

ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM AGENDA



Tuesday 28th February 2006

at 10.00 am

in Committee Room B

**MEMBERS: ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY
FORUM:**

Councillors Barker, Cambridge, Clouth, Cook, Griffin, Kennedy, Lauderdale, Lilley,
Sutheran, M Waller and Worthy

Resident Representatives:

Mary Green and Evelyn Leck

- 1. APOLOGIES FOR ABSENCE**
- 2. TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**
- 3. MINUTES**
 - 3.1 To confirm the minutes of the meeting held on 31st January 2006 (*attached*)
 - 3.2 To confirm the minutes of the meeting held on 14th February 2006 (*to follow*)
- 4. RESPONSES FROM THE COUNCIL, THE EXECUTIVE OR COMMITTEES OF THE
COUNCIL TO FINAL REPORTS OF THIS FORUM**

No items
- 5. CONSIDERATION OF REQUEST FOR SCRUTINY REVIEWS REFERRED VIA
SCRUTINY CO-ORDINATING COMMITTEE**

No items

6. CONSIDERATION OF PROGRESS REPORTS / BUDGET AND POLICY FRAMEWORK DOCUMENTS

No items

7. ITEMS FOR DISCUSSION

- 7.1 Consultation on new Primary Care Trust Arrangements in Tees Valley –
Scrutiny Support Officer
- 7.2 Scrutiny Investigation into Access to GP Services
 - (a) Our health, our care, our say'- White Paper –*Scrutiny Support Officer*
 - (b) Verbal Evidence to be from Hartlepool PCT
- 7.3 Health Scrutiny Support Programme – Building Links with Hartlepool PPI –
Scrutiny Support Officer
- 7.4 Tees Valley Joint Health Scrutiny Committee – Update Report – *Scrutiny Support Officer*
- 7.5 Suggested Additional Scrutiny Work Programme Item – Adult Learning – *Scrutiny Support Officer*

8. ANY OTHER ITEMS WHICH THE CHAIRMAN CONSIDERS ARE URGENT

ITEMS FOR INFORMATION

- i) **Date of Next Meeting Tuesday 28th March 2006, commencing at 10.00am in Committee Room B**

ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM

MINUTES

31st January, 2006

Present:

Councillor: Harry Clouth (In the Chair)

Councillors: Griffin, Kennedy, Lauderdale, Lilley, Sutheran,
M Waller and Worthy.

Resident Representatives: Mary Green and Evelyn Leck

Officers: Sajda Banaras, Scrutiny Support Officer
Pat Watson, Democratic Services Officer

Also Present: Louise Linighan, Hartlepool Access Group
Linda Pepper, Health Scrutiny Support Manager
Christine Remmer, Hartlepool Access Group
Ali Wilson, Director of Primary Care Development and
Modernisation, PCT

46. Apologies for Absence

Apologies for absences were submitted from Councillors Barker, Cambridge and Cook.

47. Declarations of interest by members

There were no declarations of interest.

48. Minutes

The minutes of the meeting held on 13th December, 2005 were confirmed (with the addition of Councillor Kennedy in the apologies received).

Matters arising – The Scrutiny Support Officer sought clarification from the Forum in relation to what information was required from TENYAS and when they should be asked to report back to the forum. Bearing in mind the proposal to reconfigure Ambulance Trusts, the Forum agreed that the relevant time would be once the reconfiguration is complete.

49. Access to GP Services – Primary Care Perspective - (Hartlepool Primary Care Trust)

As part of the ongoing investigation into Access to GP Services, the Director of Primary Care Development and Modernisation, Ali Wilson, presented a detailed report on this subject from the Primary Care perspective. The report covered the main areas which the PCT had been asked to address and detailed information was provided under each of the following headings:

- Details of the number of GPs and their geographical distribution; Indicating the Practice, the address (and other branch addresses), the Practice Population and Opening Times;
- Transportation;
- Waiting Times
- Out of Hours arrangements;
- Additional Services available to patients;
- Minor Ailments arrangements;
- Greatham and Wynyard Road Nurse Practitioner Clinics;
- Monitoring the quality of service;
- The New Contract Quality and Outcomes Framework;
- PALS Service;
- Complaints;
- Practice Patient Groups.

Following presentation of the report the following issues /questions arose:

- Relocation of the Omar and Thacker Practice to the Headland – A Member advised that the withdrawal of the No. 5 bus service was causing difficulty to a number of patients, around 500 of whom are elderly. In addition, patients now have to attend the surgery to get repeat prescriptions – they cannot be ordered over the telephone. A Member of the Neighbourhood Services Scrutiny Forum advised of the ongoing investigation they were undertaking relating to bus services and asked if the No. 5 service could be examined alongside. Ali Wilson indicated that she would check both issues and the Scrutiny Support Officer noted the issue to be passed to N S Scrutiny Forum;
- A Member expressed concern at the extra work for GPs as a result of the new White Paper. He asked if the transition would be seamless or would there be gaps. Ali Wilson agreed there could be problem area as no mention had been made of additional funding. She said “PCT funding has to be used to cover national requirements and it does not leave much. For example, if a GP wanted to open on a Saturday morning, the PCT would have to consider the business plan there is some flexibility but it’s about priorities tough choices have to be made. ... we have to get the message across to the public to use the Primary Care services that are available”;
- After Hours Care – Some Members had concerns about “after-hours” care. Ali mentioned 3 additional services, (1) Rapid Response Team (nurses) now available until midnight, reported to be an excellent

service, (2) Community Matrons for Chronic Disease work extra hours, and (3) Emergency Care Practitioners who can treat people at home. These services had been in place for 6 months.

- Practices using triage system – A Resident Representative questioned the system at her local surgery and she questioned what she felt was the inappropriate use of receptionists in this role. Ali replied that staff undertaking such tasks have to be trained and if the patient was not happy then she should take it up with the practice and if necessary complain.
- A Member asked if the Government was being lobbied for more funding because of the special needs of the Town, thyroid and cancer problems and young deaths. Ali replied that lobbying was being undertaken, funding was within the necessary band but she felt it should be higher. She indicated that actually heart disease and strokes are the highest problem areas in the town.
- Treatment at pharmacies for minor ailments – This issue was discussed and Ali advised that there are 35 to 40 different treatments for minor ailments that can be prescribed for at some pharmacies. A list of the pharmacies that can prescribe was requested.. Ali indicated that records show the system had worked and should continue to help take off some pressure.
- Services provided at Practices – A Member asked for a list. Ali advised that the information was in practice leaflets but she would provide the information.
- Representatives from Hartlepool Access Group spoke on adaptations to premises and asked how these could be undertaken without an audit being carried out first. Ali advised that the PPI do the audit – a DDA audit had been carried out in 2004/04 and recommendations made to practices. Under the relevant Act practices can comply if they can provide the service, ie a home visit, but the PCT would like to see the physical structure of all buildings complying. Ali advised the up-to-date position with regard to the portacabin at ORCEL.
- Supply and demand of Medical staff was discussed. Ali agreed there was a GP shortage and some practices employ semi-retired and/or young salaried GPs, and technicians / nursing staff (for some areas of treatment. If there is a problem area the PCT would ask if they can assist.
- In reply about concerns expressed re one practice, Ali indicated that GPs are monitored in a number of ways, ie monthly checks by the PCT, anonymous checks and through the Service Improvement Facilitator (PCT follow up any issues raised). If anyone wishes to raise areas of complaint then specific issues and any evidence should be supplied to the PCT.
- With regard to the achievements of practices during 2005/06, a Member commented that the averages indicate there is no room for complacency and asked how the funding implications would affect practices. Ali advised that practices get paid for the points they achieve. The PCT manages the money and practices are allocated to match performance. New figures are expected in April this year.
- Members asked for the funding issues in relation to the new White

Paper be discussed further at a future meeting.

The Scrutiny Support Officer advised that the investigation would continue at the next meeting to be held on 28th February at 10am.

HARRY CLOUTH

CHAIRMAN

ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM

MINUTES

14th February 2006

Present:

Councillor: Harry Clouth (In the Chair)

Councillors: Sheila Griffin, Geoff Lilley, Lilian Sutheran and Gladys Worthy

Officers: Paul Walker, Chief Executive
Andrew Atkin, Assistant Chief Executive
Adrienne Simcock, Director of Children's Services
Nicola Bailey, Director of Adult and Community Services
Ralph Harrison, Head of Public Protection and Housing
Charlotte Burnham, Scrutiny Manager
Sajda Banaras, Scrutiny Support Officer
Angela Hunter, Principal Democratic Services Officer

Also Present: The Mayor, Stuart Drummond

Councillors: Marjorie James, Victor Tumilty, Ray Waller and
Gerald Wistow

David Flory, Chief Executive, Strategic Health Authority
Rachel Chapman, Director of Communications, Strategic Health
Authority
Ali Wilson, Director of Primary Care & Modernisation, Primary
Care Trust

50. Apologies for Absence

Apologies for absence were received from Councillors Rob Cook and John
Lauderdale.

51. Declarations of interest by Members

None.

52. **Consultation on the Reconfiguration of Primary Care Trust (PCT) Arrangements in Hartlepool – Ensuring a Patient-Led NHS** (*Chief Executive, Strategic Health Authority*)

The Chief Executive of the Strategic Health Authority (SHA) gave a detailed and comprehensive presentation on the proposals to change the structure of some local health organisations. He indicated that the future of the NHS depended on securing the right quality and pattern of services which involved taking a larger view on how to provide hospital services to the highest quality in a viable way across the Tees Valley. Consultation had been undertaken across the north east on the following two options:

- Two new PCTs – one for County Durham and Darlington and one for Teesside
- Six PCTs – a new PCT for County Durham, and five PCTs covering Darlington, Hartlepool, Stockton on Tees, Middlesbrough and Redcar and Cleveland.

The national criteria for new PCTs was detailed in the presentation and included securing high quality, safe services with the improvement of engagement of GPs and rolling out commissioning by GP practices. The Chief Executive of the SHA indicated that there were advantages with both options proposed although the level of savings was reduced with the first option.

The Chief Executive of the SHA reported that there were inexplicable variations in services offered at hospitals and inequalities in access to care. Commissioning would be an important part of improving the service with the aim of providing a consistent high quality of services. The management of finances needed to be improved, possibly by devolving/delegating more budgetary control to GPs. The Chief Executive of the SHA added that local hospitals and PCTs had an over commitment of expenditure and were providing services on borrowed money, which must be repaid. It was suggested that a reduction in management and administration may lead to more investment in direct service provision.

A discussion followed where the following points were raised:

Boundaries of PCTs – It was felt by Members and Hartlepool residents that the boundaries of PCTs should be co-terminus with those of the local authority areas.

Would Hartlepool be guaranteed its fair share of funding? – The Chief Executive of the PCT indicated that resources would be allocated on the same formula basis as currently used. He gave an assurance that there would be no dilution/distraction of effort in developing services for Hartlepool and that although he could not guarantee the amount that would be allocated to Hartlepool, he reassured Members that it would be allocated on a fair share

basis.

What happens to the debt from the PCT? – The Chief Executive reported that any debt would be passed onto the new successful body to ensure repayment was undertaken and that ways of reducing this debt were still being developed.

Concern was expressed that local initiatives may lose out, for example the Connected Care initiative in Owton Ward? – The Chief Executive reassured Members that if a service or initiative was running successfully, it was unlikely that this would be changed.

Was it proposed to have a single management team? – The Chief Executive indicated that the current consultation covered the statutory boundaries of PCTs not the management arrangements. Further work needed to be undertaken on an integrated level of working.

Who makes the final decision and what is the SHA's preferred option? – It was indicated that the Secretary of State would make the final decision on the reconfiguration of PCTs based on the consultation carried out by the SHA. Initially the SHA's preferred the option had been to have bigger PCTs, but as the consultation had been undertaken they were currently unsure which option was preferable.

It was reported that across the Tees Valley area, local authorities and partners had indicated their support for co-terminus PCTs with management boards for each area. Members agreed with this position and felt that there was a strong message from all Hartlepool residents and colleagues across the Tees Valley area that this was the preferred option.

Decision

Members noted the presentation and discussion which would inform Members recommendations after the next item.

53. Consultation on the Reconfiguration of Primary Care Trust Arrangements in Hartlepool – 'Links to Our Health, Our Care, Our Say', White Paper on Future of Health and Social Care *(Director of Adult and Community Services)*

The Director of Adult and Community Services reported that the above White Paper was launched at the end of January and provided a new direction for community services including social care and health services being embedded within local communities. The main issues being:

- Sustained realignment of whole health and social care system
- Local joint decision making
- Practice based commissioning – GPs and community based professionals

making key decisions

- New partnerships between Local Authorities (LAs) and PCTs.

The White Paper was very clear with the key point being a greater co-terminosity between PCTs and LAs and the increased co-ordination of Director of Adult and Community Services and the Director of Public Health roles. As Members were aware, Hartlepool already had a joint appointment with the PCT of a Director of Public Health. The Director of Adult and Community Services outlined the commissioning and governance arrangements contained in the White Paper which included the duty of co-operation through Local Strategic Partnerships and the development of Local Area Agreements for meeting local needs and priorities.

During discussions Members agreed that the options given in the consultation did not appear valid for Hartlepool residents and that the consultation had not been undertaken correctly. As this issue was to be discussed further at the Council meeting later this week, Members agreed to defer the finalisation of their response to the consultation until the Forum's next meeting on the 28th February. A response would then be submitted to the NHS via the Tees Valley Joint Health Scrutiny Committee to be considered at its meeting on the 22nd March.

Decision

That recommendations be deferred until the next meeting of this Forum on 28th February 2006.

HARRY CLOUTH

CHAIRMAN

ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM REPORT

28th February 2006



Report of: SCRUTINY SUPPORT OFFICER

Subject: CONSULTATION ON NEW PRIMARY CARE
TRUST ARRANGEMENTS IN TEES VALLEY

1. PURPOSE OF REPORT

- 1.1 To allow Members of the Forum the opportunity to finalise their response to the consultation on new primary care trust arrangements in the Tees Valley.
- 1.2 For information, a copy of the consultation document has been attached to this report which outlines the proposals. (Appendix 1a).

2. BACKGROUND

- 2.1 Members of the Forum will be aware that there is at present a live consultation led by the Strategic Health Authority on the future configuration of PCTs serving the Tees Valley.
- 2.2 At the last meeting of this Forum held on the 14th February 2006 Members received a presentation in relation to the proposals from the Chief Executive of County Durham and Tees Valley Strategic Health Authority. Members at that stage however, wished to respond to the issue following the Council meeting of the 16th February 2006.
- 2.3 Following the Forum's consideration of the issues it is anticipated that the Forum's response to the Consultation will be submitted via the Tees Valley Health Scrutiny Joint Committee. Once all of the evidence has been collated by the Joint Committee, a response to the consultation will be submitted by the deadline of March 22nd.

3. RECOMMENDATION

- 3.1 That the Forum finalises its response in relation to the proposals to reconfigure PCT arrangements in the Tees Valley.

BACKGROUND PAPERS

No background papers were used in the preparation of this report:-

Contact Officer:- Sajda Banaras – Scrutiny Support Officer
Chief Executive's Department - Corporate Strategy
Hartlepool Borough Council
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Consultation on new Primary Care Trust arrangements in County Durham and Tees Valley:

Ensuring a patient-led NHS.

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Foreword



In July 2005, the Department of Health published a challenging programme to improve the commissioning of services. But it is a challenge we must all meet if we are to put in place the truly patient-led, high quality healthcare service we know the NHS can be.

Spending in the NHS is rising rapidly - from £33 billion in 1997/98 to over £90 billion in 2007/08. This increased investment, together with the hard work of NHS staff and the reforms we have introduced, is transforming our hospitals by reducing waiting times and lists, improved accident and emergency services and more up-to-date buildings.

Although these are improvements of which we should be rightly proud, we know there is more that needs to be done. In essence we need to ensure the NHS provides a service fit for the 21st century.

To deliver a patient-led NHS we need a strong commissioning function that can lead transformation in the NHS. The NHS has recognised it cannot do this alone and therefore needs the support of local authorities and the voluntary and independent sectors.

Alongside public health development, commissioning must place a real emphasis on safety and quality. Alongside patient choice, commissioning must ensure that services are truly responsive to patients. Commissioners need to drive these changes.

In brief, we need stronger Primary Care Trusts to design, plan and develop better services for patients, to work more closely with local government, and to support good general practice. The Primary Care Trust will be the custodian of the taxpayer's money, working to ensure that the NHS gets the best value for the public purse.

We need to enable GPs to play a full role in developing better services for patients. This is why the roll out of Practice Based Commissioning is so important.

This new approach to commissioning is about giving the levers to make services more responsive to patients to those best placed to use them. It is about enabling resources to be freed up to reinvest in new services.

Since July, Strategic Health Authorities have been discussing with their local communities how to reconfigure Primary Care Trusts. This document explains the suggested changes to your communities. I encourage you to have your say in this process to help build organisations that are fit to deliver this exciting vision for patients.

A handwritten signature in black ink, appearing to read 'Nigel Crisp'.

Sir Nigel Crisp KCB
Chief Executive, Department of Health and NHS

Preface



The NHS in County Durham and Tees Valley has secured significant improvements in services for patients in recent years. Waiting times for outpatient appointments and operations are shorter, appointments for family doctor services are more accessible, and people are being seen more quickly in accident and emergency departments. Also there are many new facilities, such as West Park Hospital in Darlington, the One Life primary care development in Middlesbrough and Chester-le-Street Community Hospital, which provide a modern setting for high quality services.

However, we know that there is much more to do to ensure that we provide, consistently, the very highest standards of healthcare as efficiently and effectively as we can for the people of the North East, as well as improving health across the region.

In response to Sir Nigel Crisp's call to strengthen Primary Care Trusts (PCTs) to make them better able to design, plan and develop better services for patients and to secure best value for the public purse we have developed two alternative models – one with two PCTs serving the area and one with six. These options have emerged from discussions with local NHS organisations, partners in local government and regional bodies, and others including MPs.

This consultation document compares the two options against a set of criteria which the Department of Health and Ministers will use to ultimately decide which of the two will be implemented in our area.

The one element common to both proposals is that the five PCTs in County Durham would merge to become one, or part of one new PCT. For Tees Valley the two options are quite different in terms of the size and scale of the new organisations and it is these differences that we need to explore through the period of consultation.

The changes to PCTs are part of a series of consultations that we are running at the same time. The others are the merging of the two Strategic Health Authorities (SHAs) serving the North East and a change to the ambulance trust boundary. We have arranged a full programme of public meetings (see page 18) to discuss all the changes and I look forward to seeing you there and hearing your views. Representatives from the SHA will also be offering to meet with local authorities, community and voluntary organisations and with patient and public involvement forums to discuss the proposals.

A handwritten signature in black ink that reads "David Flory". The signature is written in a cursive, flowing style.

David Flory

Chief Executive, County Durham and Tees Valley Strategic Health Authority

Your NHS

Important new changes in the way your local NHS is structured and managed are planned. Your views will be crucial.

The proposals at the heart of this consultation will mean new geographical boundaries for Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) across England. The solutions proposed in this document will be unique to your area and will reflect the needs, preferences and health priorities of your local communities.

Why is this so important? While most of us are passionate about the sort of services we receive in the NHS – the quality, speed and convenience of care – how many of us want to get tied up with organisational hierarchies and the mechanics of the service? We, as patients, want to receive the care we need, at the time we need it and in a setting that is convenient to us.

The answer is simple. The changes proposed here will be the defining factor in whether the NHS can sustain the huge improvements it has already achieved and go on to realise its fundamental aim: to deliver a better, more responsive health service that gives people the control and choice they have a right to expect as patients and taxpayers.

Achieving a patient-led NHS

Becoming a truly patient-led service is the next big challenge for the NHS. But what does it really mean for patients and how will we make it happen?

As a starting point the Government has captured and shared this vision in its cornerstone document, *Creating a Patient-led NHS*. It describes what patient-led services actually look like from a patient's point of view. Everyone involved in a patient-led service makes sure they:

- respect people for their knowledge and understanding of their own clinical condition and how it impacts on their life;
- support them in using this knowledge to manage their long-term illnesses better.

- provide people with the information and choices that allow them to feel in control and fit their care around their lives;
- treat people with dignity and respect, recognising them as human beings and as individuals, not just people to be processed;
- ensure people always feel valued by the health and care service and are treated with respect, dignity and compassion;
- understand that the best judge of an individual's experience is the individual;
- ensure that the way clinical care is booked, communicated and delivered is as trouble free as possible for the patient and minimises the disruption to their life; and
- explain what happens if things go wrong and why, and agree the way forward.

These are the sort of benefits we can all understand and that we want for ourselves and our families. They are the tangible end result of policies already in place to introduce:

- patient and client choice – not just in hospitals but in primary and social care too;
- better, more integrated support and care for people with long-term illnesses;
- a wider range of services in convenient community settings;
- faster, more responsive emergency and out-of-hours services; and
- more support to help people improve and protect their own health.

But for the local organisations working hard to put all these improvements in place, the system itself can often get in the way – including barriers between different professional groups and organisational boundaries.

This is why we are consulting on these major changes to how your local NHS is structured. Making a patient-led NHS a reality right across the NHS and other agencies will take more than a shared aspiration: it will need change. New standards of care; new skills, freedoms and incentives for staff; new systems for planning, securing and paying for services; and new organisations.

The NHS is not coming to this challenge from a standing start. There have been enormous changes in the NHS since the publication of the NHS Plan in 2000 and huge progress towards providing better, faster and more convenient healthcare.

In the ten years from 1997, levels of investment in the NHS in staff and services will have almost tripled, from £33 billion to more than £90 billion.

The NHS has recognised it cannot do this alone. It will also need the support of local authorities and the voluntary and independent sectors, who within 2004-5 accounted for £17.5 billion of this expenditure, employing over 1.4 million people. Along with the hard work and commitment of the 1.3 million NHS staff, this investment has genuinely transformed the quality of care people are receiving every day in health and social care:

- waiting times for hospital treatment have dropped significantly;
- fewer people are dying from killers such as cancer and heart disease;
- accident and emergency services are faster and better; and
- people now have real choice about when and where they receive their hospital treatment.

But this is only part of the journey. As much as 90 per cent of all our contact with the NHS happens not in hospitals but in primary care and community settings – that's in GP surgeries, community clinics, walk-in centres and even our own homes. And it's this reality that is driving a huge challenge for the NHS: to change our health service from one that does things 'to' and 'for' people, to one that works 'with' people – involving patients and carers, listening and responding to what they say.

Choice and diversity of services are as important for patients in primary care, as they are for those needing hospital treatment. And one of the best ways to give patients more choice and say about their local services is to give the healthcare professionals closest to them – GPs and their practice teams – a front-line role in securing the best possible services on their behalf.

This is called 'Practice Based Commissioning'.

It will mean that GPs have more say in deciding how health services are designed and delivered – ensuring they reflect the choices their patients and communities are making. It will encourage fresh thinking and trigger new ideas for the way services are run.

We need stronger PCTs to design, plan and develop better services for patients, to work more closely with local Government, and to more effectively support good general practice. In short, PCTs need to strengthen their commissioning function.

What do we mean when we talk about 'commissioning'?

At its simplest 'commissioning' is the term used to describe the processes by which the NHS spends its money. It is the processes by which the NHS plans and pays for services while assuring their quality, fairness and value for money.

Strong, imaginative commissioning is essential for creating a patient-led NHS. Commissioning will stimulate the development of a wider range of services in response to the preferences, lifestyles and needs of the local population. At the same time commissioning will help ensure that NHS resources are spent on the areas of most need.

In the past commissioning has largely been conducted through high level planning and block (fixed cost) contracts between purchasers and providers of care. This has given financial certainty in the system, but few incentives to understand and respond to the needs and preferences of patients.

This is now changing. A new financial system, Payment by Results, means that hospitals are paid a standard fee for the patients they treat. Money will truly follow patients. Patient choice will see patients deciding on where they want to be treated, determine the referrals to individual hospitals, and eventually how many patients each hospital treats.

Since April 2005 GPs have been able to become more involved with commissioning through an approach known as 'Practice Based Commissioning'. The aim is to have universal coverage of Practice Based Commissioning by the end of 2006.

These changes provide an opportunity and a need to change the way we approach commissioning and the organisational arrangements to support commissioning.

The wider picture

Under Practice Based Commissioning GPs and practice staff will have access to a commissioning budget and will lead developments to produce more responsive local services.

Practices will pay the national tariff for most hospital services, but crucially only for those services their patients use. Practice Based Commissioning will allow GPs and Primary Care professionals to develop and fund innovative community services as an alternative to hospital for some patients. GPs will have a much greater say in the services to be provided to their patients.

PCTs will support and manage the operation of Practice Based Commissioning. They will, on behalf of their practices, provide practice budgets, clinical and financial information to help GPs and negotiate contracts for the services required.

PCTs will play a crucial role in working with their practices to design, plan and develop better services for patients. They will conduct needs assessments of their local communities and work closely with local authorities so that the wider health and care needs of local communities are addressed. There are lessons concerning commissioning that can be learnt from local authorities.

The PCT will be the custodian of the taxpayer's money, working to ensure the NHS maximises the benefits of its resources and secures high quality responsive services.

The focus for SHAs will be on building the new system of commissioning and then maintaining a strategic overview of the NHS in their area.

SHAs will continue to provide leadership and performance management to the NHS. They will be responsible for ensuring that key national objectives are delivered and that services are high quality, safe and fair. Taking forward this agenda will need good leadership, within both the NHS as well as other local services.

Over time, as we move towards all NHS Trusts achieving Foundation status, performance management will increasingly be focused on the commissioners of services.

What does this mean for PCTs?

Many of the improvements seen in the NHS in recent years can be attributed to the hard work and skills of PCTs. But as the landscape of a patient-led NHS continues to change, bringing with it the new challenges of greater choice, more diverse services and improved health, so too will PCTs need to adapt and develop.

Practice Based Commissioning will be central to all this and PCTs will need to play a lead role in supporting GPs and practices as they step into their new commissioning functions, and in managing new relationships with a wider range of providers. While PCTs will be key to making the new system a success, the new processes should actually support them.

There is no national blueprint for the number or shape of PCTs - different regions will invariably need different solutions. In some areas, for instance, the formation of larger PCTs may be seen as the key to really effective local commissioning and service planning. For others, smaller PCTs may fit local needs better.

In many cases the geographical areas of the new PCTs are likely to broadly match those of local authorities. This will encourage better co-ordination between health, social care and other local services and boost the population-related spending power of PCTs.

The PCT role in more detail

The core roles and functions of PCTs are set out below. As we continue to develop the health reform policies there may be additional roles and functions identified for PCTs. An initial view of the new PCT role is as follows:

- Improve and protect the health of the population they serve by assessing need and having a robust public health delivery system including emergency planning.
- Secure, through effective commissioning, a range of safe and effective primary, community, secondary and specialised services (some specialised services will be commissioned nationally, others by groups of PCTs. There is currently a review of specialised commissioning underway. This is due to report in spring 2006). which offer high quality, choice, and value for money.
- Reduce health inequalities and ensure that the role of individuals is recognised and utilised at local level.
- Develop and sustain strong relationships with GPs and their practices and implement a system of Practice Based Commissioning.
- Work closely with local authority partners and other commissioners to ensure integrated commissioning of health and social care, including emergency planning.
- Ensure that nurses, midwives and allied health professionals play a key role in improving the health of local populations.
- Stimulate the development of a range of nursing, midwifery and allied health professional providers.
- Provide appropriate clinical leadership in a system of diverse providers.
- Develop robust communication and involvement systems to manage relationships and engage with their local residents and communities.
- Ensure that a range of services are provided for their communities in ways that most appropriately meet their local needs.

The overall management of the health system will continue to develop as we fully implement Payment by Results and patient choice and move towards greater plurality of provision through NHS Foundation Trusts and greater independent sector involvement.

The Department of Health has a significant programme of policy development work on the future regulation and management of the health system overall. Further guidance in 2006 will set out the implications of this work for SHAs, PCTs and other NHS bodies.

Protecting staff

The proposals set out in this document mean important changes for staff working in the current SHAs and PCTs. In what is likely to be an unsettling time, it will be vital to ensure that staff are fully consulted on the local proposals and have the opportunity to use their experience and creativity in shaping new services.

The new structure must also be implemented fairly and transparently in a way which protects the position of staff who transfer to other organisations and gives them new opportunities to utilise their skills and experience.

The Department of Health have recently published a human resources framework to outline the relevant appointment processes for the new SHAs and PCTs, and to support staff through these changes.

Next steps

This document is one of a series of separate consultation exercises on the proposed boundaries and structures for each new PCT. Proposals for the new SHA boundaries are also being consulted on at local level in a similar way.

The proposals which follow outline plans to create a number of new PCTs from the present ten in the SHA. They describe the implications of these changes for staff, local people, the NHS and its partner organisations.

No final decisions have yet been taken and this is your opportunity to genuinely influence the future shape of your local NHS services.

At the end of the consultation, the SHA will report the results of the consultation and advise the Secretary of State for Health whether she should make the proposed orders to dissolve or establish a PCT.

A full explanation of how to comment and by when is set out on page 17 including arrangements for people with impaired vision, hearing or other special needs.

The current situation across County Durham and Tees Valley

Within the area covered by County Durham and Tees Valley Strategic Health Authority (SHA) there are currently ten PCTs. Five of these are in County Durham - Durham and Chester-le-Street, Sedgefield, Durham Dales, Easington and Derwentside and one covers Darlington. On Teesside there are four PCTs - Hartlepool, North Tees, Middlesbrough and Langbaugh.

County Durham is served by Durham County Council (with responsibility for social services and children's services) and seven district councils. Sedgefield, Easington and Derwentside PCTs are coterminous with their respective district councils while Durham and Chester-le-Street and Durham Dales PCTs each cover two district council areas. Darlington PCT is coterminous with Darlington Borough Council, a unitary authority which provides social services and children's services to the population.

On Teesside, the Hartlepool and North Tees PCTs are coterminous with their respective unitary councils while the boundaries of the Langbaugh PCT and Middlesbrough PCT match the Redcar and Cleveland Borough Council and Middlesbrough Council boundaries except for some GP practices in Eston (Middlesbrough PCT) which are in the Redcar and Cleveland local authority area.

For people living in County Durham and Darlington, hospital services are predominantly provided by the County Durham and Darlington Acute Hospitals NHS Trust. They also go to hospitals in Sunderland, Newcastle, Gateshead, Hartlepool, Stockton and

Middlesbrough for both secondary and tertiary services. Mental health and learning disability services are provided by the County Durham and Darlington Priority Services NHS Trust, which is currently subject to a merger proposal with Tees and North East Yorkshire Mental Health NHS Trust.

For Teesside residents, hospital services are provided by the North Tees and Hartlepool Hospitals NHS Trust and the South Tees Hospitals NHS Trust, and mental health services by the Tees and North East Yorkshire NHS Trust.

The five County Durham PCTs and Darlington PCT have been working together for some time to address the issue of improving 'strategic commissioning' of hospital and other services. This work pre-dates *Commissioning a Patient-led NHS* and is a response to the PCTs' assessment of their individual ability to commission effectively.

Similarly, the PCTs on Teesside have already undertaken some work to set up a new strategic commissioning capability, again recognising and addressing the constraints of the existing PCT structures to doing this.

Options for the future

Commissioning a Patient-led NHS spells out the changes which are necessary to create a local NHS fit for its future purpose including the new role and functions for PCTs. The proposals we have developed address this including how a 15 per cent reduction in expenditure on management and administrative functions can be achieved. This money (£6 million in County Durham and Tees Valley) will be reinvested in services for patients in the PCT areas in which it is saved.

During the summer, County Durham and Tees Valley SHA had discussions with local NHS organisations, local authorities (including representatives of overview and scrutiny committees), MPs, regional bodies such as Government Office North East, community and voluntary organisations and patient and public involvement forums.

These discussions helped to inform a report that was submitted to the Department of Health in

October 2005 with proposals for the future configuration of the SHA and PCTs. This report is available on www.cdtvha.nhs.uk.

Those proposals submitted by the SHA were evaluated by an external panel established by the Department of Health and consideration has also been given to representations received from local MPs and other interested parties. Following this national process, the Secretary of State has agreed that consultation can go ahead on the following basis:

The first option is:

Create two new PCTs across County Durham and Tees Valley by merging the ten which currently exist as follows –

One new PCT for County Durham and Darlington (pop c592,000) – which would mean merging the six PCTs serving Durham and Chester-le-Street, Sedgefield, Easington, Durham Dales, Derwentside and Darlington; and

One new PCT for Teesside (pop c546,000) - which would mean merging the four PCTs serving Middlesbrough, Redcar and Cleveland, Stockton on Tees and Hartlepool.

The second option is:

Reduce the number of PCTs across County Durham and Tees Valley from ten to six as follows –

Create a new County Durham PCT – aligned to Durham County Council boundaries which would mean merging the five PCTs in County Durham. These are Durham and Chester-le-Street, Derwentside, Sedgefield, Easington and Durham Dales.

Establish five PCTs covering Darlington, Hartlepool, Stockton on Tees, Middlesbrough and Redcar and Cleveland based on the boundaries of the unitary local authorities.

Both options include bringing together, as a minimum, the existing five County Durham PCTs into one countywide PCT. It is clear from the discussions that took place over the summer that a key issue for a County Durham-wide PCT will be to ensure that locality structures are developed that enable resources and activity that are locality specific,

based largely on the district councils' boundaries, to remain so. The locality structure developed recently by the County Council will support this approach. It will be necessary to ensure that learning and practice that have been developed by the current PCTs are effectively transferred to the new PCT.

It is also important to recognise that the boards of the County Durham and Darlington PCTs had agreed to work on a collaborative approach to strengthen commissioning. Similarly work was underway between the Tees PCTs to develop an approach to strategic commissioning.

One significant element of option two is that it proposes that the boundaries of the current Langbaugh PCT and Middlesbrough PCT be amended so that they would be coterminous with Middlesbrough and Redcar and Cleveland unitary authorities respectively. This would mean six GP practices transferring into the new Redcar and Cleveland PCT.

Both options would require significant changes to the current PCTs' ways of working and internal organisational structures to ensure that the PCTs of the future are capable of fulfilling their new role and function and are able to make the necessary reductions in expenditure on management. The remainder of this document sets out how the two options would meet these requirements.

Under these options, would the PCTs be fit for purpose?

PCTs need to change to be fit for purpose. *Commissioning a Patient-led NHS*, published by the Department of Health in July 2005, set out clear criteria for successful PCTs of the future. They should:

- secure high quality, safe services;
- improve health and reduce inequalities;
- improve the engagement of GPs and rollout of Practice Based Commissioning (PBC) with demonstrable practice support;
- improve public involvement;
- improve commissioning and effective use of resources;

- manage financial balance and risk;
- improve coordination with social services and other local authority services through greater congruence of PCT and local authority boundaries.

There is also a requirement to make management and administrative savings totalling £250 million nationally. Across County Durham and Tees Valley this equates to £6 million.

The future role of PCTs, set out on page 7, is based on these criteria for success and provides further detail on some elements of the criteria. We have used the criteria as the basis for looking at the way in which the two options would deliver PCTs fit for purpose.

Developing the NHS in the future

Some NHS organisations in the North East have been largely successful over recent years. But half way through the ten year *NHS Plan* we believe that we need to become more successful in making patients feel the benefit of the changes being brought about. We aim to develop a health and social care system in the North East based upon:

- strong alliances at strategic and operational levels;
- effective clinical engagement;
- clear vision for integrated health and social care service improvement, supported by stretching success criteria and good performance management;
- capability to deliver the best possible outcomes for patients and service users, judged by world wide benchmarking;
- robust financial control and risk management;
- consistent achievement in the delivery of NHS targets.

Considering the two options

Secure high quality, safe services

The primary objective of commissioning is to secure high quality and safe services to meet the identified needs of the population, maximising the efficient and effective use of resources. A dominant feature in the local NHS has been the emergence of

increasingly large NHS hospital trusts. Of the three hospital trusts across County Durham and Tees Valley, County Durham and Darlington Acute Hospitals NHS Trust is hoping to achieve Foundation Trust status late next year and for the two Teesside trusts – North Tees and Hartlepool NHS Trust and South Tees Hospitals NHS Trust - the national process will start next year to assess their state of readiness to proceed towards Foundation Trust status over the next few years.

As real choice is further introduced on behalf of patients, and more provision is delivered from the independent sector and the community and voluntary sector as well as traditional NHS providers, the ‘healthcare market’ is in constant competition to secure a share of resources. It is the PCTs as commissioners who have to manage this market and ensure the contestability between NHS providers and others works to the benefit of patients. This role of market management is relatively new to the NHS and requires more sophisticated levels of data analysis and negotiating skills than have been required in the NHS in the past. It will require a comprehensive commissioning process that goes through a cycle of:

- consultation;
- prioritisation;
- developing strategy;
- developing service models;
- developing operational plans;
- establishing contracts and purchasing arrangements;
- performance management of those contracts.

Within both options for PCT configuration, arrangements will need to be in place to enable the PCT to work jointly with local authorities to agree functional partnerships and governance arrangements for many specific shared responsibilities, for example, meeting the needs of older people, people with learning disabilities and mental health problems and children and families.

Two PCT option

This option would enable a strategic approach to commissioning and sufficient commissioning capacity of the right calibre to manage the market

effectively. It would make it possible to ensure that the learning from the experience of working together on a more strategic approach to commissioning by the two clusters of PCTs in County Durham and Darlington and those on Teesside, could be transferred to the proposed two PCTs. This option could also make it more likely that the leaders of the new PCTs would be able to find and bring into their management teams a sufficient level of scarce skills that are relatively new to the NHS, in order to strengthen commissioning. Fewer PCTs commissioning from large trusts would introduce the potential for greater contestability in relation to quality and value for money. The two PCT option would be able to secure services to meet the needs of the bigger population base, providing choice, quality, safety and value for money through contracting with a wider range of providers.

A key element of commissioning involves working with local authorities. This option would require strong and meaningful local connections within each of the PCTs, based on the areas covered by the local authority boundaries, including joint commissioning. This would provide a local approach to assessing population needs and a framework to connect with Practice Based Commissioning and develop and sustain strong relationships with GPs and their practices. It would ensure that primary health care teams, other community based health professionals and independent contractors could play a key role in improving the health of local populations. Most importantly, it would ensure that the benefits of close working with local authority partners through integrated commissioning of health and social care could be sustained along with the continued development of a range of shared priorities and responsibilities, for example, emergency planning, community safety and crime reduction partnerships, social inclusion and economic regeneration. Larger PCTs could also encourage joint commissioning across clusters of local authorities for some specialised community care services.

Arrangements would need to be put in place to provide local connections, working with local authorities within each of the larger PCTs, to take forward effective functional partnerships and governance arrangements for the specific shared

responsibilities referred to above. For example, with older people's services, it would be necessary to agree a partnership, based on shared objectives, between the local authority, the strategic lead for the whole PCT, local providers of acute and mental health and community-based services and other relevant partners (e.g. voluntary sector providers where established). The PCT would be responsible for ensuring that services were commissioned so that the partnership agreements were met.

There would need to be clarity about what would be done once at PCT level for all the local authority areas and what would be done in specific local partnerships. For example, in relation to mental health services, the PCT commissioning team would need to commission a sufficient level of specialist services from mental health service providers to feed into and complement local partnership arrangements for integrated community based health and social care teams.

The larger PCTs would commission sufficient capacity to deliver all relevant partnership programmes to local requirements. This would be achieved through a service level agreement with either their own provider services (in the respective locality) and relevant NHS trusts or others (the voluntary or independent sector, for example) for local leadership and service capacity. The PCT would then ensure delivery through performance management.

Also, the larger PCTs would set their strategy for contribution to the local agenda and be part of the agreement for regional strategy where relevant, for example, in public health. Regional working would be straightforward, involving only four PCTs working with a single strategic health authority and other regional partners.

Six PCT option

The existing PCTs covering Darlington, Hartlepool, Stockton-on-Tees, Middlesbrough and Redcar and Cleveland have worked closely with local authorities providing social services for the past few years and as a result there have been many benefits through the development of joint commissioning, the provision of integrated services and tackling health improvement.

In order to continue to strengthen the whole commissioning agenda to ensure PCTs are fit for purpose in the future within the resources that will be available, there would need to be integration of management arrangements across the PCTs covering Durham and Darlington and Teesside. The most effective configuration of these arrangements, bearing in mind the historic patterns of patient flows to hospitals and mental health services would be County Durham and Darlington on the one hand and Teesside on the other. In practice this could mean that the integrated management structures would work with two chairs in County Durham and Darlington and four chairs in Teesside, and their respective boards and professional executive committees (PECs). There has been previous experience of sharing director posts across two PCTs in the area and this proved unworkable. The existing PCT chief executive community does not believe that it would be possible to work effectively in this way.

Each PCT would be responsible for developing local partnership agreements with relevant partners to identify local priorities for action to meet the needs of the population. These plans would feed into the integrated management arrangements to commission sufficient capacity to meet local needs and fulfil partnership agreements.

In addition, it will be necessary to explore greater economies of scale across larger areas covering six or more PCTs for some of the functions often described as 'back office functions', such as finance, estates and information technology.

In this option, the involvement of GPs in commissioning would continue to develop building on the good relationships between existing PCTs and their practices, built up over the last three years. Practice Based Commissioning requires a significant level of management support to ensure that the practices have all the information they need to make informed decisions. Support is also required to ensure that the priorities identified by the practices are translated into effective commissioning processes. This capacity would need to be part of the integrated commissioning structure across the PCTs.

There would clearly be costs associated with establishing the integrated management arrangements.

Improve and protect the health of the population and reduce inequalities

It is essential that local partnerships and work with communities continue as part of the effort to improve health and reduce inequalities. During discussions over the summer, local authorities have stressed that they wish to preserve and build upon the strong partnerships that have developed in recent years.

Consultation is currently taking place to merge the two SHAs across North East England, which would result in a simplified structure for performance management of the public health function probably with a single Regional Director of Public Health. Currently within the Government Office for the North East (GONE) there is a Regional Director of Public Health and a Public Health Group who are directly accountable to the Chief Medical Officer at the Department of Health. Each of the two SHAs has a lead for public health, as do the PCTs. The Regional Director of Public Health would ensure that PCTs have appropriate service level agreements to deliver the full range of public health functions and meet targets to improve the health of local people. Each of the PCTs, as commissioners, would then have a clear role in performance management of the local NHS public health functions.

An important requirement for all PCTs will be to have robust and integrated emergency and resilience planning, which will involve close working with a range of agencies including police, local authorities and regional bodies such as the Health Protection Agency.

Two PCT option

Within the two PCT option, locality arrangements, based on local authority areas, would be established to ensure that existing partnerships can be maintained and improved. Larger PCTs with more strategic commissioning capacity would add value

to efforts to improve health and reduce inequalities through, for example, providing a simplified and more consistent health improvement message. It would also ensure that the whole commissioning process was focused on health outcomes. This option would have the advantage of a more simple relationship with the potentially rationalised arrangements for health improvement at a regional level outlined above.

Two PCTs would offer economies of scale and a better use of resources. This option would enable networking to take place between public health specialists, with less duplication of effort. The larger PCTs would also be able to combine expertise and streamline links with the regional bodies involved in emergency planning.

Six PCT option

In relation to the six PCT option, much work has already been done by the existing PCTs working with their local authorities to develop effective approaches to improving the health of their local populations and this would continue. The direct involvement of PCTs in Local Strategic Partnerships that exists currently is valued by local authorities and partner agencies. In a number of areas this involvement has contributed to raising awareness of the importance of health improvement and the benefit it can bring to the local economy as a whole. There would be a smaller range of skills available than in the two PCT option and there would be capacity constraints.

Strong relationships with independent contractors and their practices and roll out practice based commissioning

The PCTs will be required to develop and sustain strong relationships with independent contractors and their wider primary health care teams and implement a system of Practice Based Commissioning. This will mean building on the good working relationships that have been developed over the past few years between the existing PCTs and contractors, for example, optometrists, dentists, GPs and pharmacists and their staff. There will also be the need for the development of relationships between independent contractors and primary care providers of the future. On the contracting side, specialist capability will be required to manage

Payment by Results via Foundation Trust contracts and to support Practice Based Commissioning on a clear and consistent basis.

The initial thinking about Practice Based Commissioning in its first phase of roll out, has been a locality specific process (locality in this context could include local areas within current PCT boundaries that match natural clusters of practices and local communities). Now Practice Based Commissioning is a key part of delivering *Commissioning a Patient-led NHS*, and its strategic development has been supported by the Department of Health. This agreed direction will guide the development of an SHA-wide framework for the future as part of the strengthened commissioning process and cycle.

Experience from local networks between primary and secondary care, for example, urgent care and mental health local implementation teams also gives us a model for future multidisciplinary clinical engagement to clinical service planning.

We will learn from and build upon the success of local and regional networks and National Service Framework local implementation teams to ensure multidisciplinary clinical leadership and engagement, for example, further developing diabetes services between primary care and the local hospital. Practice Based Commissioning is going to be the major vehicle for ensuring clinical engagement in future commissioning arrangements.

Two PCT option

The good relationships between existing PCTs and their practices, built up over the last three years (in some cases more) would need to be recreated. It would be possible to develop the principle of 'local solutions for local circumstances' within the SHA-wide framework, while at the same time achieving better risk management, dedicated analytical support and capability and good governance.

Six PCT option

The approach outlined above means that Practice Based Commissioning would be progressed similarly in the six PCT option. The development of service models and the infrastructure needed to support Practice Based Commissioning would probably need to be part of the integrated management

arrangements across the PCTs, to ensure there is specialist capability available, as described above.

Improve public involvement and develop robust communications systems

All PCTs will need to develop robust communications and involvement systems to manage relationships and engage with their local residents, communities, voluntary organisations and partner organisations. This will include the provision of high quality information about services and how to access them, the choices available to local people as well as information to help them stay healthy. Systems in the new organisations will be required to build on the work that has been developed in line with Section 11 of the Health and Social Care Act (2001), which requires health bodies to involve local people from the earliest stages when new services are being planned or when changes to existing services are being considered.

Early discussions with representatives from local authority overview and scrutiny committees and with members from patient and public involvement forums have shown how keen they are to preserve existing local arrangements for involvement. Future working with the patient and public involvement forums will obviously depend on the outcome of the ongoing national review.

Two PCT option

In terms of communicating with and involving patients, carers and the public, two PCTs would bring together expertise from across a larger geographical area so all would benefit from pooling resources, sharing good practice and building on the best. In the existing organisations, there is often just one member of staff with responsibility for involvement and another for communications (which includes internal communications, liaison with the media, the production of patient information and providing communications support to colleagues across the organisation for the introduction of new developments and policies).

Six PCT option

One of the strengths of the PCTs has been the way they have developed patient, carer and public involvement. Over the past three or four years, there have been substantial improvements in the way that local people have been involved in the development of local services. This has been made possible through close working with local authorities and with key local community and voluntary organisations.

Financial balance and the management of risk

All PCTs need to maintain financial balance and routinely manage the very large number of risks which have the potential to financially destabilise them. They also need to ensure that additional funds are directed to those parts of their area with the greatest need.

Strong financial leadership is essential and it is crucial that the PCT is able to attract managers with the requisite ability and experience to ensure that risks are identified and managed and that strong financial planning and control is in place.

The PCT also needs to be of sufficient size so that it can cope with financial pressures occurring in-year.

Two PCT option

Two large PCTs would be better able to attract managers with the requisite ability and experience and would also be better able to afford them from the resources available for management. Two large PCTs would also be better able to cope with financial pressures occurring in-year. This is because a large PCT would have a bigger financial base and therefore be better able to cope with cost pressures within the year.

Six PCT option

Six smaller PCTs would experience more difficulty in attracting managers with the requisite ability and experience and would have more difficulty in affording them from the resources available for management. Six smaller PCTs would be more vulnerable to financial pressures occurring in-year, which could lead to the organisation being financially destabilised.

Financial savings

Across County Durham and Tees Valley, the overall record for the management of risk and the achievement of financial balance has been generally good, although five of the smaller PCTs are currently overspending their budgets. However, this gets harder and harder each year and is now made much more difficult for PCTs because of the increasingly challenging service improvement targets; the likelihood of lower financial growth for the NHS from 2008/09 onwards than we have seen in recent years and the challenges of implementing the new financial regime Payment by Results.

In addition, an important part of *Commissioning a Patient-led NHS* is to make savings of £250 million nationally, £6 million within County Durham and Tees Valley, to be redirected away from management and administration into direct patient care. It is estimated that between £1.75 million and £2 million of the required savings can be found by merging County Durham and Tees Valley SHA and Northumberland, Tyne and Wear SHA. However, this still leaves at least £4 million to be found by PCTs.

In view of this, it is crucial that the new management and administrative arrangements are cost effective and deliver the required savings.

Within a typical PCT the cost of providing a board consisting of a chairman, non-executive directors, a chief executive, executive directors and a professional executive committee is estimated at £500,000 per annum.

Two PCT option

The two PCT option will save on the costs of eight boards amounting to some £4 million per year. This means that under this option there should be minimal impact upon management and administration beneath board level

Six PCT option

The six PCT option will save on the costs of four boards within County Durham amounting to £2 million per year and this should enable County Durham PCTs to make their required level of savings. Within those PCTs that would retain their boards, the required level of savings will need to be found below board level and by the integration of

management across PCTs and/or by sharing arrangements with other partners.

Conclusion

This paper has compared the two options for the future configuration of PCTs in County Durham and Tees Valley against the criteria set out in *Commissioning a Patient-led NHS*. In summary, the key issues of difference between the two options are outlined below.

Two PCTs

This option simplifies the PCT structure across County Durham and Tees Valley by reducing the number of organisations from ten to two.

Consideration of the criteria for the new PCTs to meet shows that this option is particularly strong in terms of securing high quality, safe services, improving commissioning and effective use of resources and managing financial balance and risk. It would facilitate the development of Practice Based Commissioning as part of the whole commissioning process. In this context Practice Based Commissioning would provide an essential link to the development of local priorities, especially where they connect with joint commissioning with the local authority. This option may be less able than the six PCT option to improve public involvement or improve coordination with social services and other local authority functions, issues which are addressed earlier in this document.

The required financial saving of £6 million across County Durham and Tees Valley could be met by merging County Durham and Tees Valley SHA and Northumberland, Tyne and Wear SHA (saving up to £2 million in each SHA area) and by implementing the option of creating two new PCTs – one for County Durham and Darlington and the other for Teesside. The savings would be realised by reducing the number of boards (non-executive and executive directors), professional executive committees, administrative headquarters buildings and other non-pay costs such as audit fees.

This would save over £500,000 per PCT giving a saving of at least £4 million from the PCT reconfiguration and reduce the total number of

potential job losses. This, together with the £2 million SHA saving, would deliver the £6 million required savings.

This option is preferred by the existing PCT chief executives in County Durham and Tees Valley (unanimously), by those NHS organisations providing services to people in County Durham and Tees Valley, by some of the professional executive committee chairs and by regional partner organisations.

Six PCTs

This option involves merging the five PCTs in County Durham and retaining the boundaries of the existing three PCTs serving Darlington, Hartlepool and Stockton on Tees. It would involve changing the boundaries of Middlesbrough and Langbaugh PCTs so that they are coterminous with the local authorities of Middlesbrough and Redcar and Cleveland.

The five PCTs for Darlington and Teesside would share the same boundaries as local authorities providing social services and children's services. Those PCTs have developed some effective local partnerships and there are examples of good work with the GPs, dentists, community pharmacists and optometrists. It may be difficult for the PCTs to be able to continue this level of partnership working with reduced management resources. If the boards of directors, professional executive committees and headquarters premises are retained then the savings will have to be generated from reducing the number of posts elsewhere in the organisations. This option is better in terms of improving the engagement of independent contractors and the roll out of Practice Based Commissioning. It supports the approach to Practice Based Commissioning that would be developed within an SHA-wide framework. This option also gives a more obvious local focus to improving public involvement and working with the local authorities on improving health and reducing inequalities and other shared priorities. It is not strong in terms of the criteria for securing high quality, safe services, strengthening commissioning and effective use of resources and managing financial balance and risk.

This option is generally preferred by the local authorities in the Tees Valley, by some of the

professional executive committee chairs and by those MPs who have expressed their views.

And finally...

The Department of Health expect us to implement *Commissioning a Patient-led NHS* to ensure a number of clear benefits for the people of the North East, the patients and others who use NHS services and the staff working for both the NHS and our partners. They will be delivered through:

- achieving economies of scale in management to re-invest savings in services for patients;
- strengthening commissioning, incorporating better engagement of clinical staff to drive change and transformation of our services;
- securing strong partnership working, particularly with our partners in local authorities;
- preparing for radical improvements to be made to "care outside hospitals";
- focusing more effort on improving the health of the population;
- strengthening academic partnerships, research and development to inform the delivery of evidence based practice.

Consultation arrangements

Consultation on options for PCT configuration across County Durham and Tees Valley is being launched on 14 December 2005 and will run for 14 weeks until March 22 2006. At the same time there will be consultation on proposals for PCTs in Northumberland and Tyne & Wear, for the SHA and the ambulance trust (for further information see below).

This document and a summary leaflet are being made available in large print and on audio tape. This document will also be made available in other formats and in languages other than English on request. The leaflet is being translated into several other languages and further translations can be arranged on request.

The documents are being sent to local NHS organisations, GPs, pharmacists, dentists,

optometrists, local authorities (including overview and scrutiny committees), community and voluntary organisations, the Commission for Patient and Public Involvement in Health, patient and public involvement forums, MPs, unions, regional organisations, regional and local media and libraries.

This document, those for the PCTs and the ambulance trust, and the leaflet are also available on the SHA and PCTs' websites.

During the consultation period, the SHA will be pleased to attend staff meetings in NHS organisations, NHS public board meetings, local authority meetings (including overview and scrutiny committees), meetings of community and voluntary organisations and of patient and public involvement forums. The SHA is particularly keen to engage with black and minority ethnic communities and people who feel they have difficulty accessing health services in the area.

There will be a public meeting in every existing primary care organisation area (see page 18). These are being held at different times of the day to ensure they are convenient for as many people as possible. More will be arranged if necessary.

Details of the public meetings will be advertised through press releases and paid for advertising.

Interpreting services can be made available at public meetings on request.

Discussions will take place with the Commission for Patient and Public Involvement in Health to offer the opportunity of large, combined events for forum members.

Details of all comments made during consultation meetings will be included in reports to the SHA board at the end of the consultation.

The report following consultation will be available on the SHA's website and will be sent to any organisations that participated.

What questions do we want to ask you?

The SHA welcomes comments on any aspect of the proposals but in particular, are keen for views on:

- What is your reaction to these suggestions in terms of concerns and opportunities in the future? (It would be helpful if you could include how your

preference could meet or address the criteria for PCTs as set out in *Commissioning a Patient-led NHS*).

- What safeguards need to be in place to ensure that we preserve and build on what works now?
- What other things do we need to think about and consider?

Who to send comments to

Comments can be sent by post to David Flory, the SHA's chief executive at:

Commissioning a Patient-led NHS
Freepost NAT 3825
Stockton on Tees
TS17 6BL

Email responses can be sent to:
consultation@ntwsha.nhs.uk

To arrange meetings or to request more copies of the consultation document, contact the communications team, telephone 0191 210 6422.

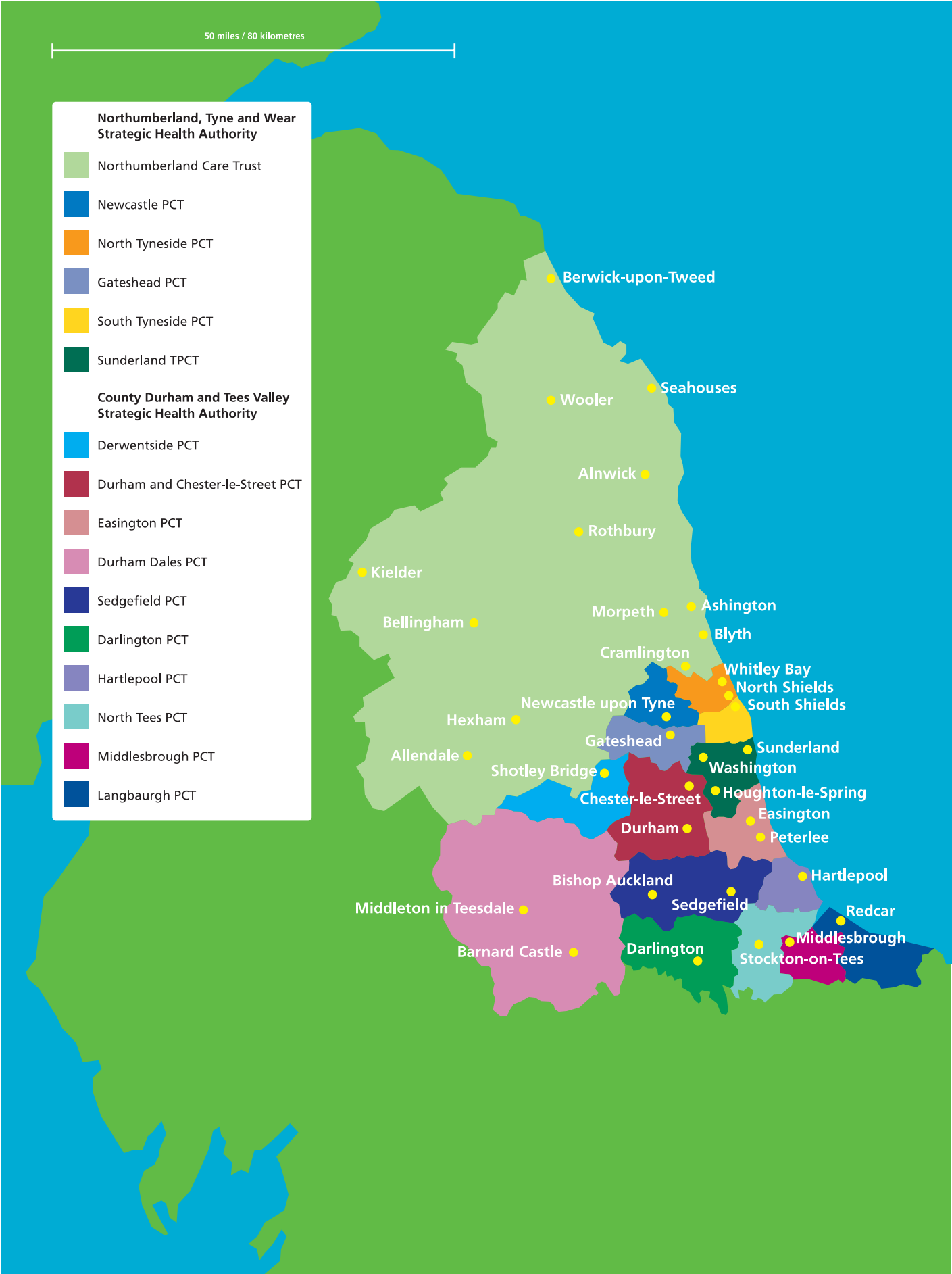
At the end of the consultation

By 12 April the SHA will have to send the results of the consultation with a recommendation to the Secretary of State. They will then be reviewed by the external panel at the Department of Health before any decision is made. The external panel, which includes non-executive directors from NHS organisations, a senior representative from a local authority, senior clinicians and national experts in areas such as patient, carer and public involvement, was established by the Department of Health during the autumn to review the reports submitted by SHAs.

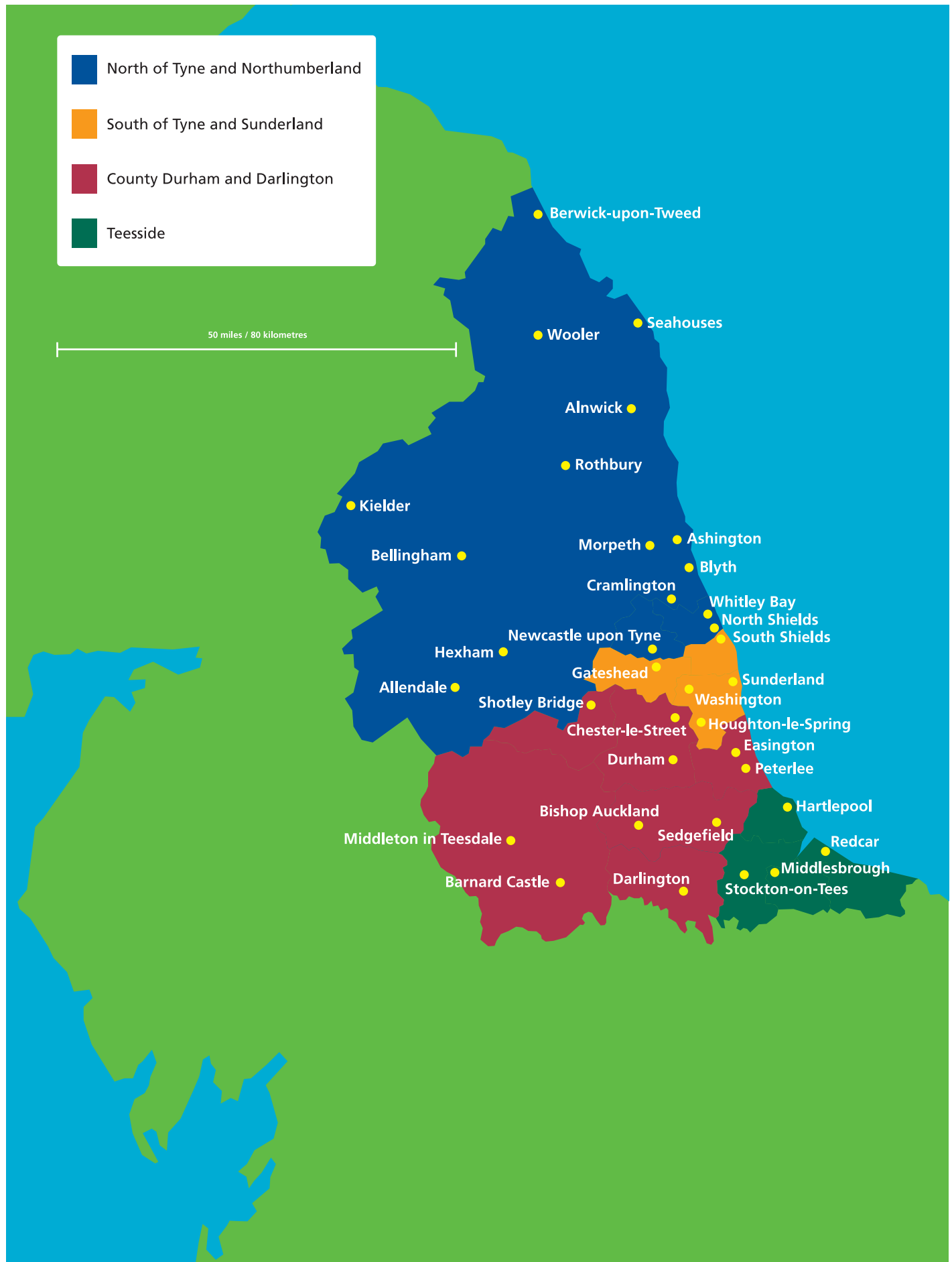
Following a decision by the Secretary of State, arrangements will be made to disestablish those PCTs which will no longer exist and establish new fit for purpose organisations in the summer of 2006.

Public Meetings

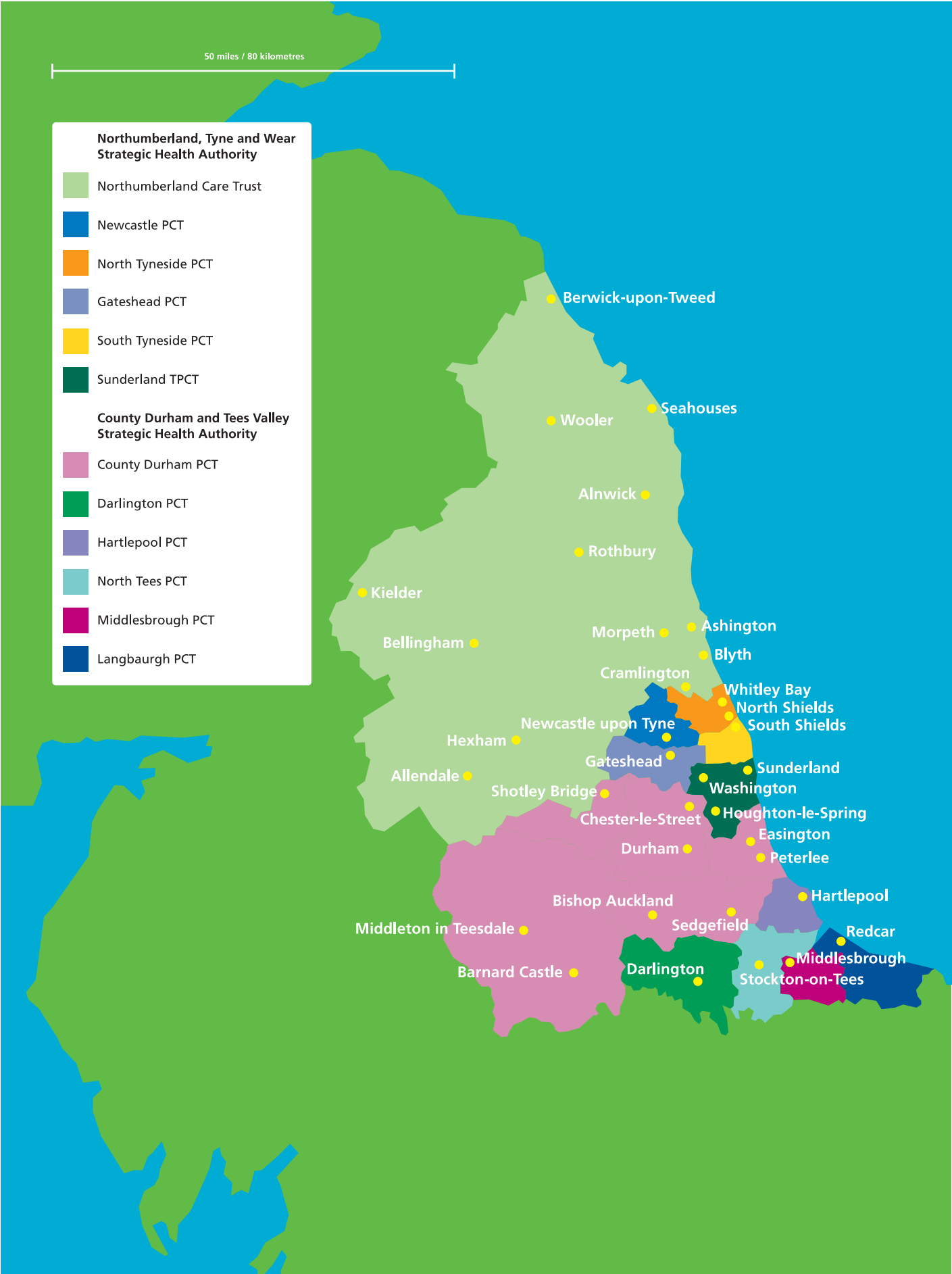
Date	Area and venue	Time
10th January 2006	Durham and Chester-le-Street Council Chamber, Civic Centre, Chester-le-Street	1.30pm-3.30pm
11th January 2006	Gateshead Council Chamber, Gateshead Civic Centre	6.00pm-8.00pm
16th January 2006	Darlington Central Hall, Dolphin Centre, Darlington	1.30pm-3.30pm
20th January 2006	Langbaugh Room 1, Guisborough Education & Development Centre, Wilton Lane	10.00am-12noon
23rd January 2006	Northumberland Riverside Café and Sports Bar, Riverside Leisure Centre, Newmarket, Morpeth	1.30pm-3.30pm
24th January 2006	Sedgefield Spennymoor Town Hall, Spennymoor	6.30pm-8.30pm
31st January 2006	North Tees Theatre, The Arc, Stockton	1.30pm-3.30pm
1st February 2006	Hartlepool Conference Suite 2&3, Belle Vue Sports and Youth Centre	1.30pm-3.30pm
3rd February 2006	Sunderland Directors' Suite, Stadium of Light	10.00am-12noon
7th February 2006	Middlesbrough Conference Hall, Teaching and Learning Centre, Middlesbrough	6.30pm-8.30pm
8th February 2006	Derwentside Main Hall, Civic Centre, Consett	10.00am-12noon
16th February 2006	Durham Dales Eden Theatre Town Hall, Bishop Auckland	3.00pm-5.00pm
17th February 2006	South Tyneside Community Room, Customs House, South Shields	1.30pm-3.30pm
20th February 2006	Easington Brandling Suite, Shotton Hall, Peterlee	6.30pm-8.30pm
21st February 2006	North Tyneside Room 6, Town Hall, Wallsend	10.00am-12noon
27th February 2006	Newcastle Council Chamber, Newcastle Civic Centre	6.00pm-8.00pm



The existing configuration of primary care organisations across North East England.



Option 1.



Option 2.

"من الممكن توفير هذه المعلومات بلغات أخرى عند الطلب. يرجى الاتصال بالسيدة "أنجيلا كلارك" على هاتف رقم (0191 210 6422) للحصول على ترجمة."

"অনুরোধ করলে এই খবরটা অন্যান্য ভাষাতেও পাওয়া যাবে। অনুবাদের ব্যবস্থা করার জন্যে অ্যাঞ্জেলা ক্লার্ক-এর সঙ্গে 0191 210 6422 - এই নম্বরে যোগাযোগ করুন।"

本資料文件可以因應要求翻譯為其他語文。請致電 0191 210 6422，與 Angela Clark 聯絡，以便作出有關安排。

निवेदन करने पर यह जानकारी दूसरी भाषाओं में मिल सकती है। अनुवाद की व्यवस्था करने के लिए कृपया एन्जला क्लार्क को 0191 210 6422 पर संपर्क करें।

"Mediante pedido, esta informação pode estar disponível noutros idiomas. Queira contactar Angela Clark pelo telefone 0191 210 6422 para organizar uma tradução".

“ਇਹ ਜਾਣਕਾਰੀ ਦੂਜੀਆਂ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਬੇਨਤੀ ‘ਤੇ ਉਪਲਬਧ ਕਰਾਈ ਜਾ ਸਕਦੀ ਹੈ। ਕਿਰਪਾ ਕਰਕੇ ਏਂਜਲਾ ਕਲਾਰਕ ਨੂੰ ਨੰਬਰ 0191 210 6422 ‘ਤੇ ਤਰਜਮੇ ਦਾ ਇੰਤਜ਼ਾਮ ਕਰਾਉਣ ਲਈ ਸੰਪਰਕ ਕਰੋ।”

درخواست کرنے پر یہ معلومات دوسری زبانوں میں بھی فراہم کی جاسکتی ہیں۔ ترجمے کا انتظام کرنے کیلئے براہ کرم انجیلا کلارک (Angela Clark) سے 0191 210 6422 پر رابطہ کریں۔

**This document is available in large print and
on audio tape.
Please contact Angela Clark on 0191 210 6422.**

“Commissioning a Patient-Led NHS”

Hartlepool Borough Council’s response to the County Durham and Tees Valley Strategic Health Authorities consultation document on new Primary Care Trust arrangements in County Durham and the Tees Valley

1. Introduction, Background and Purpose of this Paper

- 1.1 On 28 July 2005, Sir Nigel Crisp, Chief Executive of the NHS, issued a policy document – “Commissioning a Patient-Led NHS” in which he set out his views on the next steps in creating a patient led NHS. The document builds upon the “NHS Improvement Plan” (1) and “Creating a Patient-Led NHS” (2) and is intended to create a step change in the way services are commissioned by frontline staff to reflect patient choices. The policy outlines a programme of reform to improve health services. It includes proposed changes to the roles and functions of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs), which will have implications for the configuration of these organisations.
- 1.2 Sir Nigel Crisp expects that PCT reconfigurations will be completed by October 2006; SHA reconfiguration will be completed by 2007; PCTs will divest themselves of the majority of their provider functions by December 2008, to support the introduction of “contestability” (competition) in service provision. (The current position on provider functions seems to be that PCTs will be allowed to continue to directly provide services so long as they prove through market-testing that they are the most efficient, effective and economic providers.)
- 1.3 The first milestone related to the commissioning functions of PCTs. SHAs were required to review their local health economy’s ability to deliver commissioning objectives and submit plans to ensure they are achieved (including reconfiguration plans where required) by 15 October 2005. County Durham and Tees Valley SHA did not consider their review of their local health economy required them to consult with local authorities at that stage.
- 1.4 The SHA submitted its proposals for the implementation of “Commissioning a Patient Led NHS” (3) during October 2005, to an “expert panel” specifically established by the Secretary of State to examine all proposals. Their proposal, so far as Durham and the Tees Valley was concerned, was for a single PCT for County Durham and Darlington and a single PCT for “Teesside” through merging the existing PCTs for Hartlepool, North Tees, Middlesbrough and Langbaugh.
- 1.5 Hartlepool Borough Council had a prior arrangement for a small delegation of Councillors to accompany Iain Wright MP to meet with Liam Byrne MP, Parliamentary Undersecretary Department of Health to discuss the Darzi Report, on 8 November 2005. They took the opportunity to comment on the SHA’s proposals to reconfigure the Tees Valley PCTs.

(1) NHS Improvement Plan – Putting People at the Heart of Public Service (Department of Health, June 2004)

(2) Creating a Patient led NHS – Delivering the NHS Improvement Plan (Department of Health, 17 March 2005)

(3) Commissioning a Patient led NHS – proposal for implementation in Northumberland, Tyne and Wear and County Durham and Tees Valley Strategic Health Authorities

- 1.6** Having received the advice of the expert panel, and taking into consideration “representations from other interested parties”, the Secretary of State informed the SHA that proposals for the reconfiguration of SHAs and PCTs could go forward for consultation on the following basis:-

- 1 option for a SHA for the Government Office of the North East Region.
- 2 options for PCTs:-
 - Option 1 – two PCTs, a County Durham and Darlington PCT and a Teesside PCT.
 - Option 2 – six PCTs, retaining the five Tees Valley unitary authority PCTs and a single County Durham PCT.

The consultation period commenced 14 December 2005 with a completion date of 22 March 2006.

- 1.7** Sir Nigel Crisp has stipulated that proposals will be assessed against the following criteria:-

- Secure high quality, safe services;
- Improve health and reduce inequalities;
- Improve the engagement of GPs and rollout of practice based commissioning with demonstrable practical support;
- Improve public involvement;
- Improve commissioning and effective use of resources;
- Management financial balance and risk;
- Improve co-ordinating with social services through greater congruence of PCT and Local Government boundaries;
- Deliver at least 15% reduction in management and administrative costs.

As a general principle, he said “we will be looking to reconfigured PCTs to have a clear relationship with local authority social services boundaries”.

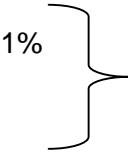
- 1.8** The SHA produced a formal document – “Consultation on new Primary Care Trust arrangements in County Durham and Tees Valley” – which David Flory, Chief Executive of the SHA presented to the Adult and Community Services and Health Scrutiny Forum on 14 February 2006. Council, at its meeting on 16 February 2006 resolved as follows:-

- To support a continued Hartlepool PCT with a management team based in Hartlepool working closely with the Council and through the LSP in order to minimise management costs and increase local control over decisions about health services (as argued in an independent report commissioned by the LSP).
- That Scrutiny Co-ordinating Committee should establish whether Option 2 in the current SHA consultation document meets this objective.
- That Scrutiny should consider whether the SHA consultation document treats options 1 and 2 even-handedly, as required by Ministers, in expressing the unanimous view of PCT Chief Executives that option 2 is “unworkable”.
- That Scrutiny should consider whether to recommend to the Council that the proposals contained in the LSP’s 2005 report be submitted to Ministers with relevant updated supporting material as the Council’s preferred option (see Appendix 1).

2. Discussion Points

2.1 What is a PCT?

The inference in the SHA consultation document is that a PCT merely consists of a PCT Board and its Professional Executive Committee (PEC), but does not include any employees. If the definition of a PCT can be shown conclusively to include employees, then the consultation process is flawed. Consultation is only being conducted on the original SHA proposal with that “option” being dressed up as two.

Cost, Accountability, Responsibility	Option 1	Option 2
1% 	2 x Board	6 x Board
	2 x PEC	6 x PEC
99%	2 x Management/ees	2 x Management/ees

2.2 Workable Options?

The consultation document states for option 2:-

“There has been previous experience of sharing director posts across two PCTs in the area and this proved unworkable. The existing PCT chief executive community does not believe that it would be possible to work effectively in this way.”

The statement effectively dismisses option 2 as being viable. However, the comments relate to management working practices which would be the same under both options. Therefore if option 1 is unworkable, so is option 2, thus we have no workable option to consider. The consultation process is flawed.

2.3 Responsibility and Accountability (Option 2)

The six PCT Boards will be responsible and accountable for their own actions, but how will they be held to account for the financial consequences of their decisions if management arrangements are pooled? For example, if Hartlepool's Board makes decisions, which results in them having a financial deficit, will it be picked up by the other partners? If so, how will Hartlepool's Board be held to account?

2.4 Savings in Overhead Costs

Sir Nigel Crisp requires £250 million of savings in overhead costs. The SHA state this equates to £6 million for County Durham and the Tees Valley.

	Option 1	Option 2	True Coterminosity
	£m	£m	£m
Reduce number of Boards and PECs:-			
8 x Boards	4		
4 x Boards		2	2
Reduce SHAs (2 to 1)	2	2	2
	<hr/> 6		
	<hr/>	2	
Merge management and admin staff in Teesside	N/A	<hr/> 6	
		<hr/>	
Integrate PCT management and commissioning teams with local authority commissioning teams (a)			0.5(?)
SHA merged with GONE (b)			0.5(?)
Back office functions administered by regional/national hubs (c)	?	?	?
	<hr/> £6m+	<hr/> £6m+	<hr/> £5m+
	<hr/>	<hr/>	<hr/>

- (a) Rather than merging the four “Teesside” management and administrative functions into one central organisation to achieve economies of scale, economies can be obtained by merging PCT and the Local Authority Commissioning Teams, with management being provided by the local authority and/or joint appointments.
- (b) GONE currently “manages” a Regional Planning Board, Regional Transport Board, Regional Housing Board etc. Why does Health need to be treated differently? Removal of SHAs altogether will produce further savings.
- (c) Sir Nigel Crisp’s letter of 28 July 2005 states:-

“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.” Back office savings are not included in the consultation paper costings.

2.5 North East – A Special Case?

The SHA appears to assume that the prime consideration under this review is to make the savings specified. The Council believes that providing the best possible health and social care services for local people should be the desired outcome. This will be best achieved through further integration of PCT and Council commissioning teams, which is also the Government's view, as expressed in the recent White Paper – "Our Health, Our Care, Our Say".

In other areas of the country eg Lancashire, the concept of true coterminosity has been accepted, with savings being made in PCTs other than those based upon unitary council boundaries. The North East is unique in having such a high proportion of unitary councils (10 out of 16 PCT areas) that the required savings can not be made within the remaining areas.

2.6 Assessment Against Criteria

SHA has assessed Options 1 and Option 2 against the specified criteria, but how was that assessment carried out? Objective or subjective? An assessment of Option 3, with brief reasons to support that assessment, is also set out below. (NB the crosses and ticks are relative measures.)

	<u>Option 1*</u>	<u>Option 2+</u>	<u>True Coterminosity</u>
▪ Secure high quality, safe services	✓	x	✓
▪ Improve health and reduce inequalities	✓	x	✓
▪ Improve the engagement of GPs and rollout of Practice based Commissioning with demonstrable practice support	x	x	✓
▪ Improve public involvement	x	x	✓
▪ Improve commissioning and effective use of resources	✓	?	✓
▪ Manage financial balance and risk	✓	x	x
▪ Improve co-ordination with social services and other local authority services through greater congruence of PCT and local government boundaries.	x	x	✓

* Assessment taken from SHA submission to Government, October 2005

+ Assessment taken from current SHA Consultation document, December 2005

“True Coterminosity” Assessment

Secure high quality, safe services

There is no evidence to suggest that PCTs are unable to commission safely. The inference from the consultation document and the presentation of it is that safety concerns are more about the lack of resource in the acute provider sector and not the commissioning agencies. Integration with Council commissioning services should produce more efficient and effective commissioning.

Improve health and reduce inequalities

It is recognised nationally that good partnership working across public sector agencies within localities is essential in reducing health inequalities. True coterminosity with integrated commissioning will enhance partnership working.

Improve the engagement of GPs and rollout practice based commissioning with demonstrable practice support

The consultation document recognises good arrangements currently exist and therefore will continue with true coterminosity.

Improve public involvement

The consultation document recognises these have been substantial improvements in public involvement over the past 3 or 4 years. A more remote PCT would lose these benefits, whereas true coterminosity will provide the platform on which to build.

Improve commissioning and effective use of resources

Surprisingly, given the importance of this criterion to NHS management, there is no reference to it in the consultation document. The SHA submission to Government states that the current system of 16 PCTs across the North East with 16 commissioning teams led by 16 directors of commissioning and/or performance ties up too much finance and makes capacity difficult to maintain. However, it then goes on to relate this capacity problem solely to the commissioning of acute services.

It seems that this concentration on acute commissioning is being allowed to jeopardise longstanding and effective commissioning arrangements with local authorities across the range of services for vulnerable people. There is no evidence to support the SHA view that larger PCTs can influence the acute commissioning agenda to a greater extent than the present structure, whilst at the same time working with local authorities on joint commissioning of non acute health and social care services.

The effectiveness of commissioning of acute services is not necessarily as a consequence of the size of the PCT. It is more likely to depend on the degree of delegation given to PCTs. True coterminosity with greater integration of PCT and local authority commissioning teams will improve the efficiency and effectiveness of those non acute services.

Manage financial balance and risk

There is no evidence to support the SHAs contention that larger PCTs have a greater ability to avoid or deal with financial difficulties. Indeed, these are concerns that measures taken within a larger PCT to alleviate overspending might result in unfair allocation of funds across existing PCT communities. Financial balance is heavily dependant upon Government policy and national decision-making.

True coterminosity will not improve upon the current risk of financial imbalance.

Improved co-ordination with Social Services and other local authority services through greater congruence of PCT and local government boundaries

Only true coterminosity will fulfil this criterion.

Overall Assessment

Option 1

“This option is contentious because of the risks that we may not be able to meet our partners’ needs for close working in vital areas of service provision such as older people, children and people with mental health problems and learning difficulties, or we may not be able to main a close and “local” relationship with GPs and other clinical and social care staff in the community.”

(SHA Submission to Government, October 2005)

Option 2

Risks are similar to Option 1 although the consultation document is written in a manner which suggests the risks are even greater under Option 2.

True Coterminosity

True coterminosity with greater integration of PCT and local authority commissioning teams is the best fit with the criteria laid down by Government.

2.7 Tees Valley Joint Submission

Stockton-on-Tees Borough Council has taken the lead role, on behalf of the Tees Valley Councils, in drafting up a joint submission supporting the coterminosity of PCT boundaries with those of the five local authorities. The draft document attached as appendix 2 has been approved by the Elected Mayors/Leaders of these authorities.

3. Decisions Required

- 3.1** Agreed to write urgently to the Secretary of State requesting her definition of the elements, which make up a PCT. Suggest the definition should include as a minimum:-

- PCT Board and Professional Executive Committee;
- Management and Commissioning employees.

And if it can be shown they are the most efficient, effective and economic means, then also:-

- Employees providing back office functions;
- Employees directly providing health services to the public.

- 3.2** Agree the consultation process is flawed in that the SHA has not consulted on the two options required by the Secretary of State (one option dressed up as two).

- 3.3** Agree the consultation process is flawed in that the SHA have not presented any workable options (if option 2 is not workable, neither is option 1).

- 3.4** Agree the consultation process is flawed in that Option 2 does not identify how six PCTs will be responsible and accountable for their activities, particularly with regard to finance, when working through two merged management and administrative teams.
- 3.5** Agree that the options presented by the SHA do not fit the requirements of the Children Act and the White Paper – “Our health, Our care, Our say – for the integration of health commissioning with Children’s Trusts and Adult Social Care Commissioning arrangements.
- 3.6** Agree true coterminosity as being the correct second option required by the Secretary of State.
- 3.7** Agree to write urgently to ANEC urging them to lobby Government that the North East is a “special case”.
- 3.8** Agree to write urgently to the SHA requesting them to cost savings to be made for integrating PCT management and commissioning teams with those of unitary councils.
- 3.9** Agree to write urgently to the SHA requesting them to cost savings to be made by merging the SHA with GONE.
- 3.10** Agree to write urgently to the SHA requesting them to cost savings to be made through regional and/or national administration of back office functions.
- 3.11** Agree the assessment true coterminosity against the required criteria.
- 3.12** Agree to support the Tees Valley Joint Submission.

‘LOCALITY PLUS’

RETAINING A COTERMINOUS PCT IN HARTLEPOOL

INTRODUCTION

This document is a submission from the Hartlepool Partnership in respect of the proposals for PCT reconfiguration arising from *Commissioning a Patient-Led NHS*, and the submission made by Northumberland, Tyne and Wear, and County Durham and Tees Valley Strategic Health Authorities [1]. It presents the case for the retention of Hartlepool PCT in respect of its coterminous boundaries with Hartlepool Borough Council, as opposed to the ‘single Tees PCT’ option proposed by the two SHAs.

Hartlepool PCT commenced operation in April 2001 and was awarded 3-star status in 2005. It has a coterminous boundary with the local authority. Hartlepool Borough Council has been given an “excellent” Comprehensive Performance Assessment (CPA) rating for each of the last 3 years and its Local Strategic Partnership, which is chaired by Iain Wright MP with the Mayor as vice-chair, has been given the top rating by the Government Office for the North East (GONE). Social Services have been awarded a consistently high 2 star rating for several years. Hartlepool is therefore a high performing ‘city state’ – achievements of which the town is proud and which should not be put at risk without due consideration of the consequences.

The reconfiguration issue was discussed by Hartlepool PCT Board on 6th October 2005, at which the Board strongly indicated its “preference to maintain a Hartlepool Primary Care Trust, which had local ownership, addressing local needs and avoiding the potentially damaging effect of organisational change on staff”.

At its meeting on 15th September 2005 the full Hartlepool Borough Council resolved to agree the views of its Cabinet, namely:

”Hartlepool PCT remains in its current form and develops

- Stronger links to the Local Strategic Partnership
- Formal pooled commissioning budgets and governance arrangements between the PCT and the Council
- Local Area Agreements
- Democratic accountability;

and Council supports the PCT in requesting that this option be included as part of the Strategic Health Authority’s consultation process.”

It is clear, therefore, that there is strong support from the main public sector bodies in Hartlepool for the retention of a coterminous relationship. Moreover, the agencies are of the view that this is also the preference of the people of Hartlepool themselves. It is within this context of strong local opinion that the future configuration of the local NHS needs to be considered.

This document is structured in the following way:

Appendix 1

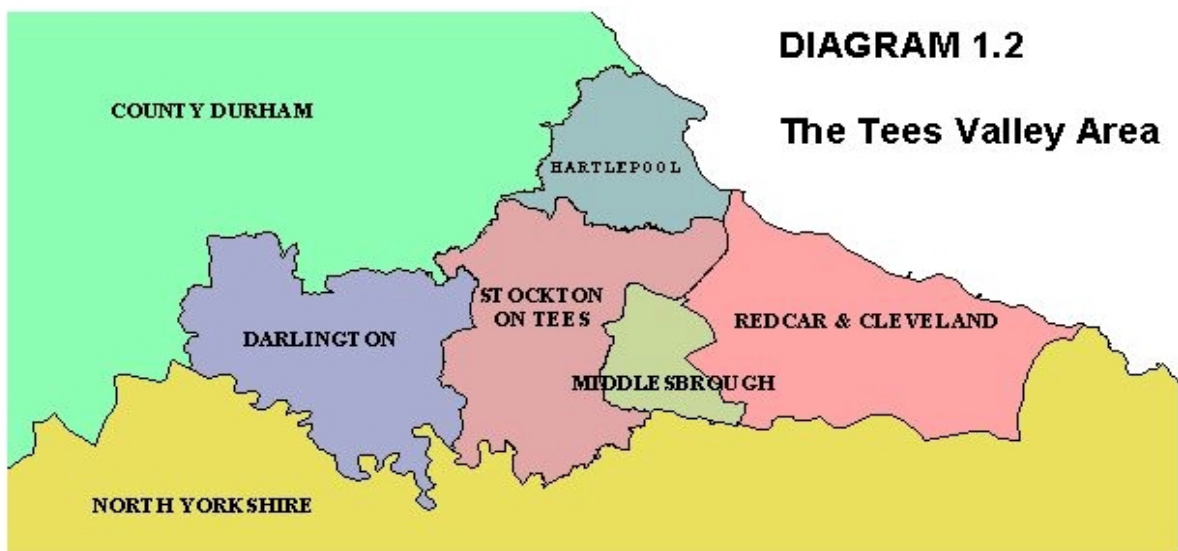
- Part I briefly refers to the distinctiveness of the Hartlepool location, history and culture and describes the health and Council configuration for Hartlepool;
- *Part II* describes some of the achievements in Hartlepool relevant to the case;
- *Part III* identifies relevant plans that are contingent upon the continuation of coterminosity;
- *Part IV* offers a risk assessment of the proposed Tees PCT option.

PART I: The DISTINCTIVE POSITION of HARTLEPOOL

It is important to emphasise the *distinctiveness* of Hartlepool. The town is not a recent creation - the first recorded settlement was at the Saxon Monastery in 640AD, and the first charter for the town was issued in 1145. The town as it is today has grown around the natural haven that became its commercial port, and around which its heavy industrial base developed. The areas vacated by heavy industry are now populated by high quality business facilities and exciting visitor attractions.

The Borough of Hartlepool covers an area of over 36 square miles and has a population of around 90,000. It is bounded to the east by the North Sea and encompasses the main urban area of the town of Hartlepool and a rural hinterland containing the five villages of Hart, Elwick, Dalton Piercy, Newton Bewley and Greatham.

The Borough comprises part of the Tees Valley area, formed by the five boroughs of Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-on-Tees. Diagram 1.2 shows Hartlepool in its regional and local settings.



This geographical distinctiveness of Hartlepool has some major implications for *Commissioning a Patient-Led NHS*. First, Hartlepool is a compact, sustainable settlement within which most of the needs of the residents in terms of housing, employment, shopping and leisure can be met. Secondly, this has resulted in a very strong sense of ‘belonging’ – a distinct sense of civic pride.

Appendix 1

The creation of Hartlepool Borough Council in 1996 was a tangible and highly popular recognition of this distinctiveness, and a reaction to the unpopularity of the former Cleveland County Council – indeed, it is worth noting that the proposed Tees PCT would recreate these old Cleveland County Council boundaries. As well as acquiring unitary status, Hartlepool BC has also developed one of the few elected mayor systems in the country – a highly successful development that has reinforced a culture of civic pride. The Borough also has its own MP, Iain Wright, who plays a leading role in supporting partnership working across the Borough.

Hartlepool faces many problems associated with deprivation. The English Indices of Deprivation 2004 [2] rank Hartlepool as being the 11th (concentration), 12th (average score), 15th (extent) and 18th (average rank) most deprived district nationally, and there are multiple symptoms of social and economic decline such as unemployment, crime and major health issues. Priority is attached to these issues through the Local Strategic Partnership and for example the proposed spending profile for neighbourhood renewal funding in the period to 2008. The view within Hartlepool is that these problems need to be [and are being] tackled *in partnership* with others – it is the reason why we have titled this paper ‘*Locality Plus*’. Health is one of the most important partners. As one of the most deprived areas in England, Hartlepool PCT has been designated as a Spearhead PCT charged with delivering the public health targets earlier than other areas – a task that can only be achieved through joint working with other local partners.

PART II ACHIEVEMENTS of the HARTLEPOOL PARTNERSHIP MODEL

The Local Strategic Partnership (LSP) is known as the **Hartlepool Partnership**. This key Borough-wide strategic planning mechanism consists of a network of partnerships and statutory, business, community and voluntary sector partners working in the best interests of the residents of the Borough. It is afforded a very high priority by its 40+ members and is chaired by the town’s MP, Iain Wright with the elected Mayor as vice chair. Hartlepool PCT is a core and vital member of the Partnership. The Hartlepool Partnership model has already registered a number of significant achievements relevant to health and wellbeing:

The Community Strategy

The Community Strategy is the product of the Local Strategic Partnership [LSP]. It serves to:

- bring together the different parts of the public sector and the private business, community and voluntary sectors;
- operate at a level that enables strategic decisions to be taken, while still close enough to individual neighbourhoods to allow actions to be determined at a local level;
- create strengthened, empowered, healthier and safer communities.

The Community Strategy consists of seven themes, each with a Priority Aim.

THEME	PRIORITY AIM
Jobs and the Economy	Develop a more enterprising, vigorous and diverse local economy that will attract investment,

Appendix 1

	be globally competitive and create more employment opportunities for local people
Lifelong Learning and Skills	Help all individuals, groups and organisations realise their full potential, ensure the highest quality opportunities in education, lifelong learning and training, and raise standards of attainment
Health and Care	Ensure access to the highest quality health, social care and support services, and improve the health, life and expectancy and wellbeing of the community
Community Safety	Make Hartlepool a safer place by reducing crime, disorder and fear of crime
Environment and Housing	Secure a more attractive and sustainable environment that is safe, clean and tidy; a good infrastructure; and access to good quality and affordable housing
Culture and Leisure	Ensure a wide range of good quality, affordable and accessible leisure and cultural opportunities
Strengthening Communities	Empower individuals, groups and communities, and increase the involvement of citizens in all decisions that affect their lives

Although Health and Care is the most evident way in which health issues are integrated into a wider strategy, it is evident that *all* of the themes impinge upon the health and wellbeing of Hartlepool residents. The Health and Care theme is the responsibility of the Health & Care Strategy Group [H&CSG], a multi-agency group chaired by the CEO of the PCT that sets the strategic direction for the development and provision of health and care services across all care groups. It oversees the work of the Planning Groups, Local Implementation Teams and Partnership Boards, and – through the Local Delivery Plan – links to the community strategy and other plans across the LSP. There are seven planning groups that feed into the H&SCG:

- welfare to work group [for people with disabilities]
- supporting people
- mental health LIT
- older persons NSF LIT
- health inequalities group
- learning disabilities partnership board
- children and families planning group

This is a broad approach to health and wellbeing, and one that encourages the PCT to work constructively and effectively with key local partners. Currently the PCT has two members on the H&SCG, alongside membership from the various parts of the Borough Council, the voluntary sector, police and probation, and hospital trusts. The LSP and the resultant Community Strategy are seen as crucial to the enhancement of health and wellbeing. The loss of the locally-focused PCT as a key partner would be of serious concern to the partners and – more importantly – make health improvement for the people of Hartlepool more difficult to achieve.

The Local Area Agreement

Appendix 1

Our achievements have resulted in a successful application to join Round 2 of Local Area Agreement [LAA] development, and the award of 'single pot' status. Single pot recognition has been based upon several factors:

- the unique geographic and organisational circumstances within the unitary authority area;
- the record of delivery by local agencies;
- an integrated strategy based on clear priorities;
- an elected Mayor and effective partnership arrangements;
- an accredited performance management framework.

The vision and expectation for the LAA is that it will establish simplified and streamlined local governance arrangements in which local agencies have the freedom and flexibility to deliver in a manner that suits local circumstances. Joint arrangements are central to this vision, and both the Borough Council and the PCT are seeking ways to use the LAA to further refine joint working and reinforce the community and public health agenda [3]. *Delivering the NHS Improvement Plan* [2005] refers to the relationship with local authorities as 'crucial' and states: 'all PCTs need to play strongly into LSPs and, where applicable, LAAs' [para 5.11]. This has been precisely the strategy for Hartlepool PCT.

In the context of the public sector reform agenda, the Council and its partners have a longer-term aspiration that the LAA will provide a platform for developing locality based governance with enhanced democratic oversight of services in Hartlepool. It is intended to pursue this with GONE as part of the ongoing negotiations around the LAA. The Council, PCT and other partners consider that the Hartlepool LAA will bring significant opportunities to establish arrangements in which local agencies have the freedom and flexibility to get on and deliver for the people of the town – and health is a critical part of this opportunity. We are not simply referring here to traditional Section 31 arrangements – our ambition for a 'Locality Plus' approach stretches to every part of the economic, health and wellbeing agenda of the locality.

This unique opportunity to develop a locality-wide 'single pot' strategy amongst local partners will be significantly undermined if a local PCT is no longer sitting round the table. We intend to vigorously pursue the 'Next Steps' agenda laid out in the Carolyn Regan letter of October 5th and believe we are in a very strong position to do so given the right partnership configuration. Within the Hartlepool Partnership we are committed to working across boundaries and we look to central government to encourage us in this mission.

Policy Networks

In Hartlepool we understand that plans, structures and processes are driven by individuals who meet regularly, are committed to a local focus and have a high degree of mutual trust and respect. We have several policy network forums, involving both elected representatives and senior officers, with PCT involvement:

Appendix 1

- The '*Foresight Group*' is an informal meeting which originally comprised the PCT CEO, the Cabinet member with the portfolio for social services, and the Director of Social Services. It now includes the Cabinet members with responsibility for Children and Adult services, the Acting Director of Social Services, and the Assistant Director of Social Services. The purpose of the group is to look at the strategic development of health and social care across Hartlepool.
- The PCT Management Team and the Borough Council SSD Directorate Team meet regularly as a Joint Directorate.
- The Cabinet of Hartlepool BC and the Board of the PCT meet as the Joint Forum to discuss shared concerns, priorities and new policy developments.

The PCT and Borough Council firmly believe that the loss of Hartlepool PCT will seriously weaken these important mechanisms and reduce significantly future opportunities to develop increased democratic accountabilities. The next phase of our governance agenda is to develop more formal arrangements to underpin our relationship, and this will be difficult to achieve with a Tees PCT.

Joint appointments and collaborative working

These networks have already had an impact with a commitment to exploring the scope for joint appointments. The two statutory agencies have now jointly appointed a Director of Public Health to take forward the shared agenda, as well as a joint Head of Mental Health who is managed by the PCT Director of Planning and Assistant Director of Social Services. In addition the Joint Forum has agreed to work towards a 'collaborative commissioning' approach for learning disability and mental health services [in 2005] and older people's and children's services [2006]. In the future the Council and PCT would wish to explore further opportunities for joint appointments and collaborative working, in relation to support arrangements as well as commissioning requirements.

PART III PLANS and ASPIRATIONS

Although our achievements in Hartlepool have been substantial, we have no intention of lessening the pace of change. The main vision and blueprint for the future is the '*Vision for Care*' agenda that has been developed jointly by the PCT and Borough Council on behalf of the H&CSG of the Hartlepool Partnership. It has been endorsed by the Board of the PCT, Borough Council Cabinet and the Hartlepool Partnership. A fundamental element of the vision is the development of multi-disciplinary, multi-agency teams working together, focusing on a whole person's needs, sharing information and budgets, and using the same systems and procedures. *Vision for Care* has been given high priority by all of the partners involved, with a large amount of management time dedicated to ensuring its implementation. The PCT has invested in a Director of Partnerships, Vision for Care, who is working with the partners to drive the policy forward.

Notwithstanding the uncertainty about the current provider activities of PCTs, the drive for multi-disciplinary working will still need to be addressed and commissioned.

Appendix 1

Given the pending shortage of community nurses, we see an integrated workforce approach as an essential part of the future equation, and this implies a closer relationship with social care and the wider local authority. Indeed, this seems to be the conclusion coming from DH – the recent publication ‘*A Workforce Response to LDPs: A Challenge for NHS Boards*’ has asked NHS Boards to improve the integration of health and social care staff, and develop strategies for redesigning staff roles to counter staff shortages in community nursing.

The recent announcement by the Secretary of State that ‘*district nurses, health visitors and other staff delivering clinical services will continue to be employed by their PCT unless and until the PCT decides otherwise*’ suggests that it is still possible for the PCT and HBC to continue plans for integrated community teams. In Hartlepool we already have integrated teams for mental health services, learning disability services, intermediate care, Sure Start and the youth offending team. However, our plans for multi-disciplinary working go far beyond this. We are planning to develop ‘primary care centres’ in neighbourhoods where people will be able to access a wide range of services including GPs, nurses, therapists, social workers, home carers, advice workers, some specialist services and shops and leisure facilities. The PCT has identified four ‘natural communities’ across the town that are coterminous with social services older people’s teams and the Neighbourhood Forum areas.

The recent social care Green Paper, *Independence, Wellbeing and Choice* emphasised the need for innovative approaches to meeting local need, and singled out the Connected Care model as one that Government wished to see developed. In Hartlepool we are already developing a Connected Care model following a visit to the Owton area of the town by officials from DH, ODPM and Turning Point. Agreement was reached to sponsor a pilot project in Owton, and the intention is to engage other Hartlepool communities in similar ways to inform the commissioning and delivery of services.

This model is intended to address the broader aspects of care for people, including those with ‘complex’ needs, and a key feature is the provision of ‘bespoke’ personalised care. Partnering is anticipated between social care providers, the police, courts, housing, employment and health, and the model is organised around several common principles:

- single point of entry
- common assessment
- shared information
- managed transitions between services
- co-location of health, social care and voluntary services
- round the clock support

The pilot is not only relevant to the pending White Paper on out of hospital care, but also to *Choosing Health* and *Supporting People*. It constitutes an excellent example of partnership working across a compact and coterminous locality. We are not convinced that this sort of innovation would flourish if the PCT was outside of the local governance arrangements. It is at this neighbourhood level that the strength of coterminosity between local partners has strengths that could not realistically be sustained by a more distant partner. The neighbourhood is the critical level at which people engage, and at which change is delivered on the ground. The Government’s five year strategy on sustainable communities [4] states that:

‘Neighbourhoods are the areas which people identify with most, the places where they live, work and relax. We intend to put more power in the hands of local people and communities to shape their neighbourhoods and the services they rely on – including housing, schools, health, policing and community safety’ [p18].

Central to the Government’s subsequent proposals for more neighbourhood engagement is the desire to develop responsive and customer-focused public services with opportunities for communities to influence and improve the delivery of public services. Crucial to this vision is the need for bodies operating at neighbourhood level to have effective partnerships between themselves – sometimes they are tackling the same or similar problems, even dealing with the same people, without knowing it. It is this recognition that underpins the *Together We Can* strategy recently launched by the Government [5] which identifies three essential ways of neighbourhood working:

- *active citizens*: people with the motivation, skills and confidence to speak up for their communities and say what improvements are needed;
- *strengthened communities*: community groups with the capability and resources to bring people together to work out shared solutions;
- *partnership with public bodies*: public bodies willing and able to work as partners with local people.

This is an innovative and challenging agenda to which Hartlepool PCT is fully committed and one that we believe would be at risk should the PCT functions be subsumed within a larger Tees PCT.

PART IV TEES PCT OPTION: RISK ASSESSMENT

Strengths of the Tees PCT Model

We understand the reasoning behind CPLNHS and we acknowledge the fact that the advent of both practice-based commissioning and payment by results needs a strong commissioning role to be in place. On the other hand, it is widely acknowledged that in the creation of large [and therefore seemingly stronger] PCTs, there is the danger of losing sensitivity to local needs along with the loss of valued partnering arrangements. There is no easy answer to this dilemma, and certainly no ‘perfect solution’.

In respect of the nine criteria for reconfiguration judgement laid down in CPLNHS, the SHA [1] concedes that *‘some criteria are better met by smaller organisations, some by larger’*. We wish to argue that it is possible to have the best of all worlds with our model based upon the principles of *‘mixed mode commissioning’* and *‘subsidiarity’*.

The main gain that could be expected from a single Tees PCT is that of greater commissioning leverage, and we acknowledge that a smaller stand alone PCT like Hartlepool would not possess such leverage. This is an important issue, but should not be overstated. First, the PCT has long recognised the need to work collaboratively across Teesside in a number of areas around strategic planning and collaborative commissioning, and proposals would have been coming to the PCT Board to enter

into a Tees and Easington Commissioning Consortium even if CPLNHS had not been forthcoming. We see no reason why a stand alone Hartlepool PCT could not enter into sensible collaborative commissioning arrangements with a wider Tees PCT under some federative arrangement.

Secondly, the benefits of merging cannot be assumed. In a review of the evidence, Field and Peck [6], for example, concluded that:

‘...strategic objectives are rarely achieved, financial savings are rarely attained, productivity initially drops, staff morale deteriorates, and there is considerable anxiety and stress among the workforce.’

Strengths of the Hartlepool PCT Model

We believe the strengths of the Tees Model can be compensated for in other ways, but the strengths of the stand alone Hartlepool PCT will be difficult to replace by a ‘locality’ arrangement made by a distant Tees PCT.

The Strength of Coterminosity

We have already demonstrated that Hartlepool PCT is an embedded partner at strategic level [in the Hartlepool Partnership] and at neighbourhood level. All are agreed that coterminosity between local authority and PCT boundaries is important, but it seems to be more important to some than others. CPLNHS notes that: *‘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.’*

Our SHA submission acknowledges the coterminosity principle but in practice has disregarded it in favour of what it believes is a stronger commissioning function. Not all SHAs take such a line – the submission by Cumbria and Lancashire SHA, for example, describes the coterminosity principle as *‘fundamental and immutable’*, and goes on to propose the retention of coterminosity for Blackpool PCT and Blackburn with Darwen PCT. Similarly, the South Yorkshire SHA submission rejects the concept of a ‘South Yorkshire PCT’ in favour of 4 PCTs coterminous with the 4 local authorities.

It is vital to emphasise that the SHA proposal for Hartlepool would leave us with a large PCT that has no coterminosity with any local authority. This is not in the best interests of the health and wellbeing of the residents of Hartlepool.

Capitalising on the ‘Out of Hospital’ Agenda

CPLNHS states that one of the purposes of the 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. It is said that: *‘The White Paper will undoubtedly explore different service models. This may mean that SHAs and PCTs will want to refine proposals on service provision.’*

Appendix 1

All of this is expected to lead to *‘more diverse community services providing earlier intervention and diagnosis, better support for people with long-term conditions, more day case procedures, and more effective care for people discharged from hospital’*.

We have demonstrated that through such initiatives as the Connected Care model, the Hartlepool partners are already at an advanced stage in this respect, and the PCT is keen to work with its partners to develop the emerging out of hospital agenda. Around 80% of the commissioning resources of the PCT are health focused and commissioned with other PCTs, whilst 20% has a joint NHS-local authority commissioning approach – an important contribution that we would wish to see increased. The PCT and local authority responded jointly to the Green Paper consultation. In doing so the partners welcomed the direction of travel and indicated that they were already developing person centred services rooted in a preventive model. It is crucial that this work continues and we believe a Hartlepool PCT is best placed to carry it forward.

Engaging with Practice Based Commissioning

The PCT has a sound relationship with local clinicians and it is important that this is not put in jeopardy by unsuitable structural change. The PCT is supportive of the shift to PBC, and our view is that it is vital that the close understanding and trust between the PCT and GP constituency is sustained during this important phase of change. The PCT PEC is also anxious that a local PCT remains in existence in order to deliver a locally sensitive shift to PBC, and there is concern that local understandings and networks will be lost in a wider configuration.

It is important in all of this to remember that the end product of PBC needs to be improvements in services for patients – PBC is not an end in itself. These improvements will be in new community based services, and ensuring that PBC is an integral part of the commissioning cycle that involves other players, partners and members of the public. In effect, then, the issue for PBC is the ways in which it engages with the wider ‘Hartlepool Agenda’ such that it can properly shape referral patterns into secondary care and into community based services. A Hartlepool PCT is the vehicle for ensuring this happens.

There will also need to be sufficient local flexibility to deal with differing local needs and the capacity and willingness of GPs to engage with the PBC agenda. This is especially true in Hartlepool, where although there is agreement to work on a single town wide commissioning group, many of the practices are currently unsuitable for practice development and the provision of a wider range of services. We believe there is still an important role here for a PCT that is coterminous with *both* the local council and the PBC governance forum. This role would consist of:

- acting as the purchasing agent: negotiating and monitoring contracts and – in federation with the Tees PCT – reducing transaction costs;
- performance managing the town wide commissioning group, ensuring local and national targets are met and financial balance achieved;
- ensuring appropriate access to public health and service improvement expertise;
- providing support to the commissioning group.

Engaging with Payment by Results

One of the criteria by which reconfiguration proposals will be judged is the ability to engage with the roll out of payment by results [PBR]. We understand that PCTs will face risks under this regime since they will be committed to paying for work at a nationally set price, but will have only limited influence over volumes. On the other hand PCTs will have an incentive to manage demand for acute services in order to reduce unnecessary admissions, and to develop appropriate community based alternatives to hospital. It is in these two respects that our relationship with our coterminous partners is crucial, for PBR will not, on its own, encourage the provision of care in a more appropriate setting – this will come through a strong local partnership committed to service redesign.

Demand management has already been identified as a top priority in the Local Delivery Plan of the PCT for 2005/6 – 2007/8. However, it is our belief that the more remote the PCT, the less will be its ability to manage demand for hospital activity in a ‘whole systems’ manner, whereas a robust local partnership based in Hartlepool offers a more effective model. The introduction of practice based commissioning will also introduce incentives to manage the demand for hospital activity and develop community based services, but it is through a constellation of local partners – PCT, GPs and the local authority – that this can become a reality. Our LDP recognises the need to strengthen primary and community services in order to reduce reliance upon secondary care, but also states that:

‘Partnership work is essential to achievement; many of the targets cannot be achieved without a multi-agency approach.’

The Hartlepool Model: Mixed Mode Commissioning and Subsidiarity

Some of the functions of the NHS are best designed and delivered locally, whereas others require the influence and impact that larger commissioning units can bring. There is evidence [7] that matrix structures in which different levels of a Primary Care Organisation are vested with specific responsibilities for service commissioning can be effective. In such a model, the planning and commissioning of extended primary care services, for example, would lie with PBC, the planning and commissioning of locality wide services [like intermediate care] would rest with the local PCT and council, and services requiring a wider population based perspective [acute and specialist services] may best be dealt with at a supra-PCT levels such as that proposed for Teesside.

Appendix 1

Our view is that the guiding principle for commissioning should be that of *subsidiarity* – activities are undertaken locally unless there are compelling reasons to aggregate or centralise them. This approach encourages an explicit focus on the relationship between organisational form and function. It is a model that makes sense for a compact and distinctive unitary locality such as Hartlepool. The strength of the PCT lies in its links with the LSP and the local authority for the commissioning of innovative locality wide services, and with both the local authority and GPs for the planning and commissioning of sub-locality activity. This does leave the need for federative commissioning with neighbouring PCTs for acute and specialist services. Hartlepool PCT has good relationships with its neighbouring PCTs and is confident that it can form robust commissioning relationships through a Tees wide PCT for acute and specialist care, while retaining the strengths that come from our commitment to corporate strategic planning and ‘new localism’.

Financial Savings

We do not think it is realistic to deliver a 15% reduction in management and administrative costs from within the PCT – to do so would put at risk the very strengths that have been identified in this submission. However, we would make two points about such savings:

- Our model will lead to future savings, but this will arise not so much from merging with neighbouring PCTs as from cost sharing with the local authority;
- Our understanding is that the 15% can be gathered from across the SHA and the other PCTs – it does not require *each* PCT to find the same level of savings.

If Hartlepool is able to retain a coterminous future with HBC, this still leaves a reduction in PCT numbers across the Durham and Tees Valley area from 10 to 3 – a reduction big enough to generate 15% savings across the patch. In addition, the SHA itself will no longer exist, further increasing the scope for saving. We would urge the panel to take a view across Durham and Tees Valley rather than apply a rigid formula to every case – the *raison d’etre* of our submission is that one size does not fit all.

Conclusion

We have examined the checklist contained in the HSMC Discussion Paper [8] and we see a strong correlation between the criteria laid out in Figure 5 and the case we have presented in this submission. In respect of the DH criteria for assessing reconfiguration, we believe the points made in this paper lead to the conclusion that a stand alone Hartlepool PCT scores more highly on the criteria than the Tees PCT proposal made by the Strategic Health Authority. Our position is summarised in the box below.

CRITERIA	TEES PCT	HARTLEPOOL PCT	COMMENT
Secure high quality, safe services	√	√	Locally with Hartlepool partners; in wider

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			arrangements where appropriate
Improve health and reduce inequalities	X	√	Through LSP and LAA
Improve the engagement of GPs and rollout of PBC with support	X	√	Sustain robust and locally sensitive relationships
Improve public involvement	X	√	PCT already locked into strong local participative forums
Improve commissioning and effective use of resources	√	√	Mixed mode commissioning and subsidiarity
Manage financial balance and risk	√	√	Both options can deliver
Improve coordination with social services and local government	X	√	Tees PCT cannot deliver here
Deliver 15% reduction in management and administrative costs	√	X	PCT cannot deliver this in isolation, but scope for cost sharing with LA and for savings across the SHA area

REFERENCES

[1] Northumberland, Tyne and Wear and County Durham and Tees Valley Strategic Health Authorities, *Commissioning a Patient-Led NHS: Proposal for Implementation*. October 2005.

[2] Office of the Deputy Prime Minister The English Indices of Deprivation 2004

[3] Hartlepool Partnership [2005], *Local Area Agreement Position Statement*.

[4] Office of the Deputy Prime Minister [2005], *Sustainable Communities: People, Places and Prosperity: A Five Year Plan*.

[5] Office of the Deputy Prime Minister/Home Office [2005], *Citizen Engagement and Public Services: Why Neighbourhoods Matter*.

Appendix 1

[6] Field, J. and Peck, E. [2003], Mergers and Acquisitions in the Private Sector: What Are the Lessons for Health and Social Services? *Social Policy & Administration*, 37[7] pp 742-55.

[7] Peck, E. and Freeman, T. [2005], *Reconfiguring PCTs: Influences and Options*. NHS Alliance/Health Services Management Centre.

[8] Glasby, J. [2005], *Commissioning a patient-Led NHS: criteria for considering the partnership implications of proposed changes*. Health Services Management Centre.

NEW PRIMARY CARE TRUST ARRANGEMENTS IN COUNTY DURHAM AND TEES VALLEY

RESPONSE OF THE TEES VALLEY LOCAL AUTHORITY CHIEF EXECUTIVES

INTRODUCTION

1. In considering the consultation document on the above issued by the SHA on 14th December 2006, the Chief Executives have taken into account a number of factors as outlined below
2.
 - the context within the proposals are made
 - a comparison with approaches adopted elsewhere in the country
 - an analysis of the options against the 'fit for purpose' criteria
 - the impact that each option might have on local partnership working
 - the application of financial models, its impact on management structure and ways of saving resources that will have the least damaging effect on the effectiveness of PCTs and Local Authorities

CONTEXT

3. Whilst covered to a degree within the document and especially in some of the criteria it is important to recognise the back cloth to the proposals. The move to have Strategic Health Authorities coterminous with Government Office areas, which we would support, reflects the recognised need to ensure that all in the Public Sector work in partnership. Such partnership is most vital at local community level and the development of Local Strategic Partnerships, shared thematic strategic plans and the emerging Local Area Agreements are all symptomatic of the way the principal public sector agencies, dominated by Local Government and the NHS, now work together. This work generates shared priorities for local communities and gathers commitment to work proactively to achieve them.
4. The health and well being agenda is rightly recognised as a shared issue. No agency on its own can ever hope to make the kind of advance envisaged in reducing health inequalities especially in communities such as those in Tees Valley. Whatever structural solution is agreed it must be fit for this purpose above any other. The recent White Paper "Our Health, Our Care, Our Say" has developed this principle and identified roles for agencies. In particular in para 2.54 the following is stated :

"Our plans to strengthen PCTs will ensure enhanced commissioning for health lies in the heart of their activities. Subject to the outcome of current local consultants on the proposed reconfiguration of PCTs and SHA boundaries we expect to see the development of greater coterminosity between health and local government bodies; both between PCTs and Local Authorities and between SHAs and Government Offices for the Region".
5. In addition to the development of health strategy Local Government and the NHS also share the responsibility of protecting and safeguarding the most vulnerable. This does not just rely on robust shared strategies but also on effective integrated implementation and performance management. Close relationships and straightforward communication channels are essential for

Appendix 2

this. Although not directly related to the consultation, the future provision of health and social care in community settings is relevant. The continued provision of integrated services often within shared management structures is vital to direct care to individuals and is the manifestation of all strategic partnership.

COMPARATIVE APPROACHES

6. In other parts of the country proposals are being developed to rectify mistaken configurations of the past. Taking West Yorkshire as an example there is a single proposal to create 5 PCTs by merging the existing 15. However this new configuration reflects coterminosity with the 5 Local Authorities and creates a simplified partnership arrangement. Economies from this are self evident and reasonable. The North East has the highest level of Unitary Authorities and it might be expected that the preservation of coterminosity would have a similar priority. Other SHAs are only consulting on the one option because proposals are so well defined.
7. There are other examples where the merger of PCTs creates sensible coterminosity and partnership. Indeed the proposal within Durham is one of them. However this approach is unnecessary in areas where the correct pattern already exists. Also worthy of challenge is the related inflexible approach to how savings are to be made. There are clearly parts of the country much better placed to make savings because of the historic profligate configuration. However some SHAs seem to have regarded the best configuration as paramount rather than the saving of money.

ANALYSIS OF THE OPTIONS AGAINST THE FIT FOR PURPOSE CRITERIA

8. Although there is no explicit indication that the seven criteria are in any way weighted, it would seem that the one relating to improving commissioning and effective use of resources is seen as fundamental. David Fiory has placed great emphasis on the need for PCTs to concentrate on this and has argued that PCTs must be able to break the dominance that hospital based NHS Trusts have in the debate about service distribution and quality. It is only through this that resources would be redirected to community and primary care from the acute sector.
9. The consultation document contrasts each option and assesses them against the seven criteria. A judgement is made in each case as to which option fits each criterion best. In reality the position is more complex as several criteria are interrelated. Indeed some rely on others to be fulfilled.

Taking each criterion in turn :

➤ **secure high quality, safe services**

- despite a suggestion that some services might not be as safe as they should ideally be, there is no real evidence that the existing PCTs (or indeed future ones) are either able or unable to commission safely. Much of the quality and safety issue relies on the way providers deliver services which is their responsibility. Those in the NHS are subject to many audit and quality frameworks both internally and externally and are themselves accountable to SHAs or the Secretary of State for this rather than PCTs. Those external to the NHS are subject to contracts.

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- if it were the case that a larger PCT might facilitate improvement in provider care this would certainly be true for non acute care but only if LAs were directly linked into the framework. An overconcentration on the problems of the acute sector leads to a mistaken belief that all other aspects of health, social and childcare can be allowed to just fit in rather than having just as much priority
 - it can also be inferred from both consultation document and presentation of it that the concerns about safe care are rather more about the lack of resource in the acute sector rather than the ability of a commissioning agency to influence provider actions. If this were indeed the case then investment in the acute sector might well continue to rise rather than be abated as anticipated.
- **improve health of the population and reducing inequalities**
- one factor recognised as fundamental to reducing health inequalities across the nation and within localities is the ability of partner agencies across the public sector and beyond to work together with shared focussed priorities that match national policy. There seems little debate that option 2 facilitates the necessary partnership arrangements whilst option 1 has the potential to damage past achievement and hinder future progress.
- **strong relationships with independent contractors and their practices and roll out practice based commissioning**
- existing PCT arrangements have fostered relationships with practitioners. Any change would inevitably jeopardise this. The very fact that it is recognised that a large PCT would have set up local arrangements to attempt to preserve relationships is to say that local arrangements are the ideal.
- **improve public involvement and develop robust communication systems**
- involvement of the public and users is the more effective if done locally and through well established mechanism that LAs and Partnerships are putting into place. Option 1 would inhibit this process or as a minimum make it more complex. In turn it is likely to reduce the effectiveness of the involvement.
- **financial balance and the management of risk**
- great emphasis is placed on the risk that any NHS organisation might encounter financial difficulties. It is also suggested that the size of the organisation influences its ability to avoid or deal with such difficulties. However this is very much opinion and there is no evidence to support the suggestion. Analysis of the 18 Trusts that have been identified for immediate turnaround support shows that 10 of the 18 organisations are NHS Trusts and 8 PCTs. It includes budgets in excess of £400m and as low

Appendix 2

as £85m but no judgement can be framed about the relationship between risk and size

- there are many other factors that influence the effectiveness of financial control
- there are several mechanisms available within the NHS that allow risk sharing and brokerage.
- in a larger PCT there would be serious concerns that a mechanism to alleviate overspending might unfairly prejudice the allocation of funds across existing PCT communities

➤ **improve co-ordination with Social Services and other Local Authority services through the greater congruence of PCT and LA boundaries**

- only option 2 fulfils this criterion; option 1 would move PCTs away from close co-ordination
- it is important to emphasise that this criterion applies across a wider range of LA functions well beyond the traditional social services area. It is this very diversity that reinforces the need for close collaboration. Very few of the LA's main functions are unaffected.

➤ **improve commissioning and effective use of resources**

- as this criterion appears to be fundamental from an NHS management viewpoint it is important that it receives a full and objective analysis. In the context of the White Paper and the general thrust of the well being agenda the ambition to control better the commissioning of acute services and hence be able to invest in community/primary ones is laudable
- where there is a potential difference of viewpoint is in the assumption that a larger PCT can necessarily influence this agenda more effectively whilst, at the same time, collaborating with LAs in the shared commissioning agenda in predominantly non acute areas
- dealing firstly with acute commissioning, the size of PCT does not necessarily influence its ability to act. That ability is more influenced by the policies that apply to the NHS commissioning model and the powers delegated to PCTs. The role of the SHA is also pivotal in that the SHA actually safeguards the process. Commissioning within the NHS is securely governed by the DH and SHAs, commissioning in the private sector is governed by explicit contract. It seems a little surprising that the NHS admits its inability to control this process and also regards a larger PCT as the solution. Also surprising is that this view is not being taken consistently across all SHAs. Also called into question is the value of having both SHA and PCT level regionally with so few PCTs. Is it not possible that the loss of the SHA level might serve the financial purpose more appropriately

- it would seem that the concentration on acute commissioning can be allowed to jeopardise the longstanding and effective commissioning arrangements with LAs across the range of services for vulnerable people. A proposal to establish locality management of a PCT only seems to show that this arrangement is the preferred model. Even if locality management were established in a larger PCT there would remain a serious concern that LAs would be obliged to adopt PCT wide policies and approaches or conversely LAs would be expected to come to a consensus on issues they would prefer to be locally decided
-
- the preferred model for LAs is for existing PCTs to continue within their shared arrangements with LAs and for acute commissioning to be undertaken in partnership between PCTs.

THE IMPACT ON LOCAL PARTNERSHIPS

10. The principle of coterminosity has influenced the development of public sector structures for many years. In the North East the principle has been adopted for some time and has successfully facilitated the development of partnerships across the main themes of the Community Strategy and emerging Local Area Agreements. The NHS has been an effective participant in these arrangements, often across all themes and not just health, adults and children. A fundamental part of this is the equivalence of membership. Invariably Chairs, Non Executive Directors, Chief Officers and Members are personally involved in the working of partnerships. This adds considerable weight to the development of strategy and the commitment to change.
11. If such membership were removed or, at best, severely limited from the PCT end it would seriously damage relationships and therefore the impact the Public Sector has in leading and achieving community development. The commitment to local initiative and drive in areas such as Health Inequalities is essential to optimise the local impact of national policy.
12. The introduction of LAAs and associated community based policy setting and delivery lends further weight to the argument for local focused partnership.

THE FINANCIAL MODEL AND ITS IMPACT ON STRUCTURE

13. The saving of management costs and its reinvestment in patient care within the locality where it is saved is the prerequisite of the proposal and therefore is a given. The argument that is used to support the general principle of larger PCTs is that by far the greater relative saving can be made in looking at Board level posts and that it would entail fewer redundancies. It is by no means clear what specific structure would support either option. Indeed in structural terms they could be very similar, albeit with different numbers of Boards. The essential feature of interest to LA is the availability of Board level commitment.
14. Whilst it is for the NHS to decide how it might implement Option 2 it is possible to identify a range of options for economising and finding value for money. Some options rely on sharing across PCTs some with LAs. Examples include :

Joint Commissioning
Financial Services
HR Services
Information and ICT Services
Governance arrangements
Property management and estate costs
Risk management
Public Health

In most of the above it is becoming common practice to find economies by such partnership and sharing.

CONCLUSION

15. The Chief Executives believe that the body of evidence supports option 2 within the Consultation Document. They do so for the following reasons :
- it develops further the already well tried coterminosity model across the North East, now supported explicitly within the White Paper
 - it quickens the pace of partnership working across the Public sector
 - it meets the requirements to develop shared health and well being priorities
 - the reservations expressed about the option's ability to strengthen NHS commissioning can be overcome in other ways
 - there is no evidence that larger organisations can be better managed financially
 - there are suitable ways available to find the required savings that should not, if well planned, infringe on the workings of PCTs

ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM REPORT

28th February 2006



Report of: SCRUTINY SUPPORT OFFICER

Subject: ACCESS TO GP SERVICES – ‘OUR HEALTH,
OUR CARE, OUR SAY’ – WHITE PAPER

1. PURPOSE OF REPORT

- 1.1 To bring to the Forum attention the attached extract from the White Paper, ‘our health, our care, our say’ which is of relevance to the issues under investigation by the Forum. **(See Appendix 2a)**
- 1.2 To set the context for receiving further evidence from the PCT.

2. OUR HEALTH, OUR CARE, OUR SAY – WHITE PAPER

- 2.1 Members at the last meeting of the Adult and Community Services and Health Scrutiny Forum held on the 14th February 2006 received a presentation from the Director of Adult and Community Services that outlined the context for the White Paper; ‘Our health, our care, our say’ and informed Members of the new direction that the White Paper sets for the health and social care system.
- 2.2 The White Paper outlines four main goals which will enable Health and Social Care Services to provide ‘**better prevention services with earlier intervention.**’ This in effect means that GP Practices and Primary Care Trusts should aim to work more closely with local government services to ensure that there is early support for prevention. It is proposed that this will be achieved by:-
 - The introduction of an NHS ‘Life Check’ for people to assess their lifestyle risks and to take the right steps to make healthier choices.
 - More support will be introduced to maintain mental health and emotional well-being.

- People will be afforded greater choice in accessing social and primary care.
- More work will be done to tackle health inequalities and improving access to community services.

2.3 It is proposed that these improvements will be achieved via by following mechanisms:-

- **Practice Based Commissioning**

This will give GPs more responsibility for local health budgets and will act as a driver for more responsive and innovative models of joined-up and innovative models of joined-up support within communities, delivering better health outcomes and well-being, including a focus on prevention.

- **Shifting Resources into Prevention**

This will set a new direction for health and social care services to meet the future demographic challenges, with a clear focus on prevention and health promotion.

- **More care undertaken outside hospitals and in the home**

There is an aim to ensure that more care is provided in local settings, including the home.

- **Better joining up of services at the local level**

There will be more joint commissioning between PCTs and local authorities.

- **Encouraging Innovation**

Innovation will be encouraged by greater patient and user choice.

- **Allowing different providers to compete for services**

In deprived areas of the Country where there are fewer doctors per head of the population there is a vision to increase the quality and quantity of primary care through a nationally supported procurement.

3. **RECOMMENDATION**

3.1 That Members note the content of the report and appendix and consider the issues raised within the context of discussions with the PCT and within the overall terms of reference for the Scrutiny investigation.

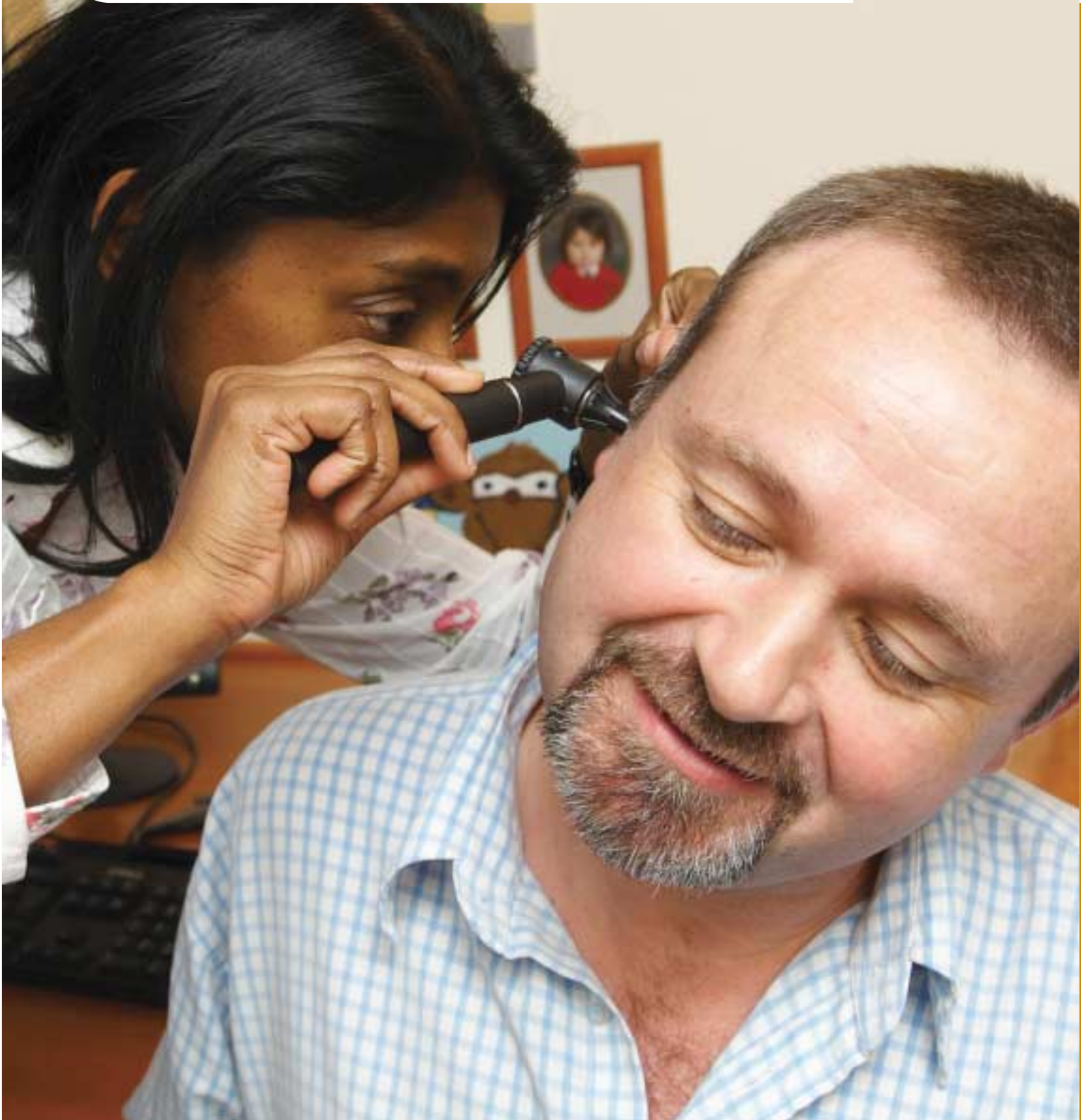
BACKGROUND PAPERS

No background papers were used in the preparation of this report:-

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CHAPTER 3

Better access to general practice



Better access to general practice

This chapter on primary care services includes:

- helping people register with the GP practice of their choice;
- rewarding responsive providers;
- increasing provision in deprived areas: supporting Primary Care Trusts (PCTs) to attract new providers;
- helping practices to expand by helping with expansion costs and making more money follow the patient;
- reviewing the funding of NHS Walk-in Centres;
- giving people more information on local services;
- new drive to improve the availability and quality of primary care provision in areas of deprivation, so that problems of health inequality and worklessness can be tackled.

Introduction

3.1 When people are asked about their local NHS, they probably think first of their GP. For the last 60 years, GPs have played a vital role in the NHS, acting as the main service provider, first point of contact for most people and the 'gatekeeper' to other services. These have always included hospital care and access to social security benefits aimed at helping people with sickness or disability.

3.2 Increasingly, however, a GP-led practice will also involve nurse practitioners and practice nurses and may include other healthcare professionals, such as physiotherapists, drug and alcohol counsellors, mental health counsellors, and therapists. In the future, there may also be specialists to give advice on employment aspects of being sick or disabled.

3.3 At one end of the spectrum is the small practice, owned and run by one or two GPs, possibly assisted by a practice nurse. At the other end is the very large practice – perhaps itself part of an integrated health and social care centre – with a full team of GPs, nurses, therapists and other professionals. New models are also developing, including NHS Walk-in Centres and a few primary care practices that are led by nurse practitioners, with a salaried GP available for those cases requiring a GP's particular skills. In this chapter, therefore, we refer to 'primary care practices' as well as 'GP practices'.

3.4 Access to high-quality primary healthcare has a vital role in helping people to live longer and healthier lives. Integration of these services with other community and social care services helps to ensure better co-ordinated support and care for each individual, better management of chronic disease, and reduced need for costly and avoidable hospital care. General practice remains best placed to offer patients their usual point of contact for routine and continuing care, and to help patients to navigate other parts of the system.

3.5 By international standards, general practice in England is efficient and of high quality.¹ Indeed, many countries view with envy our system of list-based general practice and some, for example Spain, have sought to copy it.

3.6 We implemented major reforms to primary healthcare in 2003/04. These reforms have been backed by an unprecedented increase in resources. By the end of 2005/06, investment in primary medical care services in England will have increased by well over £2 billion compared with financial year 2002/03. This investment underpins a system of incentives aimed at expanding the range of services provided in general practice, rewarding improvements in clinical quality and patient experience and recruiting and retention of key professionals.

3.7 These reforms are delivering. As a result of the hard work and dedication

of around 160,000 GPs, nurses and others working in and alongside general practice, primary care is now delivering better quality than ever before; and a wider range of specialist services are available. We have recruited 3,950 more GPs since publication of the *NHS Plan*,² including over 2,700 since March 2003 when the contractual changes came into place. Job satisfaction has increased and our GPs are now among the best paid in the world.

3.8 However, while public satisfaction with the services they receive in primary care is generally high, this varies across the country.³ Services do not always respond to the needs of local communities and individuals, for example by providing services that are appropriate to particular black and minority ethnic groups, nor do they reflect high levels of deprivation. There is also marked variation in how easy people find it to telephone their practice and make a convenient appointment. Access for some people remains difficult in some circumstances.



3.9 In order to improve access and responsiveness we need to put people more in control. If the public could genuinely choose their practice, their needs and preferences would have more impact on shaping services. We need, therefore, to make real the choices that people should have and reward existing practices and other new providers who respond to those choices.

3.10 To ensure that the NHS value of equal access for all is a reality, we must also do more to improve access and build up capacity in poorly served areas. While many people can choose between several high-quality practices, others find there is only one practice in their area with whom they can register. Particular groups of people, such as care home residents, people with learning disabilities, and people who are homeless or living in temporary accommodation, often have great difficulty in finding a GP at all.

3.11 In some places this will mean encouraging or allowing new providers, including social enterprises or commercial companies, to offer services to registered patients alongside traditional general practice. Increased capacity – and contestability – will allow people to choose services that offer more convenient opening times, tailored specialist services or co-location with other relevant services.

Making it easier to register with an open practice

3.12 Since 1948 patients have had the right to choose their GP and primary healthcare provider. This right to choose to register with a practice is a fundamental building block of the NHS:

- it is part of the public's basic right to access their NHS;
- it establishes the right to care from patients' chosen practice, supports continuity of care and forms the basis from which practices take responsibility for the wider public health of their registered population;
- it also provides the foundation for the allocation of NHS expenditure across England on a fair basis according to the needs of the local population.

3.13 For most people, choosing a general practice is one of their most important and personal health care decisions:

- on average, each person sees their GP four times a year. When practice nurses, counsellors and other staff are included, this amounts to over 300 million consultations in primary care each year. Fifteen per cent of the population sees a GP in any two-week period;⁴
- 75 per cent of people have been with their general practice for longer than five years;
- nearly one in three people have a long-term condition. People with a long-term condition particularly

value continuity of care by someone who understands their problems and whom they know and trust.

3.14 Levels of satisfaction with general practice are consistently high. Yet we know that – for some – problems persist. At times, these problems materially restrict the ability of individuals to register with a practice of their choice.

3.15 Some people, for example, would like to change their practice to another one. This seems a relatively simple right for a member of the public paying for their services through taxation to carry out. Yet it can be difficult to do.

3.16 There is not always good, accessible information on practices and what they offer.⁵ There are not always practices available that are 'open' to new registrations – that is, taking on new patients. This needs to be put right.

3.17 Other people would like the option of being able to register with a practice near to where they work, rather than where they live. At the moment many practices do not take on new patients who live outside the geographical catchment area that the practice agrees with its PCT (and which defines the area in which the practice is required to make home visits where there is a clinical need).

3.18 All these factors mean that at present choice of practice in primary care is too often more of a theoretical

proposition than a practical reality. We will put this right. We will ensure that PCTs (as commissioners), practices and new providers respond to the choices and needs of the public as the best way of driving service improvements – not to exhortation from Whitehall.

3.19 We have also considered whether patients should be allowed to register with more than one practice at the same time, increasing convenience, particularly for commuters. This is known as ‘dual registration’. However, this approach would undermine the underlying principles of registration, including continuity of care, and would be difficult and costly to introduce. Nor did this approach receive support during the *Your health, your care, your say* listening exercise, ranking seventh among options presented in the questionnaire. We are already introducing a range of policies designed to enhance access.

3.20 NHS Walk-in Centres already provide easy access to a range of primary care services to all patients on demand. A new wave of NHS Walk-in Centres in commuter areas are beginning to open. These services should continue to be developed according to local needs, to ensure that people who lead busy lives have equal access to NHS services. For all these reasons we are ruling out dual registration.

Tackling closed lists

3.21 Registration will continue as the cornerstone of list-based general

practice. However, we need to ensure that the right to register is a reality for all. **In future, patients will be guaranteed acceptance onto an open list in their locality and we will review how we can simplify the process for doing so.** Only in exceptional cases of abuse (for example violence) by patients will this not apply.

3.22 We will also simplify the handling of ‘closed’ lists. Although only 3 per cent of practices report operating closed lists, many more are ‘open but full’ – in other words, although they are not formally closed, the practice does not usually accept new registrations. This makes it harder for patients to find a convenient local practice, particularly in areas with low levels of primary care provision. It also inhibits choice and transparency and fails to safeguard against discrimination.

3.23 The existing closed list procedures will be made simpler to operate, in order to provide greater transparency for patients and to offer practices the flexibility they need to manage short-term or longer-term capacity issues. Practices will operate either an open list or a closed list. These changes will ensure that patients choose practices, not the reverse.

3.24 Linked with this, we will clarify the rules on eligibility and streamline the process for patients to register. We will make the access rules more transparent and make the registration process simpler for patients and providers.

3.25 There will be an obligation on PCTs to provide up-to-date, authoritative information to the public on whether a practice is open for new patients, the range of services it provides, its opening hours and so on. We will make it easier for everyone to get the information they need to choose a practice, including via the internet.

Making it easier for responsive practices to expand

3.26 In order to give people more choice of the practice they want, we need to ensure that popular practices benefit from taking on new patients. There are two main barriers:

- the costs of taking on new patients are not fully reflected in the current contract for GP services – money does not follow the patient;
- practices that do want to expand are not helped to do so.

3.27 Our approach is to ensure that there is an effective set of incentives in place that will deliver what patients need and expect. Rewarding responsive providers is the best way to ensure that patients' needs are taken into account.

3.28 The way we invest in general practice goes some way towards ensuring money is allocated on the basis of need and that it follows the patient. However, less than 70 per cent

Figure 3.1 General practice contract types

General medical services	Personal medical services	Alternative provider of medical services	Primary Care Trust medical services
<ul style="list-style-type: none"> • Nationally agreed contract between the Department of Health (or bodies acting on behalf of the Department of Health) and the British Medical Association. • Recent negotiations led to an overhaul of the contract, which included practice-based rather than GP-based payments, stronger quality incentives, and more flexibility to increase range of services provided. 	<ul style="list-style-type: none"> • Alternative to GMS, in which the contract is agreed locally between the practice and the PCT. • Designed to encourage local flexibility and innovation and a focus on local population needs. • Many of the developments in the new GMS contract have also been adopted in PMS. 	<ul style="list-style-type: none"> • Route for provision of primary medical services where PCT may contract with the independent sector, voluntary organisations, NHS Trusts, other PCTs, Foundation Trusts, or even GMS and PMS practices. 	<ul style="list-style-type: none"> • PCT-provided medical services. • Route to provision of primary medical services where PCT employs the GPs, nurses and others in the primary health care team. • Has been used as a lever for providing care where it has not proved possible to attract GPs to open practices.

Source: Department of Health

of payments to practices on the national contract transfer with a patient when they move, and local Personal Medical Services (PMS) arrangements are open to local negotiation. In addition, premises funding stays with the original practice and most General Medical Services (GMS) practices are protected by a Minimum Practice Income Guarantee (MPIG). This was introduced to ensure that practices did not face a fall in income in moving to the new GMS contract in 2004. This reduction in income has not happened – indeed, most practice incomes have risen substantially.

3.29 One of the aims of both the PMS and GMS was to invest in practices and their populations based on patient need.

3.30 For GMS, a review of the funding formula is due to report in time for implementation in 2007/08. This will inform the next round of discussions between NHS Employers and the General Practice Committee (GPC). On the back of the substantial additional investment in general practice between 2003 and 2007, and a need to have more money following the patient, we will also ask NHS Employers to consider the MPIG and its impact on equity when discussing incentives for 2007/08 and beyond.

3.31 We will also undertake a fundamental review of the financial arrangements for the 40 per cent of practices on local PMS contracts. Many have developed innovative new services.

CASE STUDY

Innovative GP services

The James Wigg Practice in Kentish Town – an inner-city London neighbourhood with high levels of disadvantage and health inequalities – is demonstrating the range of services that can be provided by primary care. The practice has GPs and nurses, of course, but it offers so much more.

Visiting specialists include an alcohol counsellor, a drug counsellor, an adult psychologist and psychiatrist, an ophthalmologist and a rheumatologist. Clinics are run by practice nurses for many ongoing conditions, including diabetes, asthma, hypertension and quitting smoking.

The practice makes extensive use of information technology. This means that patients can order repeat prescriptions using the internet. This emphasis on information technology has led to the practice being awarded beacon status. Patients can also conduct telephone consultations with doctors if they need advice or want to ascertain if they need to make an appointment.

3.32 However, providers are not always rewarded for attracting new patients to take advantage of innovative services. We would like all practices – whatever their contract type – to have a real incentive to take on new patients, where this is what people choose.

3.33 The second barrier to practices expanding are the steep extra costs. We will ask NHS Employers to consider the case for establishing an Expanding Practice Allowance for practices that have open lists which are growing significantly and that offer extended opening hours. Aside from such developments, we will expect PCTs to prioritise expanding practices when allocating strategic capital monies.

3.34 We will also review the arrangements for funding NHS Walk-in Centres and for paying for services provided by general practice to unregistered patients. The aim will be to ensure that all providers have the right incentives to deliver care to patients while away from their registered practice.

3.35 PCTs' existing duty to inform local residents of the services available will be extended to include information on the establishment of new services and expanding practices. This will mean that the public are better informed about the choices open to them.

Health inequalities

3.36 These changes will make registration easier for most. But there are persistent and particular problems in deprived areas which have long been under-served.⁶ We intend to increase provision in areas that are not well served – which are typically the most needy areas – to increase the equity of provision and to ensure that everyone has a real choice.

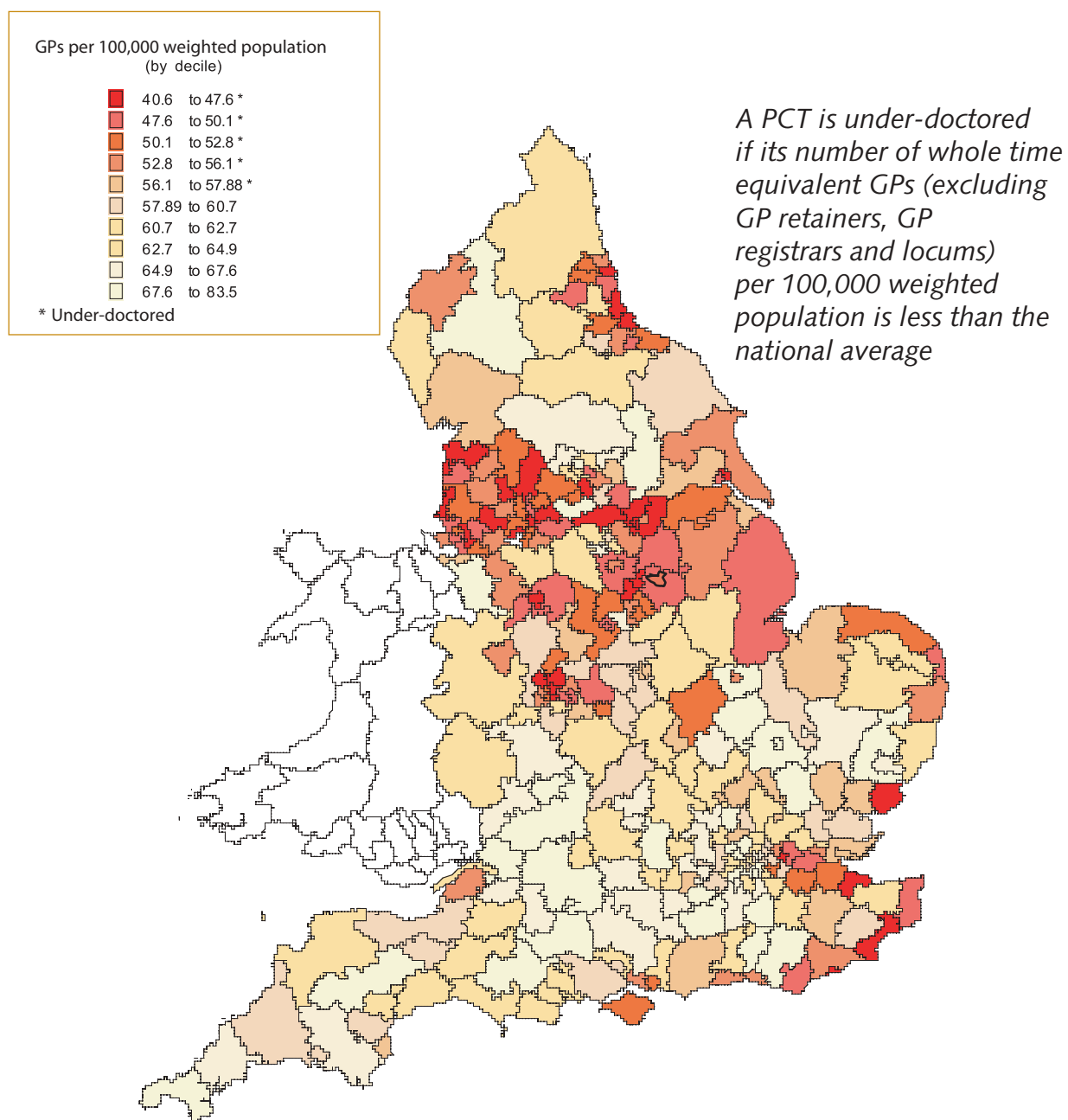
Figure 3.2 Bottom 10 per cent of PCTs with the fewest doctors

Rank	PCT	GPs (WTE) per 100,000 weighted population	Spearhead PCT
1	NORTH MANCHESTER PCT	40.6	S
2	WYRE PCT	43.2	
3	ASHFIELD PCT	43.6	
4	TRAFFORD NORTH PCT	43.8	
5	SWALE PCT	43.8	
6	OLDHAM PCT	44.0	S
7	MANSFIELD DISTRICT PCT	44.1	
8	DONCASTER WEST PCT	44.2	S
9	WALSALL PCT	44.3	S
10	KNOWSLEY PCT	44.5	S
11	WOLVERHAMPTON CITY PCT	44.7	S
12	DONCASTER EAST PCT	45.0	S
13	ASHTON, LEIGH AND WIGAN PCT	45.1	S
14	BURNLEY, PENDLE AND ROSSENDALE PCT	45.1	S
15	BARKING AND DAGENHAM PCT	45.2	S

Rank	PCT	GPs (WTE) per 100,000 weighted population	Spearhead PCT
16	BLACKPOOL PCT	45.3	S
17	NORTH STOKE PCT	45.5	S
18	EASTERN HULL PCT	45.5	S
19	WEDNESBURY AND WEST BROMWICH PCT	45.7	S
20	TENDRING PCT	46.3	
21	BARNSELY PCT	46.4	S
22	EASINGTON PCT	46.5	S
23	SHEPWAY PCT	46.5	
24	HASTINGS AND ST LEONARDS PCT	46.7	
25	NORTH KIRKLEES PCT	46.9	
26	SOUTHPORT AND FORMBY PCT	47.3	
27	SOUTH TYNESIDE PCT	47.4	S
28	OLDBURY AND SMETHWICK PCT	47.5	S
29	HARTLEPOOL PCT	47.5	S
30	BLACKBURN WITH DARWEN PCT	47.5	S

Source: Department of Health Publications and Statistics, Press Releases and Statistics: Reid announces 'Spearhead' PCTs to tackle health inequalities, 19/11/2004, Department of Health General and Personal Medical Services Statistics

Figure 3.3 Under-doctored areas across England



Source: Department of Health General and Personal Medical Services Statistics, March 2005

3.37 The distribution of general practice has been uneven since the beginning of the NHS. Research also shows that those areas with poorest health outcomes are also those with the fewest GPs.⁷ The variation is quite large. The PCTs that had the most GPs per 100,000 weighted population had more than double that of the least.

3.38 GPs are one indicator of capacity. There has been a change in emphasis in delivery of primary care, with more team-based approaches involving nurses and other professionals. Although there have been improvements in the overall number of primary care professionals, there has been no significant narrowing of inequalities in provision. Areas with insufficient provision tend to have below average health outcomes and lower levels of patient satisfaction.

3.39 Increasing the quantity and quality of primary health care in the areas of greatest need is one of the most important ways in which this Government can tackle health inequalities. It can improve services for all, so as to guarantee universal access to high-quality primary care services across all parts of the country, appropriate to the local population, and based on need. The issue of quality in primary care is considered further in Chapter 8.

3.40 Part of the new contract deal endorsed by GPs was the creation of new contractual freedoms for PCTs to bring in additional provision (see Figure 3.1). In the next stage of reform these freedoms will be used systematically to reduce inequality in primary care provision.

3.41 On their own, PCTs have not always had the size or clout to develop enough new provision in their locality to tackle inequalities. The Department of Health is currently assisting six PCTs in procuring services from a diverse set of suppliers for communities that have previously been poorly served. Now we will help **all** PCTs in under-served areas to draw upon national expertise to attract new providers of sufficient size to fill these gaps in provision.

3.42 We will do this by ensuring that PCTs actively commission additional practices, reflecting the needs and expectations of their local populations. Change will be driven locally, with local authority input, and co-ordinated nationally in a series of procurement waves. This is an urgent priority if we are to make equal access for equal need a reality.

3.43 We will ensure that both new and existing providers are allowed to provide services in underserved areas. Social enterprises, the voluntary sector and independent sector providers will all make valuable contributions in the longstanding challenge of addressing inequalities. The voluntary and community sectors often have strengths and experience in delivering services to those people who are not well served by traditional services. This will be the basis of the new Fairness in Primary Care procurement principles.

3.44 PCTs will retain full control of their proposed contract specifications, in order to ensure services are tailored to meet local needs, and they will, of course, be responsible for awarding and signing contracts.

3.45 The first wave of nationally supported procurements must address those areas with the most significant inequalities of access to primary care. The Department of Health will assist health communities with the poorest levels of general practice provision. Future waves will be shaped more broadly around the ongoing needs of local populations, ie based on the trigger mechanisms outlined in Chapter 7. They will take into account the broader set of measures, such as patient surveys, patient assignments, closed lists, and unresponsive services. We will ensure that local authorities have the opportunity to input into relevant tender specifications.

CASE STUDIES

New providers in primary care services

The current small business model of GP partnerships is likely to remain very popular. To complement this, larger organisations can bring capital and new management techniques to deliver innovative solutions, such as larger one-stop shop primary care centres, offering a wider range of services, including diagnostics and minor surgery, and convenient opening hours. Some examples include:

Entrepreneurial GPs or nurse practitioners forming large organisations

The organisations would continue as providers under GMS and PMS contracts, however they would be organised into larger units, or be based around networks, allowing the pooling of resources and the delivery of a broader set of services. Practice Based Commissioning is likely to be the prime driver for practices working more closely together.

Co-operatives

There are already 20 GP out-of-hours co-operatives, known as 'mutuals'. Mutuals are not-for-profit organisations where members are entrusted with their social ownership and governance. They can be large enough to enjoy economies of scale

and have long-term horizons, yet maintain a local responsive touch in the delivery of patient care. **Mutuo** is leading the development of such organisations. Some out-of-hours co-operatives may be interested in providing a round-the-clock service, based at one or more primary care practices.

Independent sector

The for-profit corporate sector has just begun to provide services in primary care via the use of the Alternative Providers of Medical Services contract. More broadly, **Boots** are offering chlamydia testing in some high street stores in London, and a number of organisations will run commuter-focused Walk-in Centres close to train stations, on behalf of NHS patients.

Mercury Health Primary Care (the primary care arm of an independent sector organisation) has formed a strategic alliance with **Chilvers** and **McCrea**, a company established four years ago by an NHS nurse and a GP, with 18 general medical practices in England. The alliance brings together the size and capital of a corporate body with the specialist expertise of a small entrepreneurial organisation. Mercury also has an affiliation with Frome Medical Practice, one of the largest in the country with 29 GPs.

3.46 The approach to the first wave of the Fairness in Primary Care procurement principles is as follows:

First wave of Fairness in Primary Care procurement principles

1. The Department of Health will begin immediately to identify the localities that are significantly under-provided, especially those in deprived areas.
2. Where PCTs are unable to provide robust plans for rapidly reducing inequalities of access to services, they will be invited to join the national procurement process.
3. There will be a competitive tendering process, which will provide a level playing field and ensure fairness. PCTs will purchase and contract manage the new services.
4. PCTs will draw up specifications for the new services they will procure. These must include arrangements for convenient opening hours, open lists, a practice boundary, if any, very broadly defined, as well as quality incentives comparable to those in the GMS/PMS contract.
5. The Department of Health will manage the procurement process on behalf of PCTs, ensuring the principles of contestability and value for money are realised under a fair, transparent and consistent process.
6. All providers that pre-qualify to quality standards during the tendering process will be put on an accredited list of primary care suppliers, to ensure that in the future commissioners can procure GP services faster.

It's not about making hours 'longer' but making them 'different'. For example, we don't need both morning and afternoon openings, as people who can come in the morning can also come in the afternoon. That way you don't need to stretch the resources.

PARTICIPANT AT THE CITIZENS' SUMMIT IN BIRMINGHAM

Making it easier to get care at the right time

3.47 Registration is not an end in itself. Registration ensures free access to a primary care professional and is the gateway to other services. We want people to register with a practice that provides them with the care that they want. Once a patient is registered, when they need to see a primary care professional, they expect to be seen at a convenient time and quickly.

3.48 The *NHS Plan* set a target of patients being able to see a practice nurse within 24 hours and a GP within 48 hours. This target has led to significant improvements in access to primary care and largely ended the problem of people waiting a week or more to see a GP.

3.49 But it has created new problems. A growing minority of practices stopped offering advance bookings. This is a particular problem for people who want to organise their time ahead or whose need is less urgent.⁸ It assumes that the public's time is free. Action has been taken to address this and the problem is diminishing, but more needs to be done.

3.50 The public, quite reasonably, expects both to be able to see a primary care practitioner quickly, and to have the opportunity to book an appointment in advance. *Your health, your care, your say* showed that this is a high priority.

3.51 In response to *Your health, your care, your say*, we have agreed with the British Medical Association (BMA) a new general practice contract framework for 2006/07 that already makes progress on ensuring better access. It sets practices objectives to offer patients:

- the opportunity to consult a GP within 48 hours;
- the opportunity to book appointments in advance;
- easy telephone access;
- the opportunity for the patient to consult their preferred practitioner (while recognising that this may mean waiting longer).

3.52 It is our intention to ensure that people have both the ability to get fast access when they need it and to book ahead. We will use our contracts to deliver this, together with public information on practices not complying, to enable people to make informed choices.

3.53 PCTs will be expected to provide information to all patients on the performance of all practices in an area in offering fast access and advanced booking. This information will list other local practices that are open to new registrations and are meeting the target fully. This will enable them to make informed decisions about the care and services they are receiving.

CASE STUDY

Smart practices in Lincolnshire

The Hereward Practice in Bourne is one of a number of practices in Lincolnshire that are making use of technology to improve access to services in a predominantly rural area. People registered with the practice can order their prescriptions on-line to collect from chemists the next day, can book their GP appointments using the internet and can sign in using a 'virtual receptionist' when they arrive for an appointment.

People can also access their own patient information easily from a touch-screen in the practice. Fingerprint technology is used to ensure people's records remain secure.

"It's early days at the moment," as Bob Brown, who helped develop the system, explained. "We've got 800 out of 10,000 patients registered and we need to get

information out to them about the system and how to use it. We also need to make sure they are confident that their records are secure."

Nevertheless the practice has bold ambitions for the future. "We're also hoping to develop the system so people will be able to use the touch-screens to 'choose and book'." continued Bob. "They will be able to find out which hospitals are available for them for the particular treatment they need, take a look at the hospital on the computer and even the doctor or consultant they are seeing!"

These innovations are just the start. In the future, the practice is seeking to tailor information played on a plasma screen in the waiting area to the people who are there. So if a diabetic signs in with the virtual receptionist, then information on controlling blood sugar could be played in the waiting area.

Ensuring practices are open when the public wants

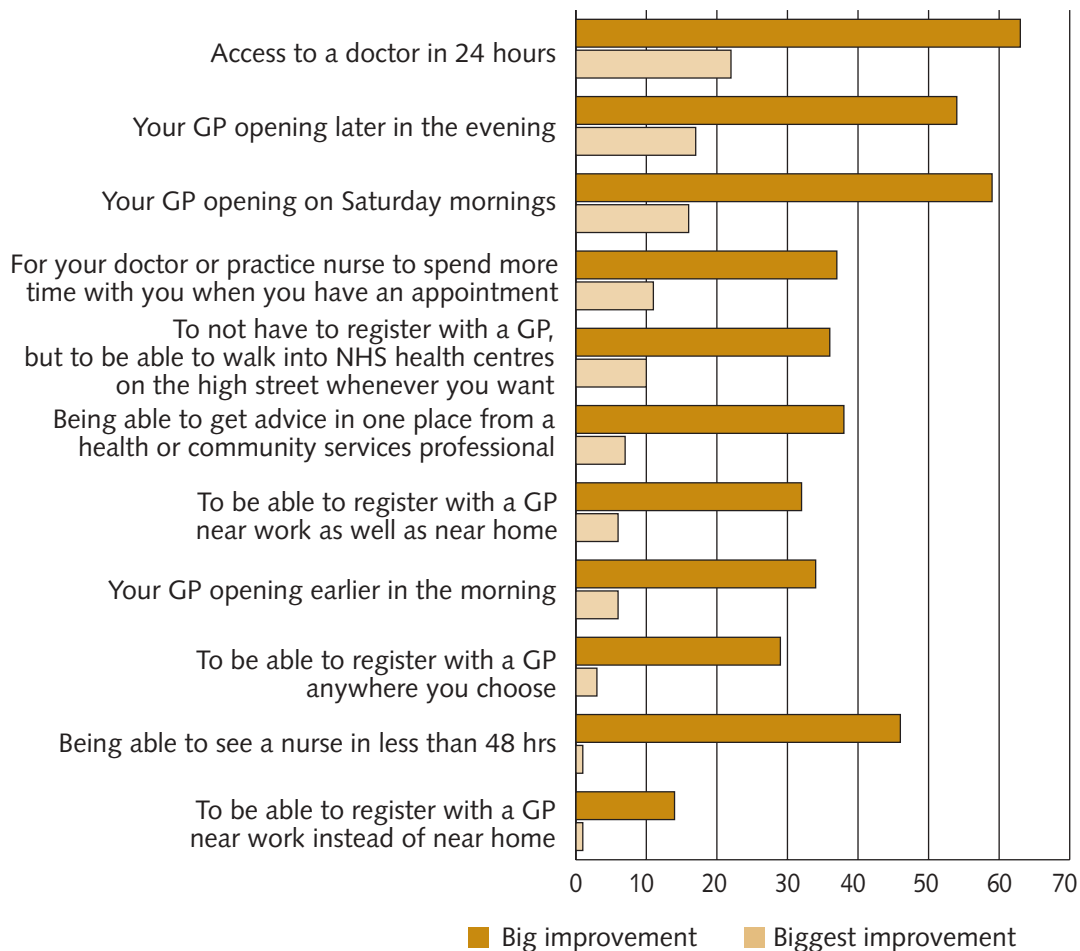
3.54 Ensuring that services are open when the public want to use them is fundamental to improving access. It was one of their highest priorities in the *Your health, your care, your say* listening exercise. We will tackle this with the professions through a variety of means.

3.55 At present, practices set their own surgery opening hours and have the ability to change these without PCT agreement. There are few incentives to offer opening times that respond to the needs of patients. We will change this.

3.56 First, it will be easier for people to choose which practice they register with. This will enable them to choose practices that offer access that fits with their lives. Practices that offer opening

Figure 3.4 Public views on access

Your health, your care, your say questionnaire: "How much of an improvement would each of these options be for you when you want to see a professional?"



Source: *Your health, your care, your say* questionnaire
n=25,666 number lowered when weighted for population

hours that the public want will gain new patients, and the money that follows them; those that don't, won't.

3.57 Second, we will directly ask the public how easy it is to get into their practice to see a GP and will reward those whose patients are satisfied. From this year, practice patient surveys, which will be standardised and

independently conducted, will ask registered practice populations whether their surgery offers convenient opening hours, including an early morning, evening or Saturday surgery.

3.58 Third, in the future, opening hours should reflect patient preferences and will be agreed with PCTs. We will seek to use the various primary care

CASE STUDY

Opening longer for patients

People told us that more convenient opening hours was the most important thing for us to tackle to improve access to GPs. They also told us that they didn't want this to mean that staff simply worked longer hours. From late November 2004, two practices in Waltham Forest, North London, piloted extended opening hours to meet their patients' needs. They also restructured staff working hours and engaged additional staff. Here's how it feels for both their patients and people working at one of the practices.

Neil Collins, a 64-year-old retired social worker, has been a patient at Forest Road Medical Centre for three years. "The longer hours scheme was piloted at my surgery for six months last year. I think it could have been advertised a bit better, but once I found out about it, it was great. I found the flexibility very useful and it meant there were more appointments, so it was easier to get to see the doctor at a time that was convenient. For example, one Friday evening I had what I thought was an infected foot. Previously, if this had happened on a Friday night, I would not have been able to get an appointment before Monday and I'd have had to go to the Walk-in Centre or Accident and Emergency. This time I was able to ring

and get an appointment for Saturday. I'm also a mental health services user and I suffer from an anxiety disorder, so I tend to worry more about certain things and the flexibility of the appointment system also helped to ease my anxiety, because I knew I could get an appointment if I needed it."

Dr Dinesh Kapoor, a GP at Grange Park Practice, said his patients reacted very positively. "They were so pleased that we were no longer saying 'Sorry, there are no appointments for two weeks' but rather, 'You want to be seen? Come now!' The new system also enabled the practice to increase the length of appointments so, as Dr Kapoor explained, "patients were getting around 50 per cent more time. Immediate access and a longer consultation time with the doctor or nurse were obviously beneficial, particularly for those suffering from chronic diseases.

"The Saturday morning service was particularly popular and it meant that fewer of our practice patients were turning up at the out-of-hours services in the local hospitals. So it contributed to saving costs at the A&E and NHS Walk-in Centres. I believe some patients have transferred to our practice as a result of the scheme."

contracts to provide more incentives for new and existing providers to offer better opening hours.

3.59 Fourth, PCTs will also ensure convenient opening hours across a range of other alternatives. These alternatives include:

- bringing in new providers offering more convenient opening hours (see paragraph 3.46);
- allowing out-of-hours providers to do evening surgeries, take booked appointments and take on registered patients;
- developing new NHS Walk-in Centres and allowing existing sites to take booked appointments.

Choosing **your** primary care professional

3.60 Patients also want to be able to see the GP of their choice within the practice. Women often prefer to see a female GP. Relationship continuity is very important. It is better for both the patient and practitioner if the patient's history and needs are shared and understood, particularly if the patient has ongoing needs.⁹

3.61 Research also shows that where a practitioner has an ongoing professional relationship with a particular patient, they tend to be more committed to the patient as a person.¹⁰ This is one of the reasons why small practices are popular and will remain an essential part of general practice.

3.62 At present, patients can state their preferred GP. If a particular GP is especially popular, this will inevitably mean that the patient cannot see them within 48 hours. It will then be for the patient to decide whether to wait, or instead to see a different GP within 48 hours.

3.63 The public does not always want to see a GP. At the national Citizens' Summit in Birmingham in 2005, over 40 per cent of people picked having a trained nurse as a first point of contact in primary care as one of their top three priorities. We will encourage existing practices and new providers – particularly through the review of urgent care services – to make best use of the first contact skills of nurses. In addition, NHS Walk-in Centres and NHS Direct are already offering this option and the further expansion and development of these services will extend this.

Innovative approaches to access

Nurse triage, perhaps using the telephone, has the potential to reduce pressure on GPs while enabling people to talk to a clinician straight away. We will encourage primary care practices to explore the potential of both nurse triage and telephone consultations, particularly if a practice's survey reveals support for these innovations.

Technology could improve access in primary care. Use of the internet could be made for the booking of GP appointments, for ordering prescriptions from GPs on-line and even, potentially, for registering with a practice on-line. We would encourage practices to explore the potential for technology to improve access and we will work with NHS Connecting for Health on the practicalities for this, as well as learning from examples of best practice.

3.64 As well as increasing the accessibility of GPs and nurses, it is important that access to other primary care professionals is improved where waiting lists exist, such as access to allied health professionals. While many services already operate a self-referral system where patients can access these services themselves without the need to see a doctor, we will be piloting this approach with a comprehensive evaluation (see Chapter 4).

Choosing services that reflect your needs

3.65 If the public has a choice of practices, then those that offer the most appropriate and responsive services will attract more patients. Practices will have to identify and meet the cultural and demographic needs of the population they serve – they will have to design services around the user in order to attract them.

3.66 Some practices will wish to expand and take on more patients outside their current boundaries, thereby increasing choice. In these circumstances they will continue to be free to agree a larger area with their PCT. Other practices or providers may, however, prefer to concentrate on delivering high-quality services to their existing patients or list size.

3.67 We also expect that some existing practices will wish to combine extended boundaries and extended opening hours for maximum coverage for people. We will expect new providers in particular to offer this option to patients.

3.68 PCTs will work closely with their local authority partners to ensure that the associated social care implications of different practice boundaries are taken into account.

3.69 Responsive primary care practices should work within an integrated set of community and local services. In the next chapter we will look at the wider

set of services with which primary care practices link.

References

- 1 Starfield B. *Primary care: balancing health needs, services and technology*, Oxford University Press, 1998
- 2 *The NHS Plan: A plan for investment, a plan for reform* (Cm 4818-I), The Stationery Office, July 2000
- 3 Wilson T, Roland M, Ham C. The contribution of general practice and the general practitioner to NHS patients. *J R Soc Med* 2006; 99; 24–28
- 4 Professor Sir Denis Pereira Gray, *A dozen facts about general practice primary care*, St Leonard's Research General Practice, University of Exeter; Emeritus Professor of General Practice
- 5 Marshall M, Noble J, Davies H, Walshe K, Waterman H, Sheaff R, Elwyn G. *Producing information about general practice services that makes sense to patients and the public*, National Primary Care Research and Development Centre, 2005
- 6 Hann M, Gravelle H. The maldistribution of general practitioners in England and Wales 1974-2003. *Br J Gen Pract* 2004; 54; 894–8
- 7 Recent Glasgow University study, plus also Department of Health workforce census figures
- 8 Bower P, Sheaff RS, Sibbald B, Campbell S, Roland M, Marshall MN et al. Setting standards based on patients' views on access and continuity: secondary analysis of data from the general practice assessment survey. *BMJ* 2003; 236: 258–60
- 9 Pereira Gray D, Evans P, Sweeney K, Lings P, Seamark D, Seamark C et al. Towards a theory of continuity of care. *J R Soc Medicine* 2003; 96; 160–6
- 10 Manious A, Baker R, Love M, Pereira Gray DJ, Gill JM. Continuity of care and trust in one's physician: evidence from primary care in the US and UK. *Fam Med* 2001; 33; 22–7

ACCESS TO GENERAL PRACTICE AND PRIMARY CARE SERVICES

This paper provides an overview of current primary care services in Hartlepool and considers the changing policy context within which future developments can be made to improve the range and quality of those services. It builds on the information provided to the Scrutiny Committee in January concerning GP access and is intended to provide further insight into the current and future provision of primary care services in Hartlepool.

BACKGROUND

Primary health care in the UK has commonly been described as the provision of comprehensive care from a community base, the first point of access to a 24-hour NHS, providing continuous co-ordination and organisation of local medical and social services, including generalist personal and family care undifferentiated by age, gender or disease aiming for universal coverage.

However, primary medical care delivery and the range of primary care services are changing. General Practitioners no longer have 24 hour responsibility for their registered patients. Primary care can be provided in a wide range of settings including pharmacies, one-stop shops, clinics and hospitals i.e., A&E, specialist clinics. Many of the investigation, diagnostic tests and treatment that were once the domain of the acute hospital setting, can now be accessed in primary care and provided by an array of highly trained general and specialist professionals.

Whilst the recent D'Arzi review emphasised the need for further development of primary care services in Hartlepool the modernisation of services must avoid the potential for the fragmentation of care, increasing health inequality, or poor access for vulnerable groups and must be delivered within the financial constraints of the PCT. The PCT and partner organisations following extensive community engagement have agreed that Hartlepool's Vision for Care will provide the context within which services are developed and delivered.

The new White Paper *Our Health, Our Care, Our Say: a new direction for community services* supports greater personalisation of both health and social care services. It emphasises the importance of access to GP and other services, the provision of greater diversity in service provision and to improvements in the supply of up to date and accessible information to help people play a greater role in self-care and in exercising choice of services.

Three new provider contracts (nGMS from April 2004, Community Pharmacy from April 2005 and Dentistry from April 2006) support these aims and offer significant potential to radically reform the range, location and quality of services.

In addition, Practice Based Commissioning will provide a powerful mechanism to achieve greater clinical and public involvement in the planning and commissioning of services that are responsive to individual and community needs.

CURRENT SERVICE PROVISION

General Practice

Hartlepool has 16 GP practices across the town within which around 59 GPs work (including long term locums). They are supported by nurses employed by the practice themselves and a range of other community staff including nurses, health visitors, allied health professions (e.g. Podiatrists, speech and language therapists etc.)

It is of relevance that Hartlepool people experience more ill health and disability and higher death rates from diseases such as cancer, heart, circulatory and respiratory disease, than other areas of the country. There is shorter life expectancy for both men and women and nine of the seventeen Hartlepool wards are in the 10% most deprived wards in the country. This can mean that the task of providing services to Hartlepool people is not an easy one. Need and subsequently demand for health care is high and this has its impact on the use of services in primary care making access to limited primary care services all the more difficult.

GP numbers

Exacerbating the problem is our low numbers of GPs for the population size. This means that many practices have a higher registered population than is considered appropriate to provide sufficient access to high quality care. The problem has been one of recruitment – heavy workload in an area of significant deprivation and ill health does not readily attract new doctors. The PCT has therefore over the last few years invested heavily in recruitment of salaried GPs to support the practices. This provides additional flexibility to make working in Hartlepool a more attractive proposition. Whilst we have had some success relatively locally we have also needed to look overseas to attract new GPs to the town. Many of the practices also employ nurses skilled in the management of chronic ill health and nurse practitioners who are able to diagnose and treat in their own right.

Open lists

The new white paper provides a commitment to the public that those practices with 'open' lists will guarantee acceptance onto their list. Indeed there have recently been 4 practices that have opened their lists for additional registration due to the employment of additional staff and improving accommodation. (Bank House surgery in the town centre, the Headland medical practice, Dr Juhasz practice West View and the PCT practice, Wynyard Road.)

Patient information

Until the publication of the white paper it was the responsibility of the practices to publicise the services they provide through a practice leaflet. In the future the PCT will be required to publicise the range of services practices provided including information on patient satisfaction with the service, the type of appointment provided etc. The PCT are currently developing their intranet and website capability that will support this process.

Whilst the practices have had consistently achieved the national 24/48 hour access targets for sometime there remain difficulties in pre booking appointments and getting through to practices on the telephone at busy times in the day. The white paper has set a new expectation to improve these issues and has linked their achievement within the general practice contract framework from April 2006.

Quality and Outcomes framework

The Quality and Outcomes Framework (QOF) rewards practices for the provision of quality care e.g. the delivery of chronic disease management services. The QOF measures achievement against 146 indicators and 3 for the depth of care and allocates points up to a maximum of 1050 across four domains: Clinical (550 points), organisational (184 points), patient experience (100 points) and 'additional services' such as preventive care (36 points). The patient experience domain includes length of consultation and patient surveys. Validation of achievement includes completion of a national database indicating the level of achievement and practice visits by an assessment team, which includes a lay assessor. These reviews are intended to provide opportunities for learning and improvement.

Out of hours care

Whilst GPs were permitted to 'opt-out' of out of hours services when the new GP contract was introduced, the white paper provides flexibility for practices to offer services across a range of times to suit patient needs including if desired Saturday opening. This would not be a contractual obligation but with the exercise of patient choice and additional patient survey and satisfaction playing an increasing role in the performance management of GP services this may be an area which will change in the future.

Currently Saturday and Sunday clinics are held by the out of hours service for those people who are unable to wait for an appointment after the weekend.

Nursing Services

The provision of primary care however is not just the domain of general practice. We have had significant success in developing nurse led services in both Greatham and Owton, two areas of the town with low GP provision. These services are provided to any patient in the area requiring primary care advice, treatment and preventative services. The nurses are highly trained can write prescriptions and refer to other services as required.

All primary care provision is supported by additional community nursing teams, a rapid response team that can provide 24 hour care when needed to keep patients out of hospital whose condition can be managed in primary care, Community Matrons – a new service aimed at supporting those with chronic disease to remain well and when ill to provide and co-ordinate care outside of hospital for as long as possible.

Pharmacy Practice and the Minor Ailment Scheme

We have also developed a pharmacy based 'minor ailment scheme' that has received national recognition and is now being adopted across the County Durham and Tees Valley area as an example of good practice. All 17 pharmacies across the town run the scheme, which provides patients with advice and treatment from a limited list of common conditions. An evaluation of the scheme in 2004 demonstrated substantial use of the scheme as an alternative to general practice. All practices and pharmacies publicise the scheme, which was extended in 2005 to include additional conditions. The new pharmacy contract offers additional opportunities for pharmacists to support the delivery of primary care services in the future. Pharmacies are expected to provide a confidential area for patient consultations, provide health promotion advice and campaign support and many now provide supervised methadone and needle exchange services to patients with substance problems. In the future the developing technology will allow electronic transfer of prescriptions and the provision of diagnostic testing that will negate the need for access to the GP for certain treatments.

CURRENT & FUTRE DEVELOPMENTS TO SUPPORT ACCESS TO SERVICES IN PRIMARY CARE

Infrastructure

Premises

Any further expansion of primary care provision requires significant investment in accommodation and workforce. This year has seen the opening of a large modern medical centre at the Headland, which provides up to date DDA compliant buildings with theatre and recovery facilities. We have already commissioned a podiatric surgeon to provide surgical foot procedures from this facility and are currently looking to expand the provision of minor surgical procedures in this setting.

Several practices have been supported to update their facilities offering greater physical accessibility for patients and an improved working environment for staff. We have commenced the building of a new primary care centre on Wynyard Road under the national Local Investment Finance Trust (LIFT) scheme that will offer extensive GP, nursing and podiatry services during extended hours. The single handed practice previously providing GP services in the area has been taken over by the PCT with additional GPs and nursing input already in place.

The PCT is working towards the development of a state of the art Town Centre development on Stranton and Park Road that will significantly improve the premises and facilities for 4 current GP practices and will offer a range of additional diagnostic and treatment services in a convenient and accessible location for the people of Hartlepool.

Workforce

We aim to develop the workforce providing care outside of the hospital and are working closely with our Adult Social care colleagues to build integrated

health and social care teams that will ensure the right care is provided with the minimum of delay by the most appropriate service. This will improve communication between the two services and ensure patients and clients are provided with seamless care that truly meets their needs.

Whilst many of our nursing workforce have specialist skills in a range of different areas e.g. respiratory disease, heart disease we are developing the teams to include additional roles including Emergency Care Practitioners who are experts in the management of urgent care and minor injury and General Practitioners with Special Interest in for example Heart Failure, Palliative Care, Musculo-skeletal care.

We have recently commenced our:

- Diabetes One stop shop that offers access to retinal screening, phlebotomy (diagnostic blood tests), podiatry and health advice;
- A Musculo- Skeletal triage and treat service that provides access to highly skilled physiotherapists, podiatrists and a GPwSI who are able to provide treatment that would have in the past taken place in hospital, thus cutting waiting times for treatment and providing high quality care that would not have been available in general practice;
- Heart failure clinics in 3 areas in the town.

We are looking in the next year to developing our Respiratory services to ensure early diagnosis and treatment in a community setting which will improve the care and experience of people with this debilitating disease.

Connected Care

The Connected Care pilot project has included a 'connected care' social audit undertaken by residents themselves with help from the University of Central Lancashire and Turning Point (a national not for profit organisation that provides support for clients with complex needs). The audit provides information on the needs of the community but also describes how these needs should be met. This innovative project has received national acclaim in that it allows service users to directly influence the specification for a connected care service. The new model of care is intended to address broader aspects of need, a feature of which is the provision of bespoke personalised care. It requires the provision of a diverse set of services and strong partnership arrangements between health and social care providers including housing employment, debt management, and policing. The audit has demonstrated the need for a service that has both a single focal point of access as well as multiply access points within existing services, improved information and information sharing, managed transitions between services, co-location of health, social care and voluntary services, round the clock support and significant changes to health and social care roles to better serve the needs of the population. Whilst the pilot has taken place in Owton, one of the most seriously deprived wards in the country the PCT and partner organisations and looking at how the learning can be rolled out to other areas of similar need.

CONCLUSION

This paper has sought to provide the committee with information about the current provision of primary care services in Hartlepool and those planned or in development that seek to provide greater access to care in the near future. It provides an explanation of the complex issues that affect access to GP and other primary care services and demonstrates the developments the PCT has put in place to improve accessibility to date.

The new White Paper suggests that these developments are appropriate to the development of services to meet local needs in the future and recognises the timescales required in implementing new ways of working.

The paper is commended to the Committee for discussion.

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Ali Wilson

Director of Primary Care development & Modernisation
February 2006

ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM REPORT

28th February 2006



Report of: SCRUTINY SUPPORT OFFICER

Subject: HEALTH SCRUTINY SUPPORT
PROGRAMME- BUILDING LINKS WITH
HARTLEPOOL PPI

1. PURPOSE OF REPORT

- 1.1 This report provides information to Members on the programme of development being designed to promote greater links between Scrutiny and Patient and Public Involvement Forums (PPIF) in Hartlepool as part of the Centre for Public Scrutiny's Health Scrutiny Support Programme (HSSP).

2. THE HEALTH SCRUTINY SUPPORT PROGRAMME

- 2.1 The Health Scrutiny Support Programme is a three year programme of support for local authority overview and scrutiny committees with powers to scrutinise health as established by the Health and Social Care Act 2001. It has three main elements, which includes the HSSP which offers five free days of support, free of charge to Health Scrutiny Committees.
- 2.2 The support for Hartlepool's Adult and Community Services and Health Scrutiny Forum has been secured to assist in both the conduct of the Access to GP Services inquiry and, pre-dominantly to develop a working relationship between Scrutiny and the PPIF.
- 2.3 The first session of that support was delivered by our HSSP advisor Linda Pepper (who attended the Forum's meeting on 31st January 2006). Having sat in on the Forums meeting on the 31st January Linda has prepared a series of questions that Members could have asked of the witness in relation to the evidence presented. **(Appendix 3A)**

- 2.4 The PCT are in attendance at today's meeting and have been provided with a copy of the questions in advance should they wish to respond to the issues raised.
- 2.5 It is anticipated that the remainder of the support will be utilized in the following manner:-
- At the Forums meeting in March - HSSP advisor to facilitate the collation of evidence between PPIF & Scrutiny.
 - April Workshop – In order to develop effective working relationships between PPIF and Scrutiny a workshop will be arranged to:-
 - Clarify the roles and responsibilities of Scrutiny and PPIF
 - Explore ways in which both Scrutiny and PPIF can work together (Including the production of a draft protocol).
 - Consider the work programme for both PPIF and Scrutiny, and the potential for joint-working.

3. RECOMMENDATION

- 3.1 That Members note the content of the report and of the supporting papers at Appendix 3a.

SUPPORTING PAPERS

- Appendix 3A Papers provided from Linda Pepper, HSSP advisor in relation to the evidence received at the Forums meeting on the 31st January 2006.
- Appendix 3B A copy of the written evidence submitted by the PCT at the Forums meeting on the 31st January 2006 has been attached to aid Members in their consideration of Appendix A.

BACKGROUND PAPERS

Background papers used in the preparation of this report have been attached as an appendix to the report.

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Report to Scrutiny Committee on Access to GP services

❖ **Evidence received from – Hartlepool PCT -31 Jan 2006**

❖ **Suggested questions as a result of presentation of document 31.1.06**

GP practices

- Which practices are single-handed?
- In order to understand list sizes it is important to know the number of partners in each practice.
- Following on from the above, it is important to ascertain the range of professionals in each of the 16 practices.
- How many GPs are PCT funded (i.e. through Personal Medical Services PMS scheme) and which ones are they? – On the evidence received only one *PCT Practice* is identified).
- GP practice leaflets – Practice leaflets were requested, which will allow Members to see what services are being offered, access details etc.

Physical access

- The document states that what is given is “a sample of the results is shown below” – is there a full document?
- Were any of the members of PPIF who carried out monitoring visits themselves in wheelchairs? Did they have checklists, for instance, from disability organisations?
- Who decided on the 6 practices, and why were these particular 6 chosen? (if longer document, again who decided and why?)
- The witness stated that the information from this monitoring was supplied to both the PCT and the relevant practices. Where a “NO” has been recorded – what happened as a result? What did the PCT do? What did the practice do? (e.g. PCT premises have to comply with DDA, GPs have to demonstrate that they have plans in place to improve)
- Although, stated that this is an “ongoing piece of work” – are there any more details?
- With regards to practices with lists that are “open but full” – what does this mean in practice? Either the list numbers are such that new patients can be taken on, or not.
- The document outlines new primary care centre at rear of Owton Rossmere Resource Centre, a LIFT initiative. How have patients and the public been involved in the progress of this project, especially given it is stated it is “designed to be patient friendly ...”
- What is the Connected Care initiative
- With the LIFT scheme to modernise community based facilities across the town – how are patients and the public involved in the planning of this?
- Did PPIF link in with Hartlepool Access Group when conducting the access survey?

Waiting times

- Table is divided into GPs and PCPs

Document states that “information collected also shows how far in advance patients can book pre-appointments with the surgery” – all this table shows is advanced booking for PCPs, and then only 5 days ahead? What about advance booking to see a GP?

- PCT says it monitors once a month -how? Clarification is needed as to who phones up, and is the timing random or regular? Is there any other monitoring besides this phone call from the PCT?
- The speaker suggested that for some practices there is a scheme whereby patients can just come down and wait for a same-day appointment (patients may not get GP they want). Who is monitoring how widespread this practice is, and how long patients may wait (potential future work by PPIF?)

Out of Hours (OOH) arrangements

Whilst noting that OOHs not a major scope to this piece of work noted below are significant issues that were raised in the meeting:-

- How do patients know about OOH arrangements? Does message on each GP answerphone give details of OOH? Or just refer to NHS Direct?
- When Primecare provide cover for when there is staff training in GP practices – does this affect waiting times?
- OOH arrangements may well be such that there is a knock-on effect on A & E? - is this assessed
- How is the contract with Primecare being monitored? How are patients views on Primecare being collected? How do patients views feed into the commissioning process?

Additional services available to patients

- document states that a “comprehensive list is currently being compiled and will be provided to the committee on completion” – what is timescale for this? (see also questions under GPs)

Minor ailments (re pharmacies)

- how does minor injuries scheme work? i.e. more details needed
- how does the public know about the scheme, and which pharmacies are part of the scheme?
- PCT says it has done an evaluation of the scheme? How were patients involved in this evaluation? Evaluation Report?

Greatham and Wynyard Rd Nurse Practitioner Clinics

How does the PCT know what patients think of these clinics?

Monitoring the quality of services

QoF

- Where were the lay assessors in the team drawn from?
- Can the points for each of the practices separate out and show “patient experience” points (max possible = 100)
- What is the response to the PCT to the practice having the lowest points (viz. Singh @ 620)?

PALS

- does PALS cover both acute and PCT?
- can PCT supply details for last year of no. of and kinds of concerns raised by patients over primary care services?

NHS complaints

- Can PCT supply details for last year of no. of and kinds of complaints raised by patients over primary care services? This should include formal complaints made directly to, and dealt with by, individual GP practices.

Practice patient groups

If only 2 practices have patient groups, how is PCT encouraging others?

Annual Patient Satisfaction Survey

Can details of last one be supplied?

Other Issues

Connected Care- Further details

Linda Pepper

Health Scrutiny Support Programme Advisor to:-
Adult and Community Services and Health Scrutiny Forum,
Hartlepool

ADULT & COMMUNITY SERVICES & HEALTH SCRUTINY FORUM REPORT

31st January 2006



Report of: HARTLEPOOL PCT

Subject: ACCESS TO GP SERVICES – PRIMARY CARE
PERSPECTIVE

1. PURPOSE OF REPORT

- 1.1 To provide details to the Adult and Community Services and Health Scrutiny Forum that will support the investigation into Access to GP services.

2. BACKGROUND

- 2.1 The attached report provides details to support the investigation into Access to GP Services which is currently being undertaken by the Adult and Community Services and Health Scrutiny Forum.

3. RECOMMENDATION

- 3.1 That Members note, and discuss, the contents of the report.

Hartlepool Primary Care Trust

Report to the Scrutiny Committee

Access to GP Service – Primary Care Perspective

Introduction

This report gives details which will support the investigation into Access to GP services which is currently being undertaken by the Scrutiny Committee. The main areas which we have been asked to address are shown below with information which will answer each point.

Details of the number of GPs and their geographical distribution

The table below shows each of the 16 GP practices addresses, population and geographical area of the town in which they are present.

Practice	Address	Practice Population	Opening Times
Dr Awad	West View Millennium Surgery Brus Corner West View Road Hartlepool TS24 9LA	4,414	Monday: 08:30 - 12:0013:30 - 18:00 Tuesday: 08:30 - 12:0013:30 - 17:30 Wednesday: 08:30 - 12:0013:30 - 18:00 Thursday: 08:30 - 12:0013:30 - 18:00 Friday: 08:30 - 12:0013:30 - 18:00 Saturday: Closed Sunday: Closed
Dr Juhasz	West View Millennium Surgery Brus Corner West View Road Hartlepool TS24 9LA	1,945	Monday: 08:30 - 12:0013:30 - 17:30 Tuesday: 08:30 - 12:0013:30 - 17:30 Wednesday: 08:30 - 12:0013:30 - 17:30 Thursday: 08:30 - 12:00 Friday: 08:30 - 12:0013:30 - 17:30 Saturday: Closed Sunday: Closed
Dr Ayre & Partners	The Health Centre Victoria Road Hartlepool TS26 8DB	7,251	Monday: 08:30 - 12:1513:45 - 18:00 Tuesday: 08:30 - 12:1513:45 - 18:00 Wednesday: 08:30 - 12:1513:45 - 18:00 Thursday: 08:30 - 12:1513:45 - 18:00 Friday: 08:30 - 12:1513:45 - 18:00 Saturday: Closed Sunday: Closed

Appendix 3b.

Dr Bolt & Partners	<p>McKenzie House 17 Kendal Road Hartlepool TS25 1QU</p> <p>Branch Surgery Throston Grange Medical Centre 82 Wiltshire Way Hartlepool TS26 0XT</p>	16,205	<p>Monday: 08:45 - 12:30 13:30 - 18:00 Tuesday: 08:45 - 12:30 13:30 - 18:00 Wednesday: 08:45 - 12:30 13:30 - 18:00 Thursday: 08:45 - 12:30 13:30 - 18:00 Friday: 08:45 - 12:30 13:30 - 18:00 Saturday: Closed Sunday: Closed</p> <p>Monday: 08:45 - 12:30 13:30 - 18:00 Tuesday: 08:45 - 12:30 13:30 - 18:00 Wednesday: 08:45 - 12:30 13:30 - 18:00 Thursday: 08:45 - 12:30 13:30 - 18:00 Friday: 08:45 - 12:30 13:30 - 18:00 Saturday: Closed Sunday: Closed</p>
Dr Brash & Partner	<p>Chadwick House 127 York Road Hartlepool TS26 9DN</p> <p>Clinics also offered at Caroline Street</p>	10,464	<p>Monday: 08:30 - 12:15 13:45 - 18:00 Tuesday: 08:30 - 12:15 13:45 - 18:00 Wednesday: 08:30 - 12:15 13:45 - 18:00 Thursday: 08:30 - 12:15 13:45 - 18:00 Friday: 08:30 - 12:15 13:45 - 18:00 Saturday: Closed Sunday: Closed</p>
Dr Dawson	<p>General Medical Centre Surgery Lane Hartlepool TS24 9DN</p>	5,199	<p>Monday: 08:30 - 12:00 13:30 - 18:00 Tuesday: 08:30 - 12:00 13:30 - 17:30 Wednesday: 08:30 - 12:00 13:30 - 17:30 Thursday: 08:30 - 12:00 Friday: 08:30 - 12:00 13:30 - 17:00 Saturday: Closed Sunday: Closed</p>
Drs Gupta & Gallagher	<p>The Health Centre Victoria Road Hartlepool TS26 8DB</p>	3,999	<p>Monday: 08:30 - 18:00 Tuesday: 08:30 - 18:00 Wednesday: 08:30 - 18:00 Thursday: 08:30 - 18:00 Friday: 08:30 - 18:00 Saturday: Closed Sunday: Closed</p>
Drs Hazle & Peverley	<p>The Health Centre Victoria Road Hartlepool TS26 8DB</p>	3,855	<p>Monday: 08:30 - 12:00 14:00 - 17:00 Tuesday: 08:30 - 12:00 14:00 - 18:00 Wednesday: 08:30 - 12:00 14:00 - 18:00 Thursday: 08:30 - 12:00 14:00 - 17:00</p>

Appendix 3b.

			Friday: 08:30 - 12:00 14:00 - 17:00 Saturday: Closed Sunday: Closed
Dr Eaton & Partners	Grange House Surgery 22 Grange Road Hartlepool TS26 8JB Branch Surgery Brierton Medical Centre Earlsferry Road Hartlepool TS25 4AZ	5,322	Monday: 08:30 - 18:00 Tuesday: 08:30 - 17:30 Wednesday: 08:30 - 12:30 Thursday: 08:30 - 18:00 Friday: 08:30 - 18:00 Saturday: Closed Sunday: Closed
Drs Dunstone & Johnston	Hart Lodge Jones Road Hartlepool TS24 9BD	5,556	Monday: 08:30 - 17:30 Tuesday: 08:30 - 17:30 Wednesday: 08:30 - 17:30 Thursday: 08:30 - 17:30 Friday: 08:30 - 17:30 Saturday: Closed Sunday: Closed
Drs Koh & Trory	The Health Centre Victoria Road Hartlepool TS26 8DB	5,463	Monday: 08:30 - 12:30 13:30 - 18:00 Tuesday: 08:30 - 12:30 13:30 - 18:00 Wednesday: 08:30 - 12:30 13:30 - 18:00 Thursday: 08:30 - 12:30 13:30 - 18:00 Friday: 08:30 - 12:30 13:30 - 18:00 Saturday: Closed Sunday: Closed
Drs Omer & Thakur	The Headland Medical Centre 2 Grove Street The Headland Hartlepool TS24 0NZ	6,286	Monday: 08:30 - 18:00 Tuesday: 08:30 - 18:00 Wednesday: 08:30 - 18:00 Thursday: 08:30 - 18:00 Friday: 08:30 - 17:00 Saturday: Closed Sunday: Closed
Dr Patel	The Surgery Station Lane Seaton Carew Hartlepool TS25 1AX	2,551	Monday: 8.45am – 6pm Tuesday: 8.45am – 6pm Wednesday: 8.45am – 6pm Thursday: 8.45am – 1pm Friday: 8.45am – 6pm

Appendix 3b.

			Saturday: Closed Sunday: Closed
Dr Ray	Gladstone House Surgery 46 Victoria Road Hartlepool TS26 8DD	5,662	Monday: 08:30 - 12:0013:15 - 17:30 Tuesday: 08:30 - 12:0013:15 - 17:30 Wednesday: 08:30 - 12:0015:00 - 19:00 Thursday: 08:30 - 12:00 Friday: 08:30 - 12:0015:00 - 17:30 Saturday: Closed Sunday: Closed
Dr Singh (PCT Practice)	Owton Rossmere Resource Centre Wynyard Road Hartlepool TS25 3LB	1,256	Monday: 08:30 - 18:00 Tuesday: 08:30 - 18:00 Wednesday: 08:30 - 18:00 Thursday: 08:30 - 18:00 Friday: 08:30 - 18:00 Saturday: Closed Sunday: Closed
Dr Stoney & Partners	Bank House Surgery The Health Centre Victoria Road Hartlepool TS26 8DB	8,800	Monday: 08:30 - 18:00 Tuesday: 08:30 - 18:00 Wednesday: 08:30 - 18:00 Thursday: 08:30 - 18:00 Friday: 08:00 - 18:00 Saturday: Closed Sunday: Closed

Transportation

Hartlepool PCT has been working with Hartlepool Borough Council on the development of the Local Transport Plan 2006-2011. The plan identifies that convenient access to high quality health and social care services is essential to improve the current poor health of Hartlepool's population. It states that public transport access to GP surgeries is good with 99% of households within 30 minutes access times. This percentage does not take account of the problems Hartlepool residents have in access to health services in secondary care as well as primary, because of the location of the treatment, physical inaccessibility, lack of available public transport services and cost of travel. Some of these constraints impact directly on those people living within areas of disadvantage where levels of health are lower.

The work on this plan is ongoing and a number of areas have been identified where intervention is required. A collaborative approach is being adopted across the partner agencies to identify and overcome travel barriers to accessing health care in Hartlepool.

Physical Access

During the summer of 2004 the Hartlepool Primary Care PPI Forum carried out a number of monitoring visits to practices throughout the town. Accessibility was one of the areas covered within the reports, although it must be noted that this was in no way a DDA (Disability Discrimination Act) audit. A sample of the results is shown below: -

Monitored	Bolt	Dunstone & Johnston	Awad	Patel	Koh & Trory	Juhasz
Sufficient car parking facilities	Yes	Yes	Yes	Yes	Yes	Yes
Easily accessible by public transport	No	Yes	Yes	Yes	Yes	Yes
Building easily accessible for disabled	Yes	Yes	Yes	Yes	Yes	Yes
Disabled parking	Yes	Yes	Yes	Yes	Yes	Yes
Easy access to building	Yes	No	Yes	Yes	Yes	Yes
Are doors easy to open both ways	Yes	Yes	Yes	No	No	No
Egress Plan	Yes	No	Yes	Yes	No	

The above is by no means an exhaustive list but give some understanding of patient perceptions of the property being used by GPs across the town.

GP practices and community health services need good quality accommodation from where they can develop and expand high quality services. The Trust's Vision of care is that all services are easily accessible and is currently involved in the development of a new primary care centre at the rear of Owton Rossmere Resource Centre on Wynyard Road. The development is part of a LIFT (Local Investment Finance Trust) programme, a private and public partnership. The new building will be state of the art, and designed to be patient friendly and accessible to all.

The LIFT scheme is being developed within Hartlepool to modernise community based health facilities across the town. These new developments will house GPs, nurses, therapists, social workers, home care workers, advice workers and some specialist working in teams. Hartlepool Primary Care Trust is therefore also developing a significant health facility in the Town Centre. This project will potentially include space for a number of GP practices that have now out grown their current accommodation. It will also be to provide multi functional suites, diagnostic and treatment facilities and a range of community health services.

Waiting Times

From December 2004 Hartlepool PCT had to ensure that all general practices had to offer their registered population access to a primary care doctor within 24 hours and a primary care professional within 48 hours of requesting to be seen i.e.100% targets. A primary care professional is defined as any clinical professional based in general practice including GPs. These two targets have remained key performance indicators affecting the star rating of the PCT. Additionally from March 2005 all practices had to also offer pre-bookable appointments to patients for not less than two days in advance.

In line with Government policy the PCT carries out an access survey on a monthly basis. The details of the survey carried out in December are shown below. This survey includes details of availability of appointments on a given day with both the GP and the Primary Care Professionals which includes Practice Nurses and Nurse Practitioners. The information collected also shows how far in advance patients can book pre-book appointments with the surgery.

Position	Practice	List Size	GPs			PCPs	
			Appointment System	Days to Appointment	Advance Booking	Appointment System	Days to Appointment
1	A	4414	Y	0	4	Y	0
2	J	1945	Y	1	4	Y	1
3	A	7251	Y	0	4	Y	0
4	B	16205	Y	1	4	Y	1
5	B	10464	Y	0	3	Y	0
6	D	5199	Y	0	4	Y	0
7	G	3999	Y	0	5	Y	0
8	H	3855	Y	1	4	Y	0
9	E	5322	Y	1	4	Y	1
10	D	5556	Y	0	4	Y	1
11	K	5463	Y	1	4	Y	2
12	O	6286	Y	0	4	Y	0
13	P	2551	Y	1	5	Y	0
14	R	5662	Y	0	4	Y	0
15	S	1256	Y	0	4	Y	0
16	S	8800	Y	0	4	Y	1

Each practice is supported by a Service Improvement Facilitator to implement demand and capacity studies to gauge activity on a daily basis and ensure appropriate skill mix is provided.

Some of the work undertaken to date includes the establishment of a working group has been established within one practice where a number of administration staff work together to improve this aspect of the service. Over the last eighteen months this group has made significant progress in establishing systems and processes to improve conditions for both the staff and patients.

Core 'Advanced Access' practices undertook a baseline measure of the time that patients were waiting for an appointment with a GP. Two practices recorded waits of 11 days and 8 days for a routine appointment. These practices now offer 'on the day' appointments and pre-bookable appointments at two weeks and one week in advance.

The PCT has constantly achieved the 100% access target since August 2004. This does still mean however that from time to time when demand is very high patients need to wait for appointments and may have difficulty getting through to the surgery.

Out of Hours arrangements

In April 2004, Hartlepool PCT assumed the responsibility for commissioning Primary Care Out of Hours (OOHs) services for Hartlepool residents. This was delivered through a commissioning consortium across Tees Valley and involved the four Tees PCTs and Darlington and the contract was awarded to Primecare following a formal tendering process. Previously OOHs had been commissioned by GP practices and provided by a commercial deputizing service working throughout most of the Teesside area with a second on-call rota, comprised of GP Principals, in place only in Hartlepool.

The Out of Hours service is now provided by under contract between Hartlepool PCT and Primecare. The cover is provided from 6pm until 8am Monday to Friday as well as weekends and Bank Holidays.

The service includes access to a clinic setting within Hartlepool General's outpatient department if they are well enough to attend or a home visit service there this is considered appropriate on clinical grounds.

Additional Services available to patients

Each practice has their own team of professional who offers services to their practice population. Each practice also has team members who are aligned to their practice, such as district nurses, community midwives and health visitors.

Many practices offer other services such as chronic disease management clinics, antenatal, child health check. A comprehensive and accurate list is currently being compiled and will be provided to the committee upon completion.

Minor Ailments

The Minor Ailments Scheme offers advice and/or treatment from Community Pharmacies across Hartlepool originally for thirteen minor conditions which, has now been increase to nineteen, utilizing agreed protocols and a PCT service specification. All 16 GP Practices and all 17 Community Pharmacies signed up to the scheme ready for its launch at the end of December 2003.

The scheme provides benefits for the patients, the practices, the PCT and the Pharmacists in Hartlepool.

- For patients~ Reduced waiting times and improved access.

- For GP practices and the PCT~ A reduction in 'inappropriate' consultations, improved access to a Health Care Professional and a reduction in drug expenditure as patients are helped to manage their condition more effectively.
- For the pharmacists~ better use of their professional skills is the major benefit in addition to their integration into the Primary Care Team.

The scheme was evaluated between January and June 04 during which time **5364** consultations have been made at pharmacies across Hartlepool and **6861** items have been supplied.

A further 55 consultations took place which resulted in **NO** treatment being supplied. Reasons for this include:

- patients presenting for ailments outside the agreed list (oral thrush when protocol is for vaginal thrush only)
- referrals where the patient was excluded from the protocol (see exclusion criteria for each protocol)

Another 3 consultations resulted in rapid referrals, fast tracking the patient back to their GP. On each of these occasions the pharmacist contacted the surgery on behalf of the patient and appointments were made for the same day.

The scheme is continuing today with average monthly consultations well in excess of 1,000 per month.

Greatham and Wynyard Road Nurse Practitioner Clinics

In order to create more capacity within primary care to improve access for patients, a Nurse Practitioner Clinic was established in Greatham area of the town. This provided the local community, many of which are elderly, with an easy accessible service where many minor ailments can be treated.

Subsequently a further clinic has been set up in the Owton Rossmere Resource Centre which provides easily accessible health care to an area of high need.

Monitoring the quality of service

There are a number of systems and process in place which provide us with a greater understanding of the quality of services being offered to patients and which ensure any problems are highlighted for action.

1. New GMS Contract Quality and Outcomes Framework

The quality and outcomes framework is a cornerstone of the new GMS contract. Practices receive payment for achievement against the quality criteria of the new contract. The quality framework comprises a number of clinical and organisational 'domains', each being made up of indicators against which achievement is measured. Quality points are available for each of the individual indicators.

A maximum of 1,050 points is available under the quality framework, with different areas of performance receiving greater weighting. A high-level break down of available points is as follows:

- Clinical indicators: 550
- Patient experience: 100
- Organisational indicators: 184
- Additional services: 36
- Other: 180

- Total: 1050

The achievement against these indicators is measured during an assessment visit to each practice. During this visit a team made up of Clinicians, PCT staff and Lay assessor look at the key areas in which the practice are claiming the points to ensure that the quality element of this achievement is met.

During 2005/06 practices achieved an average of 873.07 of the 1,050 points available. This is broken down by practice as shown below:-

PRACTICE	POINTS
GUPTA	738.28
SINGH	620.32
DUNSTON	880.72
KOH	938.81
BOLT	775.49
DAWSON	791.13
OMER	821.36
AYRE	1002.77
BRASH	848.31
JUHASZ	855.53
HAZLE	1025.42
EATON	1027.31
RAY	861.07
AWAD	864.49
PATEL	872.61
STONEY	1,045.51
PCT	873.07

2. PALS service

Patients can contact PALS if they have concerns or don't know where to go to, they give information for patients, relative's carers and friends. PALS offers a free and confidential service giving advice and support to help patients sort out any concerns that they may have about the care or treatment provided. It can also give information about the different services available from the NHS, our hospitals, GP and community health services.

3. Complaints

Patients can contact Hartlepool Primary Care Trust if they want to make a formal complaint with regard to any aspect of their health care within the community. When a formal complaint is received it is acknowledged within 2 working days and an investigation is carried out and should be completed within 20 working days.

4. Practice Patient Groups

There are two practices in Hartlepool which have their own patient group. One of the practice groups meets every quarter and discusses various issues, such as:-

- New services offered to patients - One example of this is a joint injection service. The patient group wanted the service to be available to them and the practice has now been offering this service for the past two years.
- Appointment system – Debate often takes place with regard to pre-bookables verses on the day appointments. Practice have now changed their appointment system to provide a combination of both
- Annual patient satisfaction survey results
- New ideas with regard to improve current services

Conclusion

The above information provides some of the background information that supports the ongoing work within the scope of this project.

ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM REPORT

28th February 2006



Report of: SCRUTINY SUPPORT OFFICER

Subject: TEES VALLEY JOINT HEALTH SCRUTINY
COMMITTEE – UPDATE REPORT

1. PURPOSE OF REPORT

- 1.1 To bring to the Forums attention the Final Report of the Joint Scrutiny Committee and its findings in relation to the Darzi Proposals. (I.e. the Acute Services Review).

2. ACUTE SERVICES REVIEW – FINAL REPORT

- 2.1 As Members will be aware the Joint Committee has reviewed in detail the Acute Services Proposals. Since the last update report, the Joint Committee has met on four occasions to receive further written and verbal evidence. This has now been collated and the Committee has published its Final Report.
- 2.2 Attached as an appendix to this report is the executive summary of the Joint Committee's Final Report for Members to consider. If Members wish to see a copy of the complete report, access mechanisms have been outlined below:-

- A copy of the Final Report has been placed in the Members Library
- The report can also be accessed online and is available on the Middlesbrough Council Website at:-

<http://www.middlesbrough.gov.uk/ccm/content/council-government-and-democracy/councils/council-procedures/committee-management-and-information-system.en>

Enter the web address above and follow the steps outlined:-

- Click to enter COMMIS

- Select 'Index to Meetings'
 - Select 'Joint Section 7 Consultation Committee (Acute Services Review) 2005'
 - Select 'Meeting details for 06/02/06'
- Copies can also be obtained from the Scrutiny Support Team, contact details are noted below.

3. RECOMMENDATIONS

- 3.1 That Members note the content of this report.

CONTACT OFFICER

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ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM REPORT

28th February 2006



Report of: Scrutiny Support Officer

Subject: SUGGESTED ADDITIONAL SCRUTINY WORK
PROGRAMME ITEM – ADULT LEARNING

1. PURPOSE OF REPORT

- 1.1 To make Members aware of a suggested addition to this Forum's work programme.

2. BACKGROUND

- 2.1 On 7th February 2006 the Children's Services Scrutiny Forum received a report from the Adult and Public Health Services Portfolio Holder on the Adult Learning Inspection. The Portfolio Holder was responding to the recommendations of an inquiry that the (then) Culture and Learning Scrutiny Forum started and was concluded under the Children's Services Scrutiny Forum. The Portfolio Holder's report is attached at **Appendix A**.
- 2.2 Following discussions of this item at the Children's Services Scrutiny Forum meeting on 7th February a number of suggestions were made for future scrutiny. However, given that the remits of the Scrutiny Forum's changed in July 2005 this issue now falls under the responsibilities of the Adult and Community Services and Health Scrutiny Forum.
- 2.3 Consequently, there are a couple of issues that the Children's Services Scrutiny Forum agreed to pass onto this Forum for consideration. These include:
- The specific issue of the Learning and Skills Council (LSC) funding allocation to Hartlepool Adult Learning Service. The funding allocation is lower than in previous years and it was suggested that Members may want to consider the likely impact of this on the service. It was recommended that this issue (if selected by Members for future Scrutiny) should be scrutinised prior to the close of the 2005/6 Municipal Year.

- The Children's Services Scrutiny Forum strongly recommended that the Adult and Community Services Scrutiny Forum should consider the way in which funding is allocated to Adult Learning as an in-depth scrutiny topic for the 2006/7 Municipal Year. Key issues to consider could include: how the regional LSC allocates funding; the role of Hartlepool Partnership in funding allocation; the impact of frequently realigning services to meet changing funding streams; and what are the likely long-term implications of national policy developments to Adult Learning Services and 'Lifelong Learning' generally.

3. RECOMMENDATIONS

- 3.1 That Members note the content of the report and determine whether to pursue this as a future work programme item.

Background Papers

Culture and Learning Scrutiny Forum Minutes 21st April 2005

Children's Services Scrutiny Forum Minutes 30th August 2005

Children's Services Scrutiny Forum 30th August 2005 – Re-inspection of the Adult Education Service – Adult Education Co-ordinator (HBC);

Children's Services Scrutiny Forum 30th August 2005 – Future funding of Adult Education – Adult Education Co-ordinator (HBC); and

Children's Services Scrutiny Forum 30th August 2005 – Reforming the Funding and Planning Arrangements for First Steps and Personal and Community Development Learning for Adults – Senior Learning Advisor (LSC).

Children's Services Scrutiny Forum 7th February 2006 – Adult Learning Inspection – Portfolio Holder for Adult and Public Health Services.

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CHILDREN'S SERVICES SCRUTINY FORUM REPORT

Tuesday 7th February 2006



Report of: Portfolio Holder for Adult and Public Health Services

Subject: ADULT LEARNING INSPECTION

1. PURPOSE OF REPORT

- 1.1 To inform Members of this Forum of the decision of the Adult and Public Health Services Portfolio Holder in relation to the Adult Learning – Final Report by Children's Services Scrutiny Forum.

2. BACKGROUND

- 2.1 On 21st April 2005 the (then) Culture and Learning Scrutiny Forum examined the inspection results of Hartlepool's Adult Education Service, during its last meeting of the 2004/05 Municipal Year. Members of the Forum were keen to explore this issue given the poor inspection results the service had received in March 2004.
- 2.2 Having explored the issue with the Adult Education Co-ordinator on 21st April 2005, Members of the Forum determined that they would like one further meeting to explore this issue once the re-inspection of the Adult Education Service had taken place in May 2005. It was agreed at the meeting on 21st April 2005 that the Forum should:
- (a) Seek to make recommendations to the Portfolio Holder strongly supporting Adult Learning. Prior to doing this the Forum should explore the funding criteria of Adult Education Services as a basis for taking this matter to the Portfolio Holder.
 - (b) Discuss this matter with a representative from the Learning and Skills Council (LSC) to clarify the basis of its current and future funding policies for Adult Education in Hartlepool compared with the other authorities within its responsibility; and
 - (c) Consider the importance of the contribution of Adult Education to the Authority's social inclusion objectives.

- 2.3 Since the Forum first looked at this matter the remit of the Forum changed to Children's Services, which means that the scrutiny topic now falls outside of its remit. However, when the Forum determined its work programme on 5th July 2005 it was agreed that this item should remain with this Scrutiny Forum because of the work carried out in the previous municipal year. This approach was agreed by the Scrutiny Co-ordinating Committee on 5th August 2005.
- 2.4 Consequently, on 30th August 2005 the following reports were presented to the Forum:
- (a) Re-inspection of the Adult Education Service – Adult Education Co-ordinator (HBC);
 - (b) Future funding of Adult Education – Adult Education Co-ordinator (HBC); and
 - (c) Reforming the Funding and Planning Arrangements for First Steps and Personal and Community Development Learning for Adults – Senior Learning Advisor (Learning and Skills Council).
- 2.5 During discussions Members reached the following conclusions about Adult Learning:
- (a) Members noted the 'Re-inspection of the Adult Education Service' report and presentation and commented that there appeared to have been a dramatic improvement in a short space of time. Without wishing to take anything away from the work undertaken by staff, Members commented that the first inspection had possibly been too severe;
 - (b) That the Adult Services and Public Health Portfolio Holder be advised that it is this Forum's view that Adult Education is vital to the Town, especially in community areas and in local venues where people can feel comfortable in the learning environment; and
 - (c) That Scrutiny Co-ordinating Committee be requested to arrange for the Adult and Community Services Scrutiny Forum to receive future updates from the Senior Learning Advisor of The Learning and Skills Council.
- 2.6 The contents of this report were approved by the Children's Services Scrutiny Forum on 25th October 2005 and Scrutiny Co-ordinating Committee on 14th November 2005.

3. PORTFOLIO HOLDER RESPONSE

- 3.1 On 12th December 2005 the Children's Services Scrutiny Forum's Final Report on the Adult Learning Inspection was reported to the Portfolio Holder for Adult and Public Health Services.
- 3.2 In response to the Scrutiny Forum's recommendations the Portfolio Holder:

- (a) agreed the findings and recommendations of the report, and
- (b) asked it to be noted that in light of the impending announcement from the Learning and Skills Council, in the form of the document “Future of Post 19 Funding”, Scrutiny may wish to look at the future configuration of Adult Learning services.

4. RECOMMENDATIONS

- 4.1 That Members note the contents of the report.