These relate to where people live; their socio-economic background (see glossary for classification) such as income, employment, education; their age, ethnic group and gender. Key examples are shown in Box 1A.

Tackling health inequalities is important because:

- Inequalities are widespread in society and yet many are preventable.  
- Unless concerted action is taken, most policies inadvertently widen the differences in health experience between the richest and the poorest.  
- Many of these differences have been widening in recent years.  
- Research suggests that societies with a wide gap between rich and poor experience additional social problems, for instance crime.  
- Tackling health inequalities is now a national priority, reflected in key targets.

The causes of inequalities are multiple. A socio-economic model describes the complex interaction of different factors that influence health. These include age, gender and genetic composition that are fixed and others which are amenable to change including:

- The socio-economic, cultural and environmental conditions of the society in which people live.  
- Social and community networks.  
- Living and working conditions.  
- Access to health care, employment and education.  
- Life-style choices, for instance smoking.

However individuals do not have equal choices: lifestyle choices are affected by socio-economic and cultural factors.

1.3 Approaches to tackling health inequalities

1.3.1 The five themed approaches of the Cross Cutting Review, 2002

The Cross Cutting Review, 2002 (a review involving all government departments) presented the analysis of how best to tackle health inequalities in five themed approaches.
Strengthening disadvantaged communities

The links between area-based deprivation and health inequalities are strong. Some communities experience multiple deprivation and social exclusion including a poor physical environment, poor access to health care and transport, higher rates of unemployment, poorer housing and higher crime rates. All these impact on mental and physical health, lifestyle choices, access to care and services. Tackling these requires building partnerships and community based approaches focussing on certain geographical areas (area based initiatives).

Improving the health of vulnerable groups through targeted interventions

Some groups of the population are particularly at risk of inequalities in the determinants of health and health outcomes: many have complex needs. These include the vulnerable elderly, vulnerable black and ethnic minority groups, refugees and asylum seekers and people with a disability. Ultimately these groups should be provided for within mainstream services but in the interim they might require a special focus and targeted interventions, such as outreach services.

Breaking the cycle of inequalities

Health inequalities persist through generations. The Independent Inquiry into Inequalities in Health, 1998 (The Acheson Report), emphasised that a focus on mothers and children is key to reducing future inequalities. Tackling poor education (especially early years support), unemployment and poverty are central to breaking the cycle. For example, the likelihood of being a teenage parent is strongly linked to deprivation and education. Children of teenage parents are more likely to have a low birth weight, poor educational outcomes and to be teenage parents themselves than those of older parents.

Tackling the major killers

Tackling the major killers, cancer and circulatory diseases (mainly heart disease and stroke, see glossary), will have the greatest impact on life expectancy inequalities. There are strong gender, socio-economic and ethnic differences in coronary heart disease and life expectancy. There are important inequalities in the associated risk factors, such as smoking. There is a social gradient, with step-wise reduction in life expectancy between social classes (see glossary for the classification). Thus, although the death rate is highest in social class V, most deaths occur in skilled manual groups (social class IIIM). Interventions must therefore reach not only the deprived groups, in deprived areas, but also reach skilled manual groups to have maximum impact.

Improving access to health and other public services

Those in greatest need often have the lowest levels of use and poorest access to services. There are socio-economic, ethnic and gender inequalities in access to, quality of and appropriateness of primary and secondary health care. Improving access to other public services: housing, education and social care are also important. Improving access to care requires a combination of area based initiatives, and action across a wider geographical area for example working with providers of care.

1.3.2 Tackling the underlying determinants of health inequalities

This will have the most significant impact on inequalities in the longer term and is central to all approaches. Housing for example has an important impact on life expectancy and education is an important factor in maintaining the cycle of inequalities between generations. Some communities experience deprivation of many determinants of health and require area based initiatives. However, specific interventions appropriately targeted, for example, at households not meeting decent home standards, and work with vulnerable groups are also important.

1.3.3 Complementary mechanisms relating to all themes and addressing the wider determinants of health

Complementary mechanisms are required, in differing degrees, to address most health inequalities described under the themed approaches above or to impact on the wider determinants. They provide a framework for the local implementation of policies to address health inequalities.

- **Area based initiatives**: These include community development and neighbourhood renewal and focus on communities that experience multiple deprivation and social exclusion. Innovative health or social care initiatives aimed at reaching the less affluent are also often delivered specifically to certain geographical areas.

- **Targeted action across the boroughs**: This is particularly needed to tackle coronary heart disease and smoking where there is a clear social gradient across all social classes. Risk factors for these are distributed across the boroughs, not confined to the most deprived areas alone. Health inequalities relating to specific ethnic groups who may be geographically dispersed across the boroughs, also requires action across the boroughs.

- **Improving the health of vulnerable groups, through targeted interventions**: Tailored interventions for certain groups who are at high risk of inequalities and social exclusion.
1.4 National policy context

In 1998 the Independent Inquiry into Inequalities in Health, chaired by Sir Donald Acheson presented the evidence on inequalities, summarising the scientific literature for effective action to narrow inequalities in health.\textsuperscript{3} It strongly emphasised the importance of tackling socio-material factors such as income and employment and focusing on mothers and children and highlighted the widening of inequalities in the preceding decades.

1.4.1 Key policy documents

These and their themes are outlined in Box 1B.

**BOX 1B: KEY NATIONAL POLICY DOCUMENTS (SINCE 1998)**

- *The Independent Inquiry into Inequalities in Health, 1998 (The Acheson Report).* This was a scientific review of the evidence for inequalities and effective action.\textsuperscript{3}
- *Our Healthier Nation, 1999.* This 10 year national action plan to improve the nation’s health and the health of the worst off in particular, set targets for the priority areas of cancer, coronary heart disease and stroke, accidents and mental illness.\textsuperscript{11}
- *Cross Cutting Review, 2002.* The cross government review of the evidence recommended effective action to meet the national Public Service Agreement (PSA) targets on infant mortality and life expectancy (chapter 3).\textsuperscript{4} It identified 5 themed approaches (section 1.3.1).
- *Tackling Health Inequalities: A Programme for Action, 2003.* This outlined a programme for delivery, including roles and responsibilities at national and local levels to meet national PSA targets and address the wider determinants of health in the longer term.\textsuperscript{5}
- *The NHS Plan, 2000,* The NHS Cancer Plan, and the National Service Frameworks summarise evidence-based practice and service models for different care-groups and diseases, emphasising the role of prevention and improved primary care.\textsuperscript{12,13,14,15,16,17}
- *Securing Good Health for the Whole Population, 2004 (The Wanless Report).* This recommended full engagement of communities in their health and again noted that disease prevention is the most cost-effective and efficient approach to health improvement.\textsuperscript{5}
- *Choosing Health: Making Healthier Choices Easier, 2004.* This white paper on public health emphasises prevention and life style choices. Six key priorities for delivery are: tackling health inequalities; reducing the numbers of people who smoke; tackling obesity; improving sexual health; improving mental health and well-being; and reducing harm from alcohol and encouraging sensible drinking. An implementation plan with local targets has followed.\textsuperscript{18,19}

1.4.2 National goals and Public Service Agreement (PSA) targets

The goals of national policy to tackle health inequalities and the high level Public Service Agreement targets are shown in Box 1C below.

**BOX 1C: NATIONAL GOALS AND PUBLIC SERVICE AGREEMENT (PSA) TARGETS TO TACKLE HEALTH INEQUALITIES**

There are two goals of national policy aimed at tackling health inequalities:\textsuperscript{4}

1. In the long term, up to and beyond 2010 to reduce health inequalities by tackling the wider determinants of health such as poor housing and poverty

2. To reduce inequalities in health outcomes by 2010 by 10 percent as measured by infant mortality and life expectancy at birth

Two Public Service Agreement (PSA) targets underpin the latter:

- Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between routine and manual groups and the population as a whole
- Starting with local authorities, by 2010 to reduce by at least 10 per cent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole

1.4.3 Targets and standards of relevance

The following targets and standards (given in detail in appendix 1) are relevant to reducing health inequalities. Some targets include an element that relates specifically to reducing health inequalities; meeting these targets will therefore narrow inequalities. Other targets emphasise improving health overall rather than narrowing inequalities; it will be important to ensure that differential uptake of services among the population does not lead to a widening of inequalities in health.

**National standards local action – targets for local delivery by primary care trusts (PCTs)**

This planning framework\textsuperscript{9} sets national targets for all PCTs for 2005/6 to 2007/8, some of which will assist local delivery of the two national PSA targets.
Targets for 2010 contributing to an increase in life expectancy are:

- To reduce death rates:
  - From circulatory diseases by at least 40% in people under 75, with a 40% reduction in the national inequalities between geographical areas
  - From cancer by at least 20% in people under 75, with a 6% reduction in the national inequalities between geographical areas
  - From suicide and undetermined injury (see glossary) by at least 20%
- To reduce national adult smoking rates to 21% or less; and among routine and manual groups (see glossary) from 31% (in 2002) to 26% or less
- To halt the year-on-year rise in obesity among children under 11, in the context of a broader strategy to tackle obesity in the whole population

Targets contributing to a reduction in infant mortality are:

- Decrease the proportion of pregnant women smoking at the time of delivery by 1% per year
- Increase the proportion of women who start breastfeeding by 2% per year
- Halve the under-18 conception rate nationally

PCT performance indicators 2004/05

These vary, year on year. Indicators for 2004/05 include: uptake of cervical screening and flu immunisation; the number of problem drug users in drug treatment programmes; undertaking health equity audit and reflecting actions in investment plans; and learning disability (identification in primary care and reduction in long term NHS residence). See appendix 1 for detail.

Healthcare Commission Standards

Those relating to public health and health inequalities are that healthcare organisations should:

- Promote, protect and demonstrably improve the health of the community served and narrow gaps by, making effective contributions to local partnerships
- Systematically manage disease prevention and health improvement programmes, with a focus on obesity (nutrition and physical activity), smoking, substance misuse and sexually transmitted infections
- PCTs should identify health inequalities and implement effective programmes to reduce these.

Local Government targets and performance frameworks

There are a number of “Floor targets” for local government. These set a minimum standard for improving the lives of disadvantaged groups or areas and narrowing the gap between the most deprived groups and the population as a whole. These include: reducing the number of children in low income households, improving employment rates, ensuring all social housing is in a decent condition.

There is also a new approach to comprehensive performance assessment that includes: partnership working, shared priority themes of healthier communities, older people, safer and stronger communities, sustainable communities and transport and children and young people.

1.5 The local context

1.5.1 Sutton and Merton Primary Care Trust

Sutton and Merton Primary Care Trust (SMPCT) is one of the largest PCTs in England. The Trust serves a population of around 375,000 patients registered with practices within the boundaries of the Trust. This includes around 21,000 Wandsworth residents and around 14,500 residents outside the boroughs of Wandsworth, Merton and Sutton.

SMPCT is the lead NHS organisation in assessing need, planning and securing all health services and improving health. Its main functions are:

- Improving the health of the community
- Securing the provision of services
- Integrating health and social care locally

The PCT employs approximately 1,500 staff and the local population is served by 56 general practices, 77 community pharmacies and 74 dental practices.

1.5.2 Local Strategic Partnerships (LSPs)

PCTs have the lead locally in driving forward health inequalities work with a range of partners. Tasks for PCTs include ensuring appropriate service co-ordination and engagement of the local NHS in the wider national agendas, for example, Community Safety, Regeneration and Children and Young People initiatives.

Tackling health inequalities is a key task for both the Local Authority and PCTs reflected in their respective Public Service Agreements with central government.

In Sutton and Merton, there is a local commitment by the Sutton and Merton Partnerships (as the local LSPs are known) and the associated organisations to tackle health inequalities. The constituent members of LSPs and their roles are described in box 1D.
1.6 Tackling health inequalities in Sutton and Merton: developing a platform for local action

This report describes local inequalities based upon the five themes of the Cross Cutting Review, 2002 (see section 1.3.1). Addressing the underlying determinants of health to tackle health inequalities in the long term is central to all five themes. The report is structured as follows:

- An introduction to the population of Sutton and Merton (Chapter 2)
- Addressing inequalities in infant mortality and life expectancy – the two national PSA targets (Chapter 3)
- Strengthening disadvantaged communities and tackling the wider determinants of health (Chapter 4)
- Improving the health of vulnerable groups through targeted interventions (Chapter 5)
- Breaking the cycle of inequalities - a focus on mothers and children (Chapter 6)
- Tackling the major killers - circulatory diseases, cancer and associated risk factors (Chapter 7)
- Improving access to public services - focusing on the NHS (Chapter 8)
- The way forward: recommendations for consideration by the Local Strategic Partnerships, based on the evidence of inequality, what works and opportunities for local action (Chapter 9)

1.7 The way forward

The information presented shows the breadth and complexity of health inequalities. An extensive literature emphasises the importance of agreeing recommendations and priorities with partners and involving communities in their health as the most effective and efficient way to tackle health inequalities.²,4,5

The basis of setting priorities for local action should include:

- Evidence of local inequalities, derived from local data or assumptions drawn from national data
- Evidence that the proposed action or approach is likely to be effective
- Opportunities for action based upon: national and local priorities as reflected in PSA and other targets, national or local initiatives

This report presents information on all the above and uses this information to make recommendations and suggest priorities to tackle health inequalities in Sutton and Merton. These are to be taken forward in discussion with partners.

"Inequalities in health are not acceptable. Our fundamental aim must be to create a society where more people, particularly those in disadvantaged groups or areas, are encouraged and enabled to make healthier choices. In order to close the gap, we must ensure that the most marginalised and excluded groups and areas in society see faster improvements in health."

Wanless, 2004
KEY MESSAGES

- This report is the first stage of a health equity audit and a resource for local partners to take forward action to address health inequalities.

- There is national evidence of strong inequalities related to social class, poverty, income, gender and ethnicity.³

- The causes of inequalities are multi-factorial but socio-economic factors have a major impact.⁴

- Tackling inequalities requires complementary and multiple approaches.

- Tackling the wider determinants of health is a central theme and will have the greatest impact on inequalities in the longer term.²

- Addressing inequalities in life expectancy and infant mortality is a national priority and the focus of national and local policy.²,⁹

- Sutton and Merton PCT, the local LSPs and partners are responsible for tackling health inequalities in partnership with communities.

- The following five themed chapters demonstrate evidence of stark local inequalities, describe effective interventions and recommend further local action.

- The final chapter describes the way forward for PCTs, LSPs and partners.
References


The Centre for Public Scrutiny. www.cfps.org.uk/
9.1 Introduction

This report is designed to be a resource for the Primary Care Trust (PCT) and partners to develop a programme for action to tackle local health inequalities. This chapter draws on information on local inequalities, evidence of effectiveness and opportunities for action presented in the earlier chapters to propose a way forward.

The PCT, as the strategic lead for health inequalities, should work with the Local Strategic Partnerships (LSPs) and their constituent organisations and ensure they build priorities for tackling health inequalities in Sutton and Merton into local plans. This chapter outlines:

- High level commitments to be agreed by both LSPs.
- Key recommendations, and proposed priorities for action, to be taken forward by LSPs, local authorities, the PCT and other partners.
- The way forward

High level commitments to be agreed by the LSPs

The Sutton and Merton Partnerships should commit to addressing local health inequalities and the determinants of health. Both LSPs should sign up to the principles outlined below.

**BOX 9A: PRINCIPLES FOR ACTION TO REDUCE HEALTH INEQUALITIES**

- Priorities should be agreed, and committed to, in partnership recognising that community involvement and engagement are required for sustained action.
- Actions should be based mainly on identified need and evidence of inequalities from local data: if these are not available assumptions from national data could be used.
- Action should be based on best available evidence of what works to reduce inequalities
- Actions that provide long term impact and sustainability should be progressed along with those to meet shorter-term targets.
- Health inequalities are most effectively addressed as part of mainstream delivery of national and local targets and core delivery programmes.
- Necessary resources should be identified but may be mobilised by redirecting existing resources.
- Programmes should include improved information collection and evaluation, to aid or support local understanding of need and planning of services, and monitor the impact on health inequalities.
- Opportunities for action include national policy and key targets, and building on local initiatives.

Local approaches to tackling health inequalities should include:
- Area based initiatives.
- Targeted action across the boroughs.
- Improving the health of vulnerable groups.

All approaches should balance benefit in the short term and action on the determinants of health, giving long term benefit

9.2 Recommendations

9.2.1. Area based initiatives

1. Review area based initiatives with a view to:
   - Re-focus or extend initiatives to cover areas identified as deprived by the Indices of Multiple Deprivation (IMD 2004) and indicators of childhood poverty. (Chapters 4,5,6,7,8)

   **Action:** LSPs

   - Use recommended practice of what works to review current activities. (Chapters 4,5,6,7,8)

   **Action:** LSPs

   - Target developments in primary care to areas of higher need as identified by the Index of Multiple Deprivation 2004 (IMD 2004). (Chapter 8)

   **Action:** PCT

   - Ensure that area based initiatives specifically address smoking, obesity and physical activity. (Chapter 7)

   **Action:** LSPs

2. Build on current crime prevention policy to give a specific focus to investigating and implementing actions to address crime in the Sutton North ward where one Super Output Area (SOA) is in the most deprived 1% in England for crime deprivation. (Chapter 4)

   **Action:** Safer Sutton Partnership

3. Review current mechanisms for working with local disadvantaged communities. (Chapter 4)

   **Action:** LSPs

9.2.2. Tackling the Wider Determinants of Health

4. Implement effective measures to improve local housing; this impacts on recognised inequalities in life expectancy.

   **Action:** Local authorities, through LSPs

5. Improve access to local health and other services through working with local transport providers and communities. The long term
9.2.3. Targeted action across the boroughs

6. Develop local Tobacco Control Strategies which should make all enclosed public places smoke free, introduce further local controls of advertising of tobacco products and target Stop Smoking Services at the less affluent. 
   (Chapter 7)
   Action: LSPs

7. Develop an obesity strategy that will include a commitment to prevent and treat obesity and overweight among children and adults. 
   (Chapter 7)
   Action: LSPs

8. Take action in primary care to target risk factors for the major killers including smoking, high blood pressure, obesity (nutrition and physical activity) and alcohol particularly among lower income groups. (Chapter 8)
   Action: PCT

9. Ensure that childhood obesity and smoking are addressed as an integral part of programmes aimed at improving the health and well-being of children such as Sure Start, childrens centres, the Healthy Schools Programmes and extended schools. (Chapter 6)
   Action: LSPs

10. Ensure that the effective interventions to prevent teenage conception continue after the cessation of ring fenced funding. (Chapter 6)
    Action: Local authorities

11. Ensure that pregnant women and infants at risk of poor health are offered a comprehensive package of support including high quality maternity care and, where relevant, advice on smoking, nutrition and welfare benefits. (Chapter 6)
    Action: PCT and NHS

12. Support water fluoridation, and take a lead on informing the public of the impact on inequalities in oral health. (Chapter 6)
    Action: NHS and local authorities

13. Review current initiatives to prevent childhood accidents, to ensure that they reach all children including those in lower socio-economic groups who are at greatest risk. 
    (Chapter 6)
    Action: LSPs

14. Support initiatives that enhance the ability of people to use the NHS most effectively. This should include better transport links to health facilities, improved Internet access, advocacy, support for health literacy, Expert Patient Programmes and provision of appropriate translation services. (Chapter 8)
    Action: PCT

15. Monitor the impact of practice based commissioning on health inequality and access to health care and put systems in place to minimise these. Effective innovations implemented by practice based commissioning groups should be made available to all patients in Sutton and Merton. (Chapter 8)
    Action: PCT

9.2.4 Improving the health of vulnerable groups

16. Develop a rolling annual programme of structured health needs assessment and action to reduce health inequalities including improved access to services for vulnerable groups. (Chapter 5)
    Action: LSPs.

17. Identify and address difficulties with access to primary care including registration with General Practitioners (GPs) and dentists and, where necessary, developing specific outreach primary care services. (Chapter 5)
    Action: PCT

18. Ensure comprehensive advice and support to vulnerable groups on accessing benefits. 
    (Chapter 5)
    Action: LSPs

9.2.5 Work place and employment

19. The NHS and local authorities as large local employers should actively work to improve the health of their workforce through:
   - Smoking cessation support and smoke free workplaces.
   - Encouragement of physical activity and a healthy diet.
   - The prevention and management of stress within the work place. (Chapter 7)
   Action: NHS and local authorities

20. Ensure appropriate employment opportunities for vulnerable groups. (Chapter 5)
    Action: NHS and local authorities

21. Lead local action to tackle unemployment and improve retention of employees. (Chapter 4)
    Action: NHS and local authorities

"Too often in the past we have devoted too much time and energy to analysing the problems and not enough to developing and delivering practical solutions that connect with real lives"
Choosing Health, 2004
9.2.6. Improved information, evaluation and audit

22. Establish mechanisms for improving information to describe local needs and inform planning: including sharing information sources, skills and resources, and jointly undertaking community surveys. (Chapter 4)
Action: LSPs

23. Investigate reasons underlying the high number of Merton SOAs with living environment deprivation. (Chapter 4)
Action: Merton LSP

24. Improve collection and collation of information on breastfeeding, smoking in pregnancy, childhood obesity and childhood accidents to assess local service need, evaluate services and ensure effective and targeted action. (Chapter 6)
Action: PCT

25. Collect local information on smoking (not just use of the stop smoking service) and obesity. This is essential so that services can be appropriately targeted and evaluated. (Chapter 7)
Action: PCT and NHS

26. Improve general practice recording of patient demographic information to allow monitoring of inequity in primary care. This should include ethnicity and measures of material deprivation. (Chapter 8)
Action: PCT

27. Use comparative general practice data to allow identification of, and action on inequality in care, and improve the management of chronic diseases. (Chapter 8)
Action: PCT

28. Monitor the impact of national initiatives such as practice based commissioning, Choose and Book and the new national contracts on local inequalities in care and work with primary care to address any inequality that develops. (Chapter 8)
Action: PCT

29. Ensure completion of the Health Equity Audit cycle by reviewing progress against the recommendations of this report. (Overview)
Action: LSPs and Overview and Scrutiny Committees of the local authorities

30. Undertake an annual Health Equity Audit resulting in service change. (Overview)
Action: PCT

9.2.7. Mainstream action on health inequalities

31. Include a statement in all PCT policies identifying potential impacts on health inequalities and how the policy will reduce these. (Overview)
Action: PCT

32. NHS resource allocation within the PCT should take account of need including measures of deprivation such as the IMD 2004. (Chapter 8)
Action: PCT

33. Shift mainstream services towards the populations most in need, and evaluate their effectiveness. (Overview)
Action: LSPs

34. During the planning and implementation of Better Health Care Closer to Home, the impact on inequalities in health and access to services should be systematically considered and addressed. (Chapter 8)
Action: PCT and LSPs

9.3 Proposed Priorities for Action

From among the above recommendations, the following priorities for joint action by LSPs are proposed, based on those that:
- Give the greatest potential for impact on local health inequalities
- Address health improvement and health inequalities in both the short and long term
- Use the added value of working in partnership
- Build on local opportunities

9.3.1 Priority for area based initiatives
Review area based initiatives to ensure that their focus is in line with IMD 2004 and that activity is based on what works. (See recommendation 1)

Rationale
There are local areas of multiple deprivation. Neighbourhood renewal and community development initiatives offer opportunities for addressing health inequalities in the long term and for short-term gains in health improvement through action on risk factors.

9.3.2 Priority for Tackling the Wider Determinants of health
Use this report to prioritise action on the inequalities in determinants of health, which will have the greatest impact on health inequalities. (See Chapter 4 and recommendations 4 and 5).

9.3.3 Priorities for targeted action across the boroughs
Develop and implement a tobacco control strategy. (See recommendation 6)

Rationale
Nationally smoking is the major contributor to social class health inequalities and the cycle of inequality across generations. There is wide local variation in death rates from circulatory diseases and in life expectancy.

Develop and implement a childhood obesity strategy. (See recommendation 7)

Rationale
Childhood obesity is increasing nationally and is more common in lower income households. There is strong evidence for the effectiveness of school-based programmes, and behaviours established in early life have a profound impact on adult health.
9.3.4 Priority for vulnerable groups
Develop a rolling annual programme of structured health needs assessment for vulnerable groups:
(See recommendation 16)

9.3.5 Priority for workplace and employment
Lead local action to tackle unemployment, improve retention of employees and improve workforce health. (See recommendations 19; 20; 21)

9.3.6 Priority for information and evaluation
Complete the Health Equity Audit cycle by reviewing progress against the recommendations of this report. (See recommendation 29)

9.3.7 Priority for mainstream action on health inequalities
The impact of changes in local health services, including implementation of Better Health Care Closer to Home and practice based commissioning, on inequalities in health should be systematically considered and addressed. Action should include improved primary care access, transport and advocacy services, enhancing the ability of communities to use the NHS effectively. (See recommendations 5, 14, 34)

Rationale
Planned changes in local healthcare will have a large impact on the delivery of health care into the future. Partnership working can improve access to health services through non-NHS action such as improved transport.

9.4 Moving Forward
Early findings of this report have been presented to LSPs and PCT committees and have influenced the priorities and plans below. The complete report should now inform their further development. The principles of working in partnership, involving communities and committing resources (financial and human) are central to taking this forward.

The roles and responsibilities of different partners were outlined in Chapter 1. Leads are identified in the proposed recommendations above. Key mechanisms for moving forward on action to tackle local inequalities are shown in box 9B.

As the strategic lead for health inequalities the PCT should work with the LSPs and partners, to agree the highest priorities and actions, and embed these in appropriate plans.

"With new problems coming to the fore and health inequalities persisting, the time is right for new action and fresh thinking"
Choosing Health, 2004

BOX 9B: KEY MECHANISMS TO IMPLEMENT ACTION TO TACKLE HEALTH INEQUALITIES IN SUTTON AND MERTON

Local Delivery Plans
The annual plans for delivery of the PCT agenda, including the health inequalities and other relevant targets are outlined in the Local Delivery Plans agreed with the Strategic Health Authority.

Health Improvement (HIMP) Funded Projects
Addressing health inequalities is a criterion for funding these projects. The findings of this report should guide the prioritisation for next year.

Community Plans
Both councils have developed their community plans through the LSPs. There is a high level commitment to addressing health inequalities in each. Sutton is committed to work in partnership to build area based initiatives, identify a few key priorities to address health inequalities and improve information sharing as recommended in this report. The consultation framework for the 10 year plan for Merton includes the key themes of building on area based initiatives and improving: access to health care, the health of local people, local employment and the health of local employees.

Neighbourhood renewal strategies
The Merton Neighbourhood Renewal Strategy aims to reduce inequality between the east and the west of Merton. Key health priorities include: smoking, teenage pregnancy, information sharing and consideration and implementation of the findings of this report. The Sutton Northern Wards Steering Group is developing an action plan for these wards in Sutton.

Local PSA targets and Local Area Agreements
Local PSAs are negotiated between central government and the local authority to obtain additional funding on the commitment and realisation of “stretching targets”. These will shortly be migrated into Local Area Agreements. They provide opportunities to address health inequalities priorities and release funding to tackle these.
Commissioning a Patient-Led NHS

In July 2005 Sir Nigel Crisp wrote to all Chief Executives of NHS organisations and local authorities with a paper ‘Commissioning a Patient-Led NHS’ (Attachment 1).

This provided a framework for use locally in ensuring that ‘organisations are able to operate even more effectively in the future’. The emphasis is on improving the commissioning of services alongside improvements in health and improvements in service delivery.

In October, Strategic Health Authorities, including the Strategic Health Authority for South West London, were asked to submit to the Department of Health a response to this document with a plan, including:

1. Future PCT configurations for South West London.
2. Changes to PCT provider services.
3. Roll-out of Practice Based Commissioning by December 2006.
4. Business continuity including meeting targets etc.
5. Evidence of engagement with all relevant parties.
6. Savings of at least 15% in management and administration costs.

Although the initial submission concluded that there should be consultation on two options for PCT configuration – single borough and multi borough PCTs – a subsequent submission was made to the Department of Health on 1 November stating the preferred option for the configuration of Strategic Health Authorities and PCTs for London.

This submission confirmed there was unanimity that there should be one Strategic Health Authority for London and a consensus that the needs of Londoners would currently best be met by maintaining borough-based PCTs.

There are currently only two PCTs in London that cover more than one borough – City & Hackney and Sutton & Merton. Given the relative size of the City, it is proposed that the former remains in its current configuration. As far as Sutton & Merton is concerned, further discussions are taking place with the PCT and the London Boroughs of Sutton and Merton to determine whether they wish to remain as one PCT or function as a two borough PCT. There will be public consultation on the Strategic Health Authority configuration starting in early Dec. We are also clarifying whether separate consultation is required on this PCT configuration within Sutton and Merton.

This is a starting point for significant change in the NHS, both nationally and locally. The key elements of these changes are detailed below:-

Practice Based Commissioning

GP practices will take on responsibility from the PCT for commissioning services that meet the health needs of their local population. The Department
expects 100% coverage of Practice Based Commissioning by no later than the end of 2006.

Provider Services

It is expected that PCTs will develop services outside hospital and reflect the outcome of the current consultation ‘Your Health, Your Care, Your Say’. It is expected that through co-terminosity with Local Authorities, PCTs will further develop the integration of health and social care. There is a general recommendation that there will be significant opportunities for greater flexibility of provider services in the future as there is no longer an assumption that PCTs will be the provider of services as is currently the case. PCTs will be expected to make arrangements to secure services from a range of providers rather than just through direct provision. This will bring the issue of contestability to community-based services which will help ensure that services are provided to the highest quality standards and are cost effective.

Hospital and Mental Health Procurement

PCTs are expected now to commission services from providers within a pan-London framework so that commissioning is undertaken in the most effective manner.

The proposal recommends the need for London Strategic Health Authorities to release the capital share of the savings target, specifically £42m for London, to be saved from management and administrative costs to be reinvested in local Cancer and palliative care services.

Financial Savings

The submission outlined areas that could be targeted for savings that included:

1) Governance
2) Integration with Local Authorities
3) Share support functions.
4) Pan London projects
5) Relocation of lower cost premises
6) General efficiencies

Conclusion

As stated above – these changes represent a significant change in the way NHS services are provided and commissioned. It is expected that the changes will bring about radical improvements to the lives of the population.

Angela Gibson
4 November 2005
COMMISSIONING A PATIENT-LED NHS

Date: 28 July 2005
Gateway reference number: 5312

To all:
Chief Executives of NHS organisations
Chief Executives of Local Authorities
Directors of Social Services
Primary Care Trust PEC Chairs

INTRODUCTION

This brief document builds on the *NHS Improvement Plan* and *Creating a Patient-Led NHS*. Its focus is on creating a step-change in the way services are commissioned by front-line staff, to reflect patient choices. Effective commissioning is a pre-requisite for making these choices real. It does so in the overall context of improving the health of the whole population.

This will require:

- better engagement with local clinicians in the design of services;
- faster, universal roll-out of Practice Based Commissioning;
- developing PCTs to support Practice Based Commissioning, and take on the responsibility for performance management through contracts with all providers, including those in the independent sector;
- reviewing the functions of SHAs to support commissioning and contract management.

Delivering these changes is an essential part of creating a patient-led NHS. They complement the policies of choice of provider, payment by results, and the commitment to press on with the NHS Foundation Trusts programme.

The changes will also prepare the NHS to implement improved care outside of hospital, following the White Paper on which we will be consulting throughout the autumn.

Improvements in commissioning, the determination to make progress on working with Local Authorities on *Choosing Health*, and the commitment to make £250 million of savings in overhead costs, require NHS organisations to change and develop.
These changes in function will mean that the NHS will want to reconsider the optimal configuration of PCTs, and where appropriate Care Trusts, and SHAs and their fitness for purpose. This will be done alongside the reform in the provision of ambulance services described in 'Taking Healthcare to the Patient'.

The pace of change will be for local consideration and consultation. However, the Department expects that PCTs will make arrangements for universal coverage of Practice Based Commissioning to be in place by December 2006, that PCT changes will be in place by October 2006 and that SHA changes will be complete by April 2007. Changes to PCT service provision will be complete by December 2008. Some areas may choose to go faster. However, the Department will not approve proposals for restructuring unless proposals satisfy the criteria set out in this document.

As the NHS moves from being a provider driven service to a commissioning driven service, the Department of Health will review its own commissioning and provider support functions over the next few months to ensure fitness for purpose.

The purpose of these changes is to see improvements in health and in services. Reconfiguration is not an end in itself. This process is about ensuring organisations are properly configured and fully prepared for their new role. The Government's main priorities remain the delivery of PSA targets for this year and looking forward to 2008; and effective implementation of a patient-led NHS, so that improvement becomes embedded in the fabric of the NHS.

It is very important that as we make these changes we support the people who will be affected and ensure continuity of service for the public.

SIR NIGEL CRISP
Chief Executive of the NHS

28 July 2005
THE PROGRAMME - DEVELOPING COMMISSIONING

1. This process falls into two stages:
   • the first stage is about getting the right configuration for commissioning and the right people in the right places. This will involve a review, coordinated by the SHAs and engaging PCTs, other stakeholders including local government and NHS staff;
   • the second stage is about enhancing the ability of Practices, PCTs and SHAs to do their new job.

Stage 1

2. Strategic Health Authorities will be responsible for coordinating the exercise locally, working with local people and patient groups, NHS organisations, local government, MPs and other stakeholders. They will be expected to consider Practice, PCT and SHA functions to deliver a fit for purpose health system with an effective and objective commissioning function able to deliver high quality care and value for money alongside the improvement of health promotion and protection. This may or may not involve mergers and reconfigurations. Any such changes will be subject to local consultation and assessment by the Department.

3. Proposals will be assessed against the following criteria of the PCT’s ability to:
   • secure high quality, safe services;
   • improve health and reduce inequalities;
   • improve the engagement of GPs and rollout of Practice Based Commissioning with demonstrable practice support;
   • improve public involvement;
   • improve 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.

4. As a general principle we will be looking to reconfigured PCTs to have a clear relationship with local authority social services boundaries. This does not need to mean a rigid 1:1 coterminosity – big Local Authorities might have more than one PCTs whereas a number of small Unitary Authorities might fit into one PCT.

5. Most PCTs currently provide services. As PCTs focus on promoting health and commissioning services, arrangements should be made to secure services from a range of providers – rather than just through direct provision by the PCT. This will bring a degree of contestability to community-based services, with a greater variety of service offerings and responsiveness to patient needs.
In some types of services, there may be a range of providers – for instance, in the voluntary sector – already able to deliver. In other areas, no obvious alternative providers may exist. One of the purposes of the forthcoming consultation and White Paper on health and care services outside hospital will be to consider how to develop a wider variety of local services and models of provision in response to patient needs.

6. In the proposals that they develop locally and put forward by 15 October, Strategic Health Authorities should show how:

- commissioners will be actively seeking new and innovative ways to improve new services with a range of providers;
- they have assessed what services should move away from direct PCT provision and at what pace;
- where PCTs continue to manage services, decision-making on commissioning and on provision will be separated in order to enhance contestability.

7. The White Paper will undoubtedly explore different service models. This may mean that SHAs and PCTs will want to refine these proposals on service provision. However the direction of travel is clear: PCTs will become patient-led and commissioning-led organisations with their role in provision reduced to a minimum. We would expect all changes to be completed by the end of 2008.

8. We are also looking to reconfigured SHAs to move towards alignment with Government Office boundaries where appropriate, though SHAs may make a case that that is not appropriate in their particular area. SHAs will be expected to deliver a significant reduction in management and administrative costs through their configuration proposals.

9. SHAs are asked to submit proposals at the latest by 15 October 2005 which show how they will meet the criteria detailed at paragraph 3. This will include:

- their proposals for future organisational configurations (covering PCTs, SHAs and reflecting proposed changes to Ambulance Trusts which are moving to a faster timetable);
- proposals on changes to PCT – managed service provision, recognising that some of these proposals may need to be developed further following the publication of the White Paper into the end of the year;
- a plan for the roll-out of Practice Based Commissioning;
- a business continuity plan to ensure financial balance, delivery of short term targets and no loss of momentum towards 2008 targets;
- evidence of the views and contributions of all the relevant parties they have consulted.

10. The Department will then test proposals – including those where no change to the current PCT configuration is deemed necessary. The aim is to agree with each SHA by the end of November 2005 that they may proceed to consultation – or where this is not necessary, that the plan can be implemented.
11. Statutory consultation will be undertaken locally and completed by the end of March 2006 at the latest. Whilst there is no requirement for all SHAs to undertake their consultation simultaneously and the Department would not wish to slow fast movers down to the rate of the slowest, there are practical advantages in a small number of clustered consultations, which the Department will facilitate.

12. All legal, staffing and recruitment processes will be handled locally, though the Department will seek to cluster SHAs moving at a similar pace to provide support and offer redeployment opportunities to staff. SHAs should consider the advantages of running parallel processes with other local SHAs to offer staff the maximum opportunity to find the right job. The Department will work with SHAs to ensure that human resource policies are consistently and fairly applied across the country.

13. All PCT reconfigurations should be complete by October 2006 with SHA changes completed by April 2007. Changes to PCT service provision will be complete by December 2008.

Stage 2

14. This second stage is about identifying the development support that organisations will need to be successful in future.

15. SHAs will have already reviewed the appropriate organisational design of PCTs and themselves to discharge their new roles and changes in provider responsibilities as part of the configuration exercise in stage 1. This second stage will therefore focus on internal capacity and capability to discharge new functions, and particularly leadership ability. It will be as rigorous as that for NHS Trusts applying for NHS Foundation Trust status where strengthening the composition of Boards and improving governance systems have featured strongly. It should also learn from the experience of local government as it has developed its role as a commissioner of social care services.

16. As part of this process, PCTs and SHAs across the country will undergo an independent diagnostic and benchmarking assessment, which will ensure that the resultant development programme will be appropriately targeted and consistently applied.
**ROLES AND RESPONSIBILITIES IN COMMISSIONING**

**Practice Based Commissioning**

17. The Government is committed to Practice Based Commissioning as a way of devolving power to local doctors and nurses to improve patient care. It is also a way of aligning local clinical and financial responsibilities.

18. Under Practice Based Commissioning, GP practices will take on responsibility from their PCTs for commissioning services that meet the health needs of their local population. Commissioning practices, or groups of practices will have the following main functions:

- designing improved patient pathways;
- working in partnership with PCTs to create community based services that are more convenient for patients;
- responsibility for a budget delegated from the PCT, which covers acute, community and emergency care;
- managing the budget effectively.

19. Under Practice Based Commissioning GPs will not be responsible for placing or managing contracts. That will be done by PCTs on behalf of practice groups, with back office functions including payment administered by regional/national hubs. GP Practices will also receive management support, the size of which will be dependent of the numbers of practices involved. Further details on these arrangements will be set out in October following discussion with relevant stakeholders.

20. There is a strong desire in general practice to make rapid progress in rolling out Practice Based Commissioning more rapidly. In line with this desire, and given the strategic importance of commissioning to the system reform agenda, the Department can confirm that it expects to see PCTs make arrangements for 100% coverage of Practice Based Commissioning by no later than the end of 2006. Individual practices will have the option to take on commissioning to a greater or lesser extent depending on their wishes and their capabilities.

**Primary Care Trusts**

21. PCTs will ensure access and choice to a range of high quality health services and ensure that the Government’s commitments to health, reducing health inequalities and health services are delivered for local people.

22. As custodians of their population’s health budget, they are responsible for ensuring prioritisation and value for money in ways which have maximum impact on health and secure all necessary health services.
23. Their functions, which can be provided by external agencies, partners and consortia working on their behalf, will remain as follows:

- improving the health of the community and reducing health inequalities;
- securing the provision of safe, high quality services;
- contract management on behalf of their practices and public;
- engaging with local people and other local service providers to ensure patients views are properly heard and coherent access to integrated health and social care services is provided;
- acting as provider of services only where it is not possible to have separate providers – and with arrangements for separating out decisions on commissioning from provider management;
- emergency planning.

24. As proposed in paragraph 3.20 of *Creating a Patient-led NHS*, the need for PCTs to be involved in contract negotiation will be reduced by the development of national and regional standard contracts, with the ability to tailor locally. This will allow them to focus on health improvement and securing high quality services and reduce costs.

25. PCTs will be accountable to their local communities and to the Secretary of State through Strategic Health Authorities.

**Strategic Health Authorities**

26. SHAs will focus on the following functions:

- performance managing the NHS local public health function and working closely at a regional level (with the Department’s Regional Directors of Public Health in the Government Offices of the Regions) recognising the latter’s cross-government multi-agency roles in improving population health and reducing health inequalities as well as health protection;
- ensuring successful delivery through:
  - performance management of PCTs;
  - strategic planning and the oversight of major investment and reconfigurations;
  - supporting research, innovation, education and training and ensuring its integration with service commissioning;
  - tertiary level commissioning when this cannot be undertaken by PCTs;
  - overseeing and managing the system in association with the regulators;
- ensuring robust and integrated emergency planning;
- taking their NHS Trusts to Foundation status.

27. Strategic Health Authorities will be accountable to the Secretary of State through the NHS Chief Executive.
NHS Foundation Trusts

28. NHS Foundation Trusts will have the following main functions:

- deliver service agreements with PCTs on a contractual basis, making the best use of available resources;
- work with PCTs, Practice Based Commissioning groups and clinical networks in the redesign of services to ensure that they are patient centred and integrated across the continuum of primary and secondary care;
- work with PCTs and other partners to contribute to health improvement in the local community, recognising their contribution to employment and economic development locally;
- provide a good environment for training, development and research;

29. NHS Foundation Trusts will be expected to deliver these functions through the empowerment of clinical teams and patients, by working across institutional boundaries, reaching out and providing services as close to local communities as possible. Focusing on the redesign of services to make them more patient centred, they will encourage innovation and creativity and maximise the benefit of NHS resources across the whole health community.

30. NHS Foundation Trusts are accountable to an Independent Regulator (known as Monitor) for compliance with their terms of authorisation. The terms of authorisation sets out the business of the NHS Foundation Trust. They are also accountable to local people through their governance arrangements and to PCTs for the delivery of contracted services. NHS Foundation Trusts are required to consult with Overview and Scrutiny Committees and Public and Patient Forums in the same way as other NHS organisations and are subject to inspection by the Healthcare Commission.

NHS Trusts

31. The implementation of Commissioning a Patient-led NHS for NHS Trusts is about successfully preparing them all to move towards NHS Foundation Trust status by April 2008.

32. To help NHS Trusts prepare, Monitor, the Department and the SHAs will lead a rigorous development programme to identify areas where NHS Trusts need to develop to reach the standard required for foundation status. This programme is currently being piloted in Birmingham and the Black Country and Cheshire and Merseyside SHAs. Roll-out across the country is scheduled to be completed by the end of 2006 at the latest. The existing NHS Foundation Trust community will be asked to support the roll-out process.
33. The diagnostic process covers:

- financial health and delivery track record of Trust;
- leadership and governance;
- risk assessment of local health economy covering PCTs and SHA.

34. The development interventions identified as needed as a result of this process will be coordinated by the SHA in conjunction with Monitor and the Department.

Other providers

35. Alongside this programme for NHS Trusts, there will be a progressive move towards greater use of other providers, including those from the independent sector.

Ambulance Trusts

36. The review of ambulance services published on June 30 (Taking Healthcare to the Patient) proposed to strengthening ambulance services with an associated reduction of a least 50% in the number of ambulance trusts.

37. Ambulance Trusts will also be supported in preparing themselves to move towards Foundation status.

Next Steps

38. The Department stands ready to offer advice and assistance on request through John Bacon for SHA issues, Peter Bradley for Ambulance Trusts and Duncan Selbie for all other organisations.
TIMETABLE

Commissioning Functions

- August – mid October 2005: SHAs to review their local health economy’s ability to deliver the commissioning objectives and submit plans to ensure they are achieved, including reconfiguration plans where required
- March 2006: all statutory consultation completed
- By October 2006: all reconfigurations undertaken
- October 2005: commissioning development support programme launched (2 year programme)
- March 2006: first wave of enhanced Practice Based Commissioning implemented
- December 2006: PCTs have in place arrangements for universal coverage of Practice Based Commissioning
- April 2007: SHA reconfiguration complete
- December 2008: Changes in PCT service provision complete

Trusts

- mid September 2005: Monitor and SHAs to publish diagnostic tool for NHS Trusts
- January – June 2006: SHAs conduct NHS Trust diagnostic process
- July 2006: SHAs to report back on NHS Trust review, scheduling Trusts for transition to Foundation status

Ambulance

- September - November 2005: formal consultation to elicit patient and public views
- December 2005: Ministerial decision and announcement
- from January 2006 onwards: legal (establishment orders, TUPE, transfer of assets and liabilities) and board recruitment processes begin
- April 2006: implementation begins – first trusts established in shadow form with the option of moving to statutory status from July 2006
- by March 2007: implementation complete – all Trusts in place and fully operational