To all members of the Council

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DATE: 10 July 2009 OUR REF: CF YOUR REF:

Dear Councillor

CABINET - TUESDAY, 14TH JULY, 2009

I am now able to enclose, for consideration at next Tuesday, 14th July, 2009 meeting of the Cabinet, the following appendix which was omitted from the agenda previously circulated. Please insert this after page 105.

Agenda No Item 13
Jointness Between the Council and the Primary Care Trust (Pages 1 - 12)

Appendix 1

Yours sincerely

Cherry Foreman

Democratic Services Officer

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Agenda Item 13

CHESHIRE EAST: JOINT PCT BOARD/ CABINET MEETING
MONDAY 27TH APRIL, 2009 **APPENDIX 1**

DIMENSIONS OF JOINTNESS

1.0 Introduction

1.1 This is a joint paper from the Chief Executive of Central and Eastern Cheshire Primary Care Trust (PCT) and from the Strategic Director of the People Directorate of Cheshire East Council.

1.2 In this paper we work through the various potential dimensions of jointness between them which the Council and the PCT might wish to develop.

1.3 We offer some proposals for ways in which that agenda of jointness might be taken forward.

1.4 We are looking for a steer from Board Members and Cabinet Members, and in the light of that we will then place formal recommendations before the Board and the Cabinet.

2.0 Background

2.1 Jointness between the Council and the PCT was agreed to be desirable, and on that basis it was built into the structure which Councillors agreed for the People Directorate of Cheshire East Council, particularly around the arrangements for undertaking joint commissioning.

2.2 On 13th October, 2008 a joint meeting took place between the Cabinet of Cheshire East and the Board of the PCT.

2.3 As further guidance and advice come out about the Comprehensive Area Assessment it becomes more and more clear that one dimension of the local system which will be scrutinized closely will be the extent to which the Health and Council parts of that system are working effectively with one another to deliver better outcomes for local people.

2.4 On 1st April, 2009 the Care Quality Commission (CQC) came into being. The CQC brings together the Health Commission and the Commission for Social Care Inspection. As a result, the PCT and the Council will now be inspected in a more joined up way by a single Inspectorate. That Inspectorate will certainly be looking for evidence of jointness in terms of performance.

2.5 For all of these reasons, and others, it is imperative that the jointness agenda should be taken forward now with vigour. A great deal of discussion has taken place about jointness. Now is the time to consider some specific proposals for action and to agree a realistic timetable on which that action will be implemented.

3.0 Mapping the Dimensions

3.1 There are a number of different dimensions along which jointness might be pursued.

3.2 It is helpful to have a framework in order to map out those dimensions and to work systematically through them.

3.3 We suggest the following framework:

- Strategy
- Structure
- Staffing
- Skills
- Sites
- Systems
- Style

3.4 In this paper we shall go through that framework, making specific proposals in relation to each one in turn.

4.0 Strategy

4.1 First of all, it would seem helpful to have an agreed strategy about jointness. Such a strategy would need to answer several questions:

4.1.1 What is our shared Vision in terms of the jointness which we have agreed that we want to achieve?

4.1.2 What is our rationale for that Vision?

4.1.3 How long are we planning to take to implement that Vision?

4.2 No doubt we will want to set out our rationale to extent in terms of the outcomes experienced by those who have contact with us and who use our services. Those outcomes for service users and carers might be:

4.2.1 That when they access services they have a simple and smooth experience, rather than being passed backwards and forwards from one organisation to another.

4.2.2 That they experience those services as coherent and joined up, rather than fragmentary.

4.2.3 That information about them is responsibly and safety shared between the organisations, so that they are not serially asked the same questions again and again.

4.2.4 That they receive consistent advice from the organisations.

4.3 There are likely to be organisational outcomes which will be part of that rationale too, around improving the organisations' understanding of needs, their best use of the resources available and their performance in line with local and national priorities and targets.

4.4 There would be a number of uses of such a strategy, particularly in terms of communication with the general public, with service users and carers, with partners and with staff.

4.5 We propose:

4.5.1 That in the light of the discussions prompted by this paper and this joint meeting, the PCT Chief Executive and the Strategic Director be asked to develop a draft strategy on jointness to be considered by the PCT Board and the Cabinet of the Council.

4.6 Sitting behind such an overarching strategy, there will be a number of specific strategies, setting out, for areas of service where our interests and our activity overlap significantly, what we are seeking to achieve jointly. Those, for the most part, will be Joint Commissioning Strategies.

4.7 There are different starting points and different circumstances in each of the main service areas, so a uniform approach would be unrealistic. The Children Plan, for instance, ought to constitute the commissioning strategy for services for children and families, not just jointly, but across the whole system. In the area of services for Adults with Learning Disabilities there has been a Pooled Budget for some time, and the Council has exercised the Lead Commissioner role.

4.8 We ought to agree those areas of activity in which it seems likely to be beneficial to develop and agree Joint Commissioning Strategies, and then agree a timetable for their delivery. Several areas suggest themselves for attention:

4.8.1 Continuing Health Care Needs and the resources which transfer from the PCT to the Council under Section 28A have long been a source of tension. The possibility exists of redefining those resources, so that they are "ours", rather than "mine" and "yours", and then reaching agreement about the problems which they might be spent to address.

4.8.2 We are both challenged to implement the National Dementia Strategy, and Dementia in old age is likely to be one of the biggest problems to be tackled in Cheshire East. The Council has the legacy of a number of Community Support Centres (CHCs) which are no longer fit for purpose, and there are therefore decommissioning and re-commissioning possibilities which should be examined jointly.

4.8.3 In the light of the work being done to Redesign Adult Social Care it would be opportune jointly to revisit our strategies and approach to services for those with mental health problems.

4.9 We propose:

4.9.1 That the PCT Director of Commissioning and the Council's Heads of Services for Adults and for Children and Families to be asked to agree those service areas in which Joint Commissioning Strategies should be developed.

4.9.2 That they should then agree a programme and timetable for the delivery of those draft Joint Commissioning Strategies, so that they can be taken through the governance systems of the two organisations.

4.10 It does seem likely that new governance arrangements will be needed in order more effectively to handle much greater jointness between the PCT and the Council. The Pooled Budget for Learning Disability Service has already been mentioned. In total, that amounts to approximately £66m (pan-Cheshire/PCT outturn figure for 2008/9). Joint Commissioning Strategies in other service areas may lead to the pooling or to the aligning of budgets. In both cases it would make sense to introduce a joint structure of governance. That would also be necessary if NHS Community Services and Council Social Care Services were to be integrated in some way.

4.11 This is far from new territory. Several systems around the country have come up with ways of doing this. One approach is for:

4.11.1 The PCT Board and the Council Cabinet to agree which resources are to be jointly commissioned.

4.11.2 The Board and the Cabinet to identify a small number each of Directors/ Cabinet members, and to agree to give them delegated authority over those resources.

4.11.3 Those Directors and Cabinet Members to form a Joint Commissioning Board which would make decisions about the use of those resources and report at intervals to the parent bodies.

4.12 We propose:

4.12.1 That the PCT Chief Executive and the Council's Strategic Director be asked to work up some more detailed recommendations for the establishment by the PCT and the Council of a Joint Commissioning Board.

4.13 It is also likely to be necessary for us to develop Joint Strategies in particular areas of activity and engagement where our interests overlap and where we are both working with the same partners and stakeholders.

4.14 One such area is the Third Sector. We both fund and support Third Sector organisations. We both involve Third Sector organisations in consultation and participation exercises. We both have an interest in developing the contribution which is made by Third Sector organisations.

4.15 We propose:

4.15.1 That appropriate managers from the PCT and the Council be asked to work together on the production of a Joint Strategy in relation to Cheshire East's Third Sector.

5.0 Structure

5.1 The overarching structure within which both the NHS and the Council sit is, of course, that of the Local Strategic Partnership (LSP).

5.2 Cheshire East Council's LSP has now begun to meet and to consider the sub-structure which will be needed to inform and support its work.

5.3 That sub-structure is likely to consist of a number of Thematic Groups. Some of those Thematic Groups are already in existence, for we are required by statutes and regulations to have them in place. An obvious example is Cheshire East's Children's Trust.

5.4 Other Thematic Groups will need to be set up afresh, albeit that they will build upon good work already done. The LSP is likely to want to have a Health and Wellbeing Thematic Group which it can commission to progress collaborative work on that front.

5.5 The core of the work of the LSP's Health and Wellbeing Thematic Group will be the relevant targets in the Local Area Agreement. However, there will be other work for that Thematic Group to do. For example, it will need to work out how it is going to relate to and connect with the Local Area Partnerships. Although the joint Strategic Needs Assessment (JSNA) will be commissioned by the LSP, its Health and Wellbeing Thematic Group is likely to be the engine which will drive the development of the JSNA.

5.6 We propose:

5.6.1 That the PCT Chief Executive and the Council's Strategic Director (People) be asked to draw up recommendations for a remit and Terms of Reference for a Health and Wellbeing Thematic Group.

5.6.2 That they be asked to present those recommendations to the LSP.

6.0 Staffing

6.1 The commonest manifestation of jointness between PCTs and Councils is the joint appointment by the two organisations of a Director Public Health (DPH). That arrangement is now in place for a majority of PCTs and Councils.

6.2 Within Cheshire East we do not start with a blank sheet of paper. The PCT already has a Director of Public Health, whom it appointed.

6.3 However, it would still be possible for the PCT, the Council and the DPH to reach agreement on the ways in which they wanted to see their jointness expressed through the Public Health contribution. It would be appropriate, for instance, formally to designate the DPH as the advisor to the Council's Health Scrutiny Committee. And the Director of Public Health and her colleagues will have a lot to contribute to the Council's own strategy for its interventions to improve the health of the local population.

6.4 We propose:

6.4.1 That the Director of Public Health and the Head of Health and Wellbeing Services be asked to draw up a draft agreement setting out the ways in which Public Health will interface with the Council.

6.5 The PCT has its full complement of managers and, in order to ensure the safe continuity of services, the Council has had to populate its structure with managers. That reality, however, does not limit our scope to make joint arrangements where that seems likely to generate better outcomes. It is not necessary for individuals to be jointly appointed, as long as they are jointly deployed.

6.6 A great deal of the jointness which we are seeking can be realised through agreements about ways of working. That is particularly relevant in the area of Joint Commissioning. For example, in order to deliver our Joint Commissioning outcomes and particularly to make a reality of the Think Family ambition, we shall want the PCT Director of Commissioning, the Head of Adult Social Care and the Head of Services for Children and Families to work together closely, not on an occasional basis but routinely.

6.7 We propose:

6.7.1 That the Director of Commissioning, the Head of Adult Services and the Head of Services for Children and Families be asked, as they work on Joint Commissioning (see 4.9.1 and 4.9.2 above), to identify the need for joint staffing arrangements, including both joint appointments and secondments.

6.7.2 That they should also develop recommendations for the PCT Chief Executive and the Strategic Director about the pattern of collaborative working between the three of them which should be implemented.

6.8 One profound way in which staff might be brought together would be through the integration of service provision.

6.9 Cheshire East Community Health, the "arms length" provider part of the PCT, is currently consulting with its staff about future organisational options. A series of consultation meetings with those staff has taken place during March and April, 2009. Four options have been presented:

6.9.1 The status quo – remaining as part of the PCT, but at arms length and with separate governance arrangements.

6.9.2 Becoming a Community Foundation Trust.

6.9.3 Becoming a Social Enterprise Company.

6.9.4 Integrating vertically with an existing NHS Trust or horizontally with the Council's Social Care Service Provision.

6.10 The Board of the PCT is anticipating reaching conclusions about this by October, 2009. Clearly, it will be important that dialogue is maintained between the PCT and the Council during the process of deliberations leading to a final decision.

7.0 Skills

7.1 There are plentiful opportunities for adopting joint approaches to the training and development of our staff groups.

7.2 At the simplest level we ought to be sharing our Training Plans with one another, and exploring the scope for doing some of that work together. For example in the NHS and in the Council we shall be training our staff in Customer Care, and it seems highly unlikely that we would be taking radically different positions on that practice area.

7.3 Training, of course, is a means not an end in itself. The outcome sought is a changed organisation. It would seem appropriate that we should share with one another our Organisational Development strategies, to see how they might fruitfully be harmonized. A number of specific measures might be taken in order to promote that harmonisation:

7.3.1 Agreement of common competencies in specific areas of work.

7.3.2 Arrangements to enable staff from one organisation to learn more about the other by shadowing relevant colleagues.

7.3.3 A practice of encouraging the secondment of staff between the organisations.

7.4 A particular possibility is the development of a Leadership Academy across, and perhaps eventually beyond, the NHS and the Council:

7.4.1 Such an Academy would have the task of developing the leadership skills of those managing the organisations.

7.4.2 A Leadership Academy might be organised just with Cheshire East Council or it might be more effective and efficient to base it upon a sub-regional footprint.

7.4.3 It could embrace a whole continuum of leadership development opportunities, all the way from individual learning packages through to an accredited MBA programme.

7.5 We propose:

7.5.1 That the Council's Head of Human Resources and Organisational Development and the relevant manager in the PCT be asked to share Training Plans and Organisational Development strategies with a view to identifying the potential for greater jointness in those areas.

7.5.2 That they be asked to asked to explore and report upon the scope for developing a Leadership Academy.

8.0 Sites

8.1 Between us we have a lot of land and a great many buildings.

8.2 We have plenty of experience from which we have learned that jointness can be enormously enhanced by the co-location of staff.

8.3 We also have particular plans which require that we work jointly in relation to plant and accommodation – for example, the ambition to have a single point of access into service for children and families.

8.4 It therefore makes sense for us to not only to review our Asset Strategies together, but also to ensure that we maintain continuing dialogue on that front.

8.5 We propose:

8.5.1 That the Council's Head of Assets and the PCT manager responsible for Estates be asked to identify how a joint approach can be developed to the management of land and buildings.

9.0 Systems

9.1 Common sense would suggest that there must be big opportunities for developing greater jointness between the Council and the NHS Community in Cheshire East in terms of systems.

9.2 In practice, of course, there are constraints. Local Authorities have generally been free to commission the systems which they believe will meet their needs. The NHS, as a National organisation, has commissioned many systems on a National or a Regional basis, giving less freedom to local NHS units. All of the organisations will have invested in the purchase and development of systems, and it is difficult to turn around those programmes within a short time.

9.3 In that context it seems appropriate to focus attention upon concrete possibilities. One of the great advantages which we have is that both the PCT and the Social Care parts of the Council are users of PARIS, albeit of course that they use different modules of that product.

9.4 A number of possibilities arise from greater jointness in developing the implementation of PARIS:-

9.4.1 Linkages could be established between the modules being used by the PCT and by the Council. Such linkages would make it possible for a District Nurse to commission Social Care input to a case which she was managing through the Care Planning

Module. Similarly, it would become possible for a Social Worker to schedule a visit by a Health Visitor, using the Child Health module. It must be remembered that those who use our services want them to "wrap around" their needs in a seamless way. They have much less interest in who actually provides or pays for the services. Already, within our Community Mental Health Teams we have NHS staff commissioning Local Authority services and Local Authority staff commissioning NHS services.

9.4.2 Linkages between Care Notes would allow the staff of the different organisations either to view or to contribute to one another's Case Notes, or both, where they had service users in common. Older People, for example, in the course of their care career will pass through a number of different services – General Practice, in-patient hospital treatment, Occupational Therapy, District Nursing, reablement, Home Care, and so on. Their interests are best served if those services have and share a full and rounded understanding of their needs, interests and experiences.

9.4.3 Linkages could be developed to enable much better sharing of data when referrals are made to the different organisations. At the simplest level, it would be useful to know, when a referral was received, whether that individual was known to other organisations and what sort of services they were receiving from them. There would be scope to use the individual's NHS number to generate reports showing the distribution of needs around Cheshire East, and data of that sort could contribute positively to our shared responsibility for developing our Joint Strategic Needs Assessment.

9.5 PARIS is not the only common system between the Council and the NHS community in Cheshire East. Over the years the Social Care Services, the PCTs, the Partnership Trust, the Acute Hospitals and several other organisations have been developing the Single Assessment Process (SAP), a system designed to enable different agencies to contribute to building up a comprehensive assessment of an individual's needs. It would seem timely, in the context of a commitment to greater jointness, to review SAP and particularly to look at how it can and should connect with PARIS.

9.6 There are also opportunities for greater jointness in terms of ICT Infrastructure:-

9.6.1 The Council is fortunate in inheriting an impressive Wide Area Network from the former County Council. There must be scope to build on that to develop a shared digital communications infrastructure across the public sector in Cheshire East.

9.6.2 The Council is currently thinking about the Data Centre services which it will need. It would make sense to do that thinking jointly with the PCT.

9.6.3 In our multi-disciplinary teams we have for some time struggled with incompatibility of hardware and support. NHS and Council staff working alongside one another have had to have two different machines on their desks. Given our commitment to

greater jointness at operational team level we ought to be working to harmonize both the hardware and the support. That goes for more than just computers. The recent experience in Cheshire East of bringing together different telephone systems shows just how wasteful that diversity can be.

9.7 We make two specific proposals:-

9.7.1 That appropriate officers should be commissioned to map out in more detail the opportunities available from a more joint approach to implementing PARIS and, on the basis of that, to put forward on a costed Action Plan.

9.7.2 That a joint working group be set up to explore in more detail the options for greater sharing of ICT infrastructure.

10.0 Style

10.1 The dimension of style embraces the cultures which we aspire to develop and sustain within our organisations and the working practices which we might agree to harmonize.

10.2 Both the PCT and the Council have committed themselves to localism – being locally present, visible, accessible and engaged. The PCT has for some time been planning and operating on a town based model. The Council has recently agreed the development of seven Local Area Partnerships (LAPs).

10.3 One working practice which we might jointly agree to introduce as an expression of that commitment is that of the Case Committee:

10.3.1 The idea of the Case Committee is that, on a locality basis, we put in place a regular arrangement which would bring together NHS and Council officers (and others, as appropriate) to focus joint attention upon the Top Twenty cases causing local concern (twenty is an arbitrary figure – the actual methodology would need to be agreed on the ground, in the context of the resources available).

10.3.2 In every locality there is a relatively small number of cases which consume a very significant amount of resources. One objective would obviously be to take stock of the resources being allocated from various organisations, to establish whether those inputs are effectively coordinated and to explore whether they might be used differently to achieve better outcomes.

10.3.3 Arrangements of this sort are by no means novel. They tend to feature prominently in Recovery Plans, when organisations are having to scrutinize their most expensive cases. Our proposal is that this working practice should be introduced as a deliberate strategy, not as a crisis response, and that it should be built into the design of the arrangements which we are seeking to develop locally.

10.3.4 The Case Committee approach has the potential to enable more effective prevention on a joint basis. For example, both organisations know well how to spot the signs of deterioration in Older People, which often mark the beginning of a period of very heavy use of NHS and Social Care Services. Case Committees

might be used to focusing more attention upon addressing those patterns of deterioration.

10.3.5 Case Committees would also be positive in promoting the development of locality commissioning on a joint basis. After all, the essential business of a Case Committee would be commissioning – looking at how money is currently being spent, asking what outcomes are being achieved from that expenditure, and exploring ways of getting better results by spending the money differently. The lessons from that practice would also be used to develop the design of local services.

10.4 We propose:

10.4.1 That the PCT Director of Commissioning and the Council's Head of Services for Adults be asked to work up proposals for the establishment of Case Committees, as a component of the Local Area Partnership structure.

10.5 A simple definition of Style is "the way we do things around here". One of the things we do is to set and manage budgets.

10.6 We have our own ways of putting together budgets and Recovery Plans, but there do seem to be some common features:

10.6.1 When the financial context becomes known, a lot of work is done within the organisation to develop options.

10.6.2 Those options are then debated and developed – again, within the organisation.

10.6.3 At a relatively late stage in the process – often when there is small room for change – a consultation exercise will take place,

10.6.4 Only towards the end of the process, during the consultation phase, is information shared with partners.

10.7 It is clear that that approach will have to change. Substantial parts of the funding which used to be fully in the hands of our organisations will in future be in the term of Area Based Grants (ABGs). As a consequence we shall no longer be in a position to decide upon their utilisation ourselves. We shall be obliged to share that decision making with others, through the Local Strategic Partnerships. That will require us to develop budget setting processes which are more transparent and more inclusive.

10.8 If we are really committed to pursuing greater jointness, we ought to be developing a Budget setting process and practice which involves a genuine sharing of constraints, opportunities, thinking and options at a much earlier, formative stage. Obviously, there are risks associated with that, but if our commitment to jointness does not take us out of the comfort zone of current ways of working, it does not amount to much.

10.9 We therefore propose:

10.9.1 That as the Council's Borough Treasurer works up proposals for a Budget setting process for 2010/11 and beyond, she involves in that work the PCT Director of Finance.

10.9.2 That the Borough Treasurer and the Director of Finance be asked to develop joint proposals for a more open and collaborative process between the organisations.

10.10 The sub-system which consists of the Council and the NHS Community in Cheshire East is both big and complex. The LSP exists to address the rebalancing of the whole system, but there is still a substantial challenge when it comes to gaining and maintaining an effective strategic oversight of the NHS and Council sub-system.

10.11 We believe that it would be advantageous to bring the leaders of that sub-system together at intervals to take that strategic oversight, to focus on areas where greater jointness may deliver better results, and to frame advice on that for the LSP.

10.12 We propose:

10.12.1 That the Council Chief Executive be asked to set up a quarterly meeting of herself with the Chief Executives of the Primary Care Trust and the NHS provider bodies in Cheshire East.

10.12.2 That at six monthly intervals those meetings should be joined by the Leader of the Council and appropriate Portfolio Holders, and by the Chairpersons of the NHS Boards.

11.0 Conclusions

11.1 We already do a lot together. The challenge before us now, with the creation of a new Unitary Council, is to take that jointness onto a new level.

11.2 This paper contains a number of proposals, but we are not advocating a multiplicity of little projects. Our proposals express a vision of a virtual public sector in Cheshire East, at the heart of which would be a profoundly joined up Council and PCT.

12.0 Next Steps

12.1 We are looking for a steer from the Board and the Cabinet.

12.2 Around those proposals which find favour we will commission the work from the appropriate colleagues, pull that together into a coherent Action Plan, and put forward formal recommendations for decision making in the appropriate arenas.

Mike Pyrah
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Central and Eastern Cheshire Primary Care Trust

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Cheshire East Council

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