ADULTS, COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM AGENDA

HARTLEPOOL BOROUGH COUNCIL

Friday 23rd June 2006

at 12.00 noon

in Committee Room "B"

*** PLEASE NOTE THIS IS AN ADDITIONAL MEETING ***

MEMBERS: ADULTS, COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM:

Councillors Barker, Belcher, Brash, Fleet, Griffin, Lauderdale, Lilley, Rayner, Wistow, Worthy and Young.

Resident Representatives: Dennis Brightey, 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 13th June 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 Reconfiguration of PCTs – *Chief Executive and Director of Adult and Community Services (to follow)*

8. **ANY OTHER ITEMS WHICH THE CHAIRMAN CONSIDERS ARE URGENT**

ITEMS FOR INFORMATION

i) Date of next meeting Tuesday 25th July 2006, commencing at 10.00 am in Committee Room "B".

ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM

MINUTES

13th June 2006

Present:

Councillor: Gerald Wistow (In the Chair)

Councillors: Councillors Caroline Barker, Jonathan Brash, Mary Fleet, Sheila Griffin, Geoff Lilley and Gladys Worthy.

Resident Representatives:
Mary Green and Evelyn Leck

Officers: Charlotte Burnham, Scrutiny Manager
Sajda Banaras, Scrutiny Support Officer
Angela Hunter, Principal Democratic Services Officer

1. Apologies for Absence

Apologies for absence were received from Councillors Stephen Belcher and John Lauderdale.

2. Declarations of interest by Members

The following declarations were made at this point in the meeting:

Councillor Caroline Barker – private and non-prejudicial
Councillor Jonathan Brash – private and non-prejudicial
Resident representative Evelyn Leck – private and non-prejudicial

3. Minutes of the meeting held on 25th April 2006

Confirmed.

4. Matters Arising

Minute 74 was referred to regarding the North Tees and Hartlepool NHS Trust – 'Annual Health Check'. A representative from the Hartlepool and North Tees NHS Trust gave assurance that there would be no redundancies of front-line staff. However, there had since been reports in the press indicating that they were a possibility. Members were concerned at the inconsistency of

information available and requested that updated information from reports already considered should be reported to the Forum as and when appropriate.

5. Responses from the Council, the Executive or Committees of the Council to Final Reports of this Forum

No items.

6. Consideration of request for scrutiny reviews referred via Scrutiny Co-ordinating Committee

No items.

7. Consideration of progress reports/budget and policy framework documents

No items.

8. The Role of Adults, Community Services and Health Scrutiny Forum *(Scrutiny Support Officer)*

The Scrutiny Support Officer submitted a brief report outlining the background to the approach to overview and scrutiny in the Council. The role of Scrutiny Co-ordinating Committee was discussed and a more detailed description was given of the role and functions of the Adults, Community Services and Health Scrutiny Forum.

The key roles of Scrutiny were detailed as:

- Policy development and review
- Holding the executive to account
- Investigating issues of local concern

The Chair of the Forum indicated that contact had already been made with the Chief Executives of the local Health Trusts with a view to inviting them to attend a future meeting of this Forum. It was suggested members of the Forum meet half hour prior to these particular meetings to ensure they were fully prepared.

Members felt that inviting the Chief Executive's to the Forum would be of great benefit and should enable a lot of questions to be answered.

Decision

Members noted the report.

9. Determining the Scrutiny Forum's Work Programme for 2006/07 *(Scrutiny Support Officer)*

The Scrutiny Support officer presented a report which contained information to enable the Forum to compile its Work Programme for 2006/07. The report included some suggested topics from the Portfolio Holders for Adult Services and Public Health and Culture, Leisure and Transportation as well as the Director of Adult and Community Services. The sections of the Corporate Performance Plan detailed the relevant sections for the Forum's consideration were attached by way of appendix.

The Scrutiny Support Officer also suggested that in line with national health scrutiny guidance a 3-year rolling work programme should be established in order to enable the NHS to prepare their input into the inquiries in advance. An additional list of budget and policy framework items and progress reports was circulated to members for their information. The Chair indicated that it would be useful to schedule into the diary when a response to an inquiry would be required from the Executive. It was noted that an additional meeting had been scheduled to take place on Friday 23rd June at 12 noon at which the Director of Adult and Community Services would present a report to advise members of the issues and options facing Hartlepool PCT.

A discussion followed where a number of topics were suggested for inclusion in this year's work programme or in the 3-year rolling programme. However, it was indicated that the Forum needed to be mindful of separate studies being undertaken by another group and the risk of duplicating effort. The Food Service Plan was discussed and Members requested further information to ascertain if this would link into the work the Forum was undertaking.

Decision

Members agreed to the following:

a) For inclusion in the Work Programme for 2006/07:
   (i) Social prescribing
   (ii) Development of PCT services

b) For inclusion in years 2 and 3 of the Rolling Work Programme:
   (i) Primecare (Out of Hours Service)
   (ii) Eligibility Criteria
   (iii) Adult Learning
   (iv) Smoking

10. Any Other Business – Tees Valley Health Scrutiny Committee *(Scrutiny Support Officer)*

Members were reminded of this Forum's input into the above Committee. Three representatives were nominated from this Forum at Annual Council onto the above Committee and they were:

Councillors S Belcher, G Lilley and G Wistow.

It was suggested that an item be placed on the agenda after each of the above Committee's in order that information can be reported back to the Forum.

11. Any Other Business – Local Authority Free Bus Pass Eligibility Criteria

The Chair indicated that an issue had been raised with him that related to joined up working and a potential waste of GPs time. A patient, despite undergoing a medical examination to qualify for Disability Living Allowance with the Department of Work and Pensions (DWP), was requested by the local authority to undertake a second medical examination to qualify for a free bus pass. The Forum resolved to request that the Portfolio Holder addresses this issue to ensure that applicants only undergo one medical examination.

GERALD WISTOW

CHAIRMAN

ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM REPORT

23rd June 2006

HARTLEPOOL BOROUGH COUNCIL

Report of: **Director of Adult and Community Services**

Subject: **PCT Reconfiguration – Tees Valley**

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1. PURPOSE OF REPORT

1.1 The purpose of this report is to advise members of the Adult and Community Services and Health Scrutiny Forum of the issues and options facing Hartlepool PCT as part of the requirement to meet 15% savings on management costs in accordance with the requirements set out in Commissioning a Patient Led NHS.

2. BACKGROUND

2.1 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" and "Creating a Patient-Led NHS" 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.

2.2 The SHA submitted its proposals for the implementation of "Commissioning a Patient Led NHS" 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 Langbaurgh.

2.3 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. The Hartlepool Borough Council response to the options being consulted is attached as **APPENDIX 1.**

2.4 In May 2006 the Secretary of State's announced that there would be twelve PCTs in the North East region which included four PCTs in Tees Valley that are co-terminous with their corresponding Local Authority boundaries.

2.5 Following on from the Secretary of State's announcement on PCT reconfiguration the Strategic Health Authority wrote on the 30th May 2006 **(APPENDIX 2)** to all Local Authority Chief Executives to outline the savings requirement from the twelve PCTs. The twelve PCTs have to reduce management expenditure by £10 million without impacting on service delivery. For the Tees Valley PCTs this amounts to approx £2 million and, for Hartlepool specifically, the savings requirement is £376k.

2.6 As part of the announcement on the future configuration of PCTs, the Secretary of State outlined some conditions that could be considered to ensure the required efficiency savings were met and these included the consideration of whether shared management arrangements would benefit the PCTs in meeting the criteria for enhancing PCT performance, (e.g. the need to improve the commissioning function particularly in respect of acute hospital services).

2.7 The Department of Health has given PCTs guidance on how those efficiency savings can be made and these conditions limit even further the way in which the PCTs can release savings. For example no savings can be made from management costs relating to the implementation of Choosing Health i.e. no management savings can be made from areas relating to Public Health. Any savings made as a result of PCT deficit reduction can be considered so savings against vacant managers posts can not be counted twice.

2.8 In his letter of the 30th May the Strategic health Authority Chief Executive David Flory indicated that the twelve PCTs should submit proposals by the 5th June on how these issues and efficiency savings would be addressed. The Tees Valley PCT Chief Executives have submitted their proposals but these proposals have not been shared with the PCT Staff, PCT Board or the corresponding Local Authority.

3. PROPOSALS

3.1 As no formal proposals have been shared with the Local Authorities, then the options considered here are a combination of those that the Local Authority can assume the PCT Chief Executives have considered and those that involve greater integration with the Local Authorities, which one can assume have not been considered as a serious consideration by the PCT Chief Executives as no formal discussions have taken place with the Local Authority in relation to the way in which the 15% savings can be made.

3.2 **Option 1**

3.2.1 Retain a Hartlepool PCT as it currently stands with its own management team, Board and Professional Executive Committee (PEC). This option is not deemed to be viable by the PCT Chief Executive as the PCT ability to make the savings target and continue to provide services that are unaffected is not achievable. The PCT's management costs amount to £2.514 million in total which equates to a savings target of £376k that would have to be achieved by the end of 2007/08. This is in addition to achieving financial balance by 2007/08 with a deficit of approx £6m. However due to the way in which savings are allowed to be generated (as per the DOH guidance) certain assumptions have to be made such as the necessity for a PCT to continue certain statutory functions. These include Board costs, statutory requirements, support infrastructure and Finance. Allowing for these costs, the opportunity to make 15% savings is reduced significantly, being based on a figure of £1.173m, rather than the higher starting point.

3.2.2 The costs charged against PCT management costs are predominantly staffing costs. Consequently, any reductions in staffing would incur redundancy costs and could also incur early pension payments. In most situations, these could be managed in the lead up to 2008-09.

3.2.3 However, there are a number of staff where there is no financial benefit, since in the event of their being made redundant, the annual cost of early pension would be higher than the salaries they are paid. The management costs associated with these staff amount to £209k and again reduce the ability to make savings within the timescale allowed.

3.2.4 Consequently, 15% reductions are, in effect, based on management costs of £964k, (i.e. £1173k - £209k) as the costs above this level provide extremely limited scope to vary, as they reflect minimum requirements to maintain the organisation.

3.2.5 Taking £376k out of the remaining management costs equates to a reduction in the order of 37% and is clearly not feasible, given the workload that existing staff are undertaking.

3.2.6 The option of staying as we are on the face of it seems the most advantageous from a Local Authority perspective, but the ability of the remaining PCT staff to work jointly with the Local Authority would be extremely limited as the majority of the key players would either not be in place or unable to manage a joint agenda due to the need to cover the statutory work of the PCT. This work would need to be undertaken by the remaining managers in the PCT due to the reduction of staff and the consequent lack of available skills and capacity within the remaining PCT.

3.3 **Option 2**

3.3.1 This option would see each PCT having its own Trust Board, with a corresponding PEC (Professional Executive Committee), but with a complete sharing of the management team across the Tees Valley area: in effect a single Chief Executive, one team of Executive Directors with some kind of locality team based in each PCT office. This proposal may have a range of variables such as the sharing of a PEC across the Tees Valley or the merging of the PEC in PCTs with the Practice Based Commissioning Group/s. This is the group (mainly GPs but the Director of Adult and Community Services and the Director of Children Services are members in Hartlepool) that will lead all Locality Commissioning in the future. This group is likely to be supported by a Tees wide acute based commissioning team whose role is to support and manage the contracting issues that arise from Practice Based Commissioning.

3.3.2 A variation on this option may be to move over a period of time to a Tees Valley option , so the interim arrangement could see a PCT Board, Chief Executive, Director of Finance and Director of Public Health for each area, moving over time to work more jointly with the other Tees PCTs. The savings could be made by sharing of some management arrangements such as Directors of Planning etc and the sharing of other contracted back office functions such as :

- use of one financial ledger system
- One payroll system
- Single IT services across Tees
- Rationalisation of other back office functions such as HR, Estates, performance, information management, communications etc.

The PCTs and SHA may feel that this option may be more politically acceptable and may be something that will be presented.

3.3.3 Option 2 or some variation on it as highlighted in 3.3.2 is very likely to be proposed by the PCT Chief Executives and supported by the Strategic Health Authority as it will meet the 15% savings target easily and is more in keeping with the Strategic Health Authority's initial proposals for a single Tees Valley PCT.

3.3.4 From a Local Authority perspective this option will significantly hinder continued work in Hartlepool as it will distance the PCT management team from the Local Authority. It will make working via the Local Area Agreement difficult and will mean Hartlepool will be constantly trying to ensure the needs of Hartlepool and its residents figure in plans and decisions being made in a Tees Valley arena.

3.4 **Option 3**

3.4.1 This Option is not something that has been considered formally either by the PCT Board, Tees Valley PCT Chief Executives or the Strategic Health Authority. This option or any variation on it could see:

- Complete integration of the Adult and Community Services management arrangements with the PCT in relation to both commissioning and provision, with some elements of children's services forming part of the Children's Trust. We have agreement to develop integrated Locality Teams of District Nurses, Social Care Services and Occupational Therapists and have had discussions with the PCT regarding the development of a joint commissioning team for out of hospital commissioning. This however can not now be considered in isolation from the development of Practice Based Commissioning.

- The creation of an adult provider trust that encompasses all of the PCT community health services and the adult social care provision into one organisation that could be some kind of social enterprise or a formal Care Trust arrangement.

- The development of a Commissioning Partnership that works with/for the Practice Based Commissioning Group to commission out of hospital services for the residents of Hartlepool. This arrangement could cover adult and children's issues or focus purely on adults. This proposal, however, could be very difficult as the Practice Based Commissioning Group (PBC) currently focuses mainly on acute services and may be very reticent to share control/influence in relation to any services they commission.

The PBC group is a newly formed group and is still at very early stages of its development and has not yet began to grasp many of the complex issues that surround the commissioning of services for non acute or out of hospital options that are not purely focussed on GP practices e.g. services for people with MH/LD or wider issues for older people. These options are core business for the adult social care services.

3.4.2 Any of the above options would still mean that the required savings of 376k would still have to be made. This has to be a cashable saving as the savings are then to be reinvested into front line health care. The requirement to make savings would be broader within the context of a joint approach with the PCT as we would be able to offer up savings from the whole partnership not just the PCT element of the management costs. However as already stated the PCTs have a range of contracts that are in place for things such as finance systems, payroll systems and IM & T systems that would still have to be honoured reducing the ability to focus on single systems for these areas. However some back office functions could still be considered for savings.

3.4.3 There are risks that the Local Authority would need to consider if any of the proposals presented in Option 4 were to be considered. These risks will be outlined in section 5 of the report.

3.4.4 The options presented in section 4 would see a more formalised partnership with the PCT which would ensure that the needs of Hartlepool residents were central to any decisions made regarding health or social care issues. The options in section 4 would without doubt offer the best opportunity for continued partnership across health and social care in Hartlepool and would ensure that Hartlepool itself influenced the shape of services in the future.

4. RISK IMPLICATIONS

4.1 Options 1, whilst seeming to be an attractive option does have inherent risks for Hartlepool. Whilst option one retains a full Hartlepool PCT the implications of the need to make 15% management savings mean that the PCT itself would struggle to remain viable and would be very limited in its capacity to plan and work effectively with the Local Authority.

4.2 Option 2 does ensure the 15% savings would be met but would have significant risks for Hartlepool. The development of a Tees wide management team would mean that Hartlepool's needs could potentially be subsumed or overlooked within a wider PCT management team.

It may prove difficult to form a close working relationship with a more distant team and the potential for the implementation of the LAA would be affected as the management team would have to consider the wider needs of the Tees Valley and not just those of Hartlepool. Our ability to influence the nature and shape of decisions and service developments would be limited and as the smaller Local Authority Hartlepool, would have to constantly punch above its weight to have its needs considered. This is not an option that would appear to be in the best interests of Hartlepool.

4.3 Option 3 offers a very attractive option locally but again has some inherent risks. The PCT would still have to achieve financial balance by 2007/08 placing great pressure on its staff and services over the next year. The PCT has already been using management savings to ensure it achieves recurrent balance and obviously these savings can't be considered again as part of the 15% requirement. The potential to make £376k savings is possible but the impact of doing so on the Local Authority needs to be considered. If savings at this level were made the Local Authority would either have to support the PCT by providing funding to make the savings or the new joint management arrangement would need to pick up some of the PCT's work/capacity requirements to ensure the full range of health and social care issues were effectively managed.

We have had an early look at the PCT management structure **(APPENDIX 3)** in order to identify where possible overlap or duplication may occur, but this needs to be undertaken jointly with the PCT to ensure that this is done in an informed manner. The current PCT structure is available as one of the background papers should members wish to consider it but as already mentioned, a number of posts in the structure such as the Director of Planning post are vacant and are being used to support the PCT to achieve financial balance.

4.4 The option for full integration is something that we would be keen to consider ordinarily but the requirement to make such significant savings would mean that from the start the service may struggle to capitalise on the opportunities for effective commissioning due to the potential lack of capacity in its management arrangements. This may not offer the best possible start in terms of the future needs of the joint organisation.

4.5 Without doubt the services provided by the Local Authority would be impacted upon in terms of capacity and great care would be needed to ensure that the Social Care star rating did not suffer as a result of spreading the management teams' capacity across two organisations.

4.6 Both organisations would need to go into a joint arrangement with the belief that over a period of time greater efficiencies could be made, whilst recognising there may be a need for greater financial and political support from the Local Authority for the first two years in order to achieve the savings required and to ensure the services delivered remain of a high quality.

4.7 A risk that does need to be considered is the new requirement for all PCTs and their management teams to undergo a Fitness for Purpose assessment to ensure they are able to achieve and deliver health services in a way which is deemed to be acceptable and effective. This Fitness for Purpose process is a national process but is coordinated on a regional basis by the SHA. For un-reconstituted PCTs such as Hartlepool the process is now underway; for newly configured PCTs this process will commence in the autumn. However for the management team in those newly configured PCTs a recruitment process is already underway for key posts. The Fitness for Purpose process begins with an internal self assessment against nationally set criteria followed by peer reviews of the Board, its management team and their effectiveness, by another PCT in the first instance. This is then followed by a formal challenge session to both the Board and the management team by the SHA and an external consultancy organisation which is supporting the Fitness for Purpose process nationally.

As a result of this process any organisational arrangement needs to meet the required standard and leadership at Chief Executive level is assessed partly by this process. If the PCT is not deemed to be 'fit for purpose' then the SHA has the ability to intervene and ensure adequate arrangements are put in place to remedy the situation. It would therefore be essential that any arrangement that is jointly considered by the Local Authority and PCT would have to undergo this process to ensure its Fitness for Purpose.

5. FINANCIAL CONSIDERATIONS

5.1 As stated previously there are significant financial issues that would need to be considered by the Local Authority if it chose to pursue a more formal joint arrangement with Hartlepool PCT. The impact of making 15% management savings in Hartlepool PCT and the requirement to achieve recurrent financial balance by 2007/08 is not an prospect to be taken lightly. Any joint arrangement would need the council, the PCT Board and the SHA to be fully committed to supporting the joint service over the next two years (both politically and financially) to ensure a truly integrated and effective arrangement is put in place to meet the health and social care needs of Hartlepool residents and to achieve the aspirations and principles set in Vision for Care.

6. LEGAL CONSIDERATIONS

6.1 The Council may choose to take legal advice in relation to the options in this paper for a number of reasons;

- If the SHA go forward with Option 1 then the council may want to seek legal advice in relation to any possible legal redress the council may want to take, as this proposal seems contrary to the spirit of the Secretary of State's decision to commit to co terminus PCTs in Tees Valley area.

- If the council decide to pursue more formal integration with the PCT then advice will be needed in a range of issues, such as the legal and accountability issues of the Council and the PCT Board in relation to the joint services alongside many other staffing, financial and HR issues that will need to be considered as part of any formal partnership arrangement.

7. RECOMMENDATIONS

7.1 The Adult and Community Services and Health Scrutiny Forum is asked to receive the report and to give consideration to the options outlined in this paper with a view to advising the cabinet and full council on the best way forward for Hartlepool Borough Council in relation to the PCT reconfiguration issues.

8. REASONS FOR RECOMMENDATIONS

8.1 This paper has been bought to the scrutiny committee to ensure that members are aware of the issues that may impact on the future of health care in Hartlepool. The reconfiguration of the PCTs and the impact of implementing Commissioning a Patient led NHS in respect of the 15% management savings are likely to have a lasting effect on the health economy in Hartlepool. Members will want to explore the issues and make recommendations to the Cabinet in relation to a way forward from a council perspective in these issues.

Contact Officer

Nicola Bailey – Director of Adult and Community Services

Background Papers

The following papers were used in the preparation of this report

1. "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.

2. Letter from David Flory SHA Chief Executive to Local Authority Chief Executives - Dated 30th May 2006

3. PCT Organisational Structure

"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

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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 Langbaurgh.

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 or 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 in "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 **£m**	**Option 2** **£m**	**True Coterminosity** **£m**
Reduce number of Boards and PECs:-			
8 x Boards	4		
4 x Boards		2	2
Reduce SHAs (2 to 1)	2	2	2
	6		
		2	
Merge management and admin staff in Teesside	N/A	6	
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)	?	?	?
	£6m+	£6m+	£5m+

(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.)

	Option 1*	Option 2+	True Coterminosity
▪ 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 loose 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.

County Durham and Tees Valley NHS
Strategic Health Authority

Teesdale House
Westpoint Road
Thornaby
Stockton on Tees
TS17 6BL

Direct line: 0191 210 6410
Ref: MC/sf

Tel: 01642 666700
Fax: 01642 666701

30 May 2006

Mr Paul Walker
Chief Executive
Hartlepool Borough Council
Civic Centre
Victoria Road
Hartlepool
TS24 8AY

Dear Mr Walker

I thought that it would be helpful to write with an outline of the process underway in the region to reorganise the SHAs and PCTs in line with the intentions set out in 'Ensuring a Patient Led NHS'.

The new region-wide SHA will take over from the two existing SHA's on 1 July. The Appointments Commission is currently considering the applications for non-executive positions on the board of the new Authority. The recruitment of an executive team is underway. We confidently expect the new SHA to be in place on the 1 July.

In line with the government's election Manifesto commitment to save from the reorganisation, an annual £250 million nationally in management costs, the region has to reduce its management expenditure by £14 million. Merging the two SHAs will save £4 million, mainly through staff reduction. This is a sensitive process in which there will be an attempt to build individual staff preferences into the decisions.

Following the Secretary of State's announcement on PCT reconfiguration we will have twelve PCTs in the region. The twelve have to reduce management expenditure by £10 million and we have asked the existing PCTs to demonstrate how they would cut management expenditure by 15% without impacting on service delivery. They will provide responses by 5 June. In line with the conditions laid down by the Secretary of State, the PCTs have been asked to consider whether shared management arrangements would benefit the PCTs in meeting the new criteria for enhancing PCT performance.

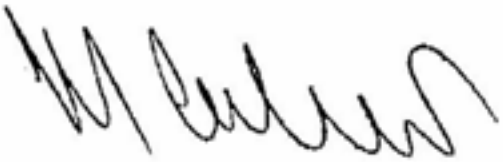
No decisions at this stage, have been made on the ways in which expenditures can be reduced – but it is unrealistic to believe that a £10 million cut by PCTs can be achieved without a reduction in management jobs.

The Appointments Commission has advertised nationally for Chair appointments in all PCTs. It is currently advertising the appointment of non-executive board members . Where the PCT configuration remains unchanged a new PCT is nonetheless established on 1 October and has a new functional relationship in the system.

I would emphasise that, once we are through the reorganisation phase, the £14 million regional savings on management costs will go into front line healthcare in the region to the direct benefit of North East patients.

There is a great confidence here that, whilst the reorganisation is difficult, the new structures offer a real opportunity to take the North East healthcare system forward in a substantial way. We measure our success in a number of ways including how speedy, effective and sensitive are the parts of the system in responding to patient needs. We believe the new structures will enable us to maintain and increase the continuous improvement we have achieved in the past four years.

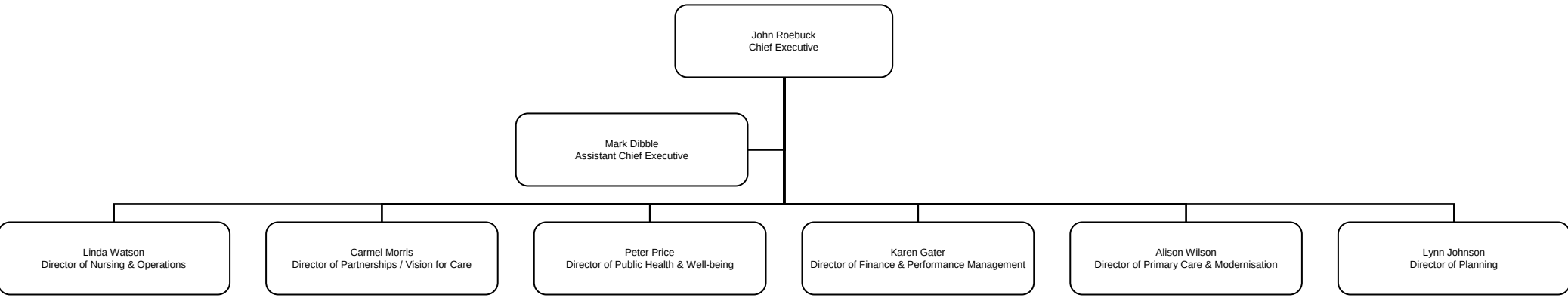
Yours sincerely



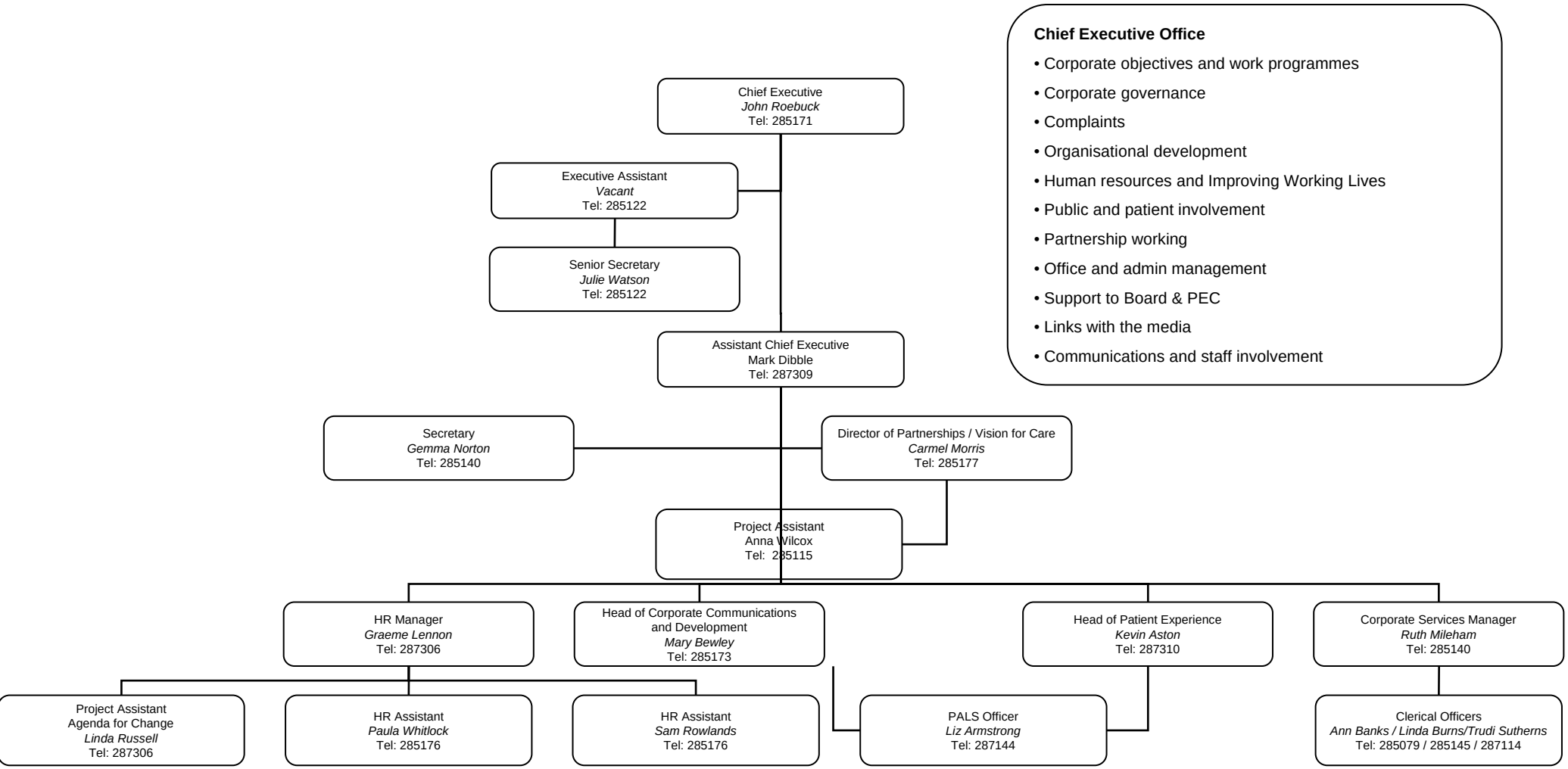
Peter D Carr
Chair
Northumberland, Tyne & Wear SHA

Michael Cardew
Chair
Co Durham & Tees Valley SHA

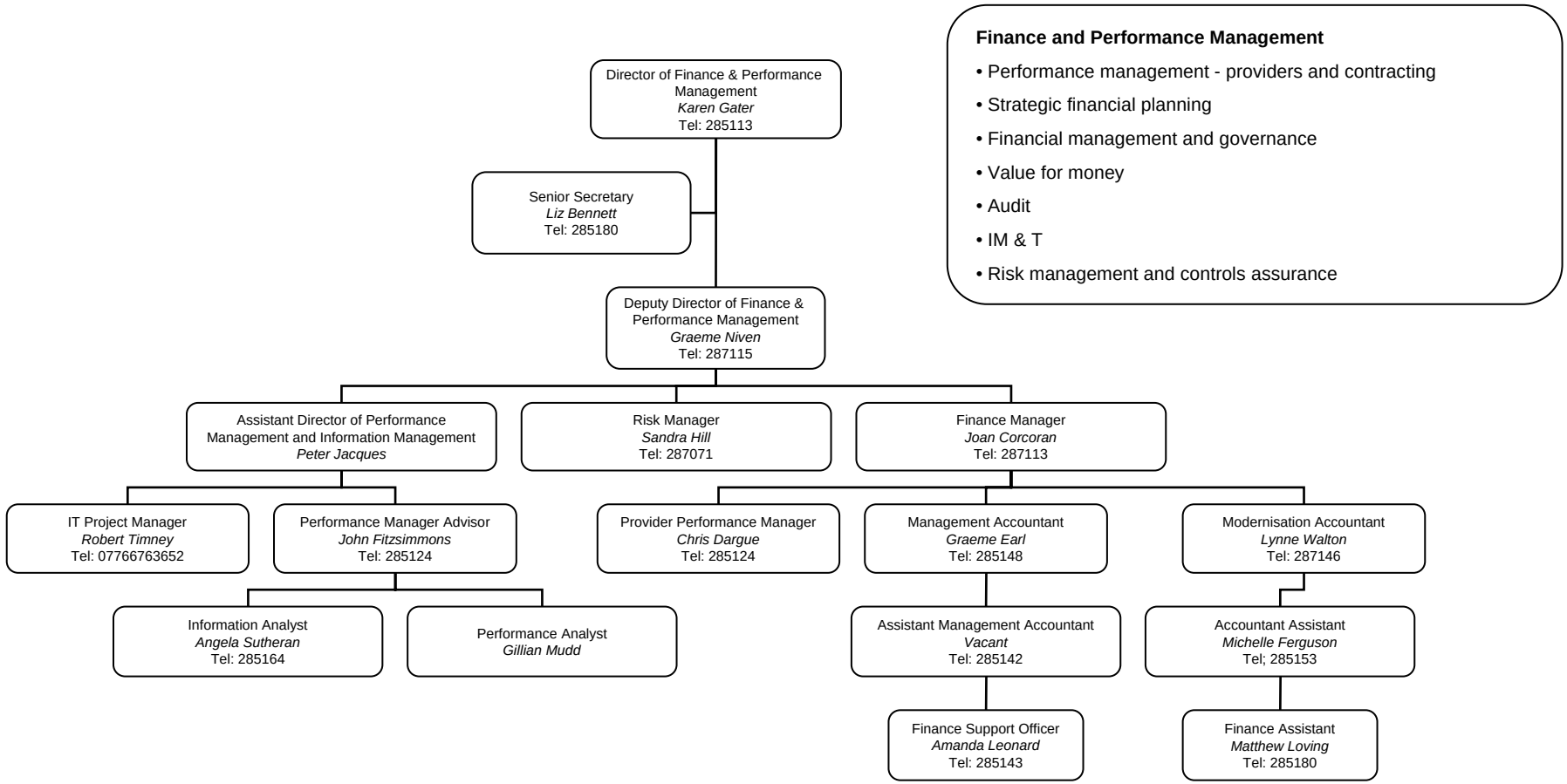
Hartlepool Primary Care Trust



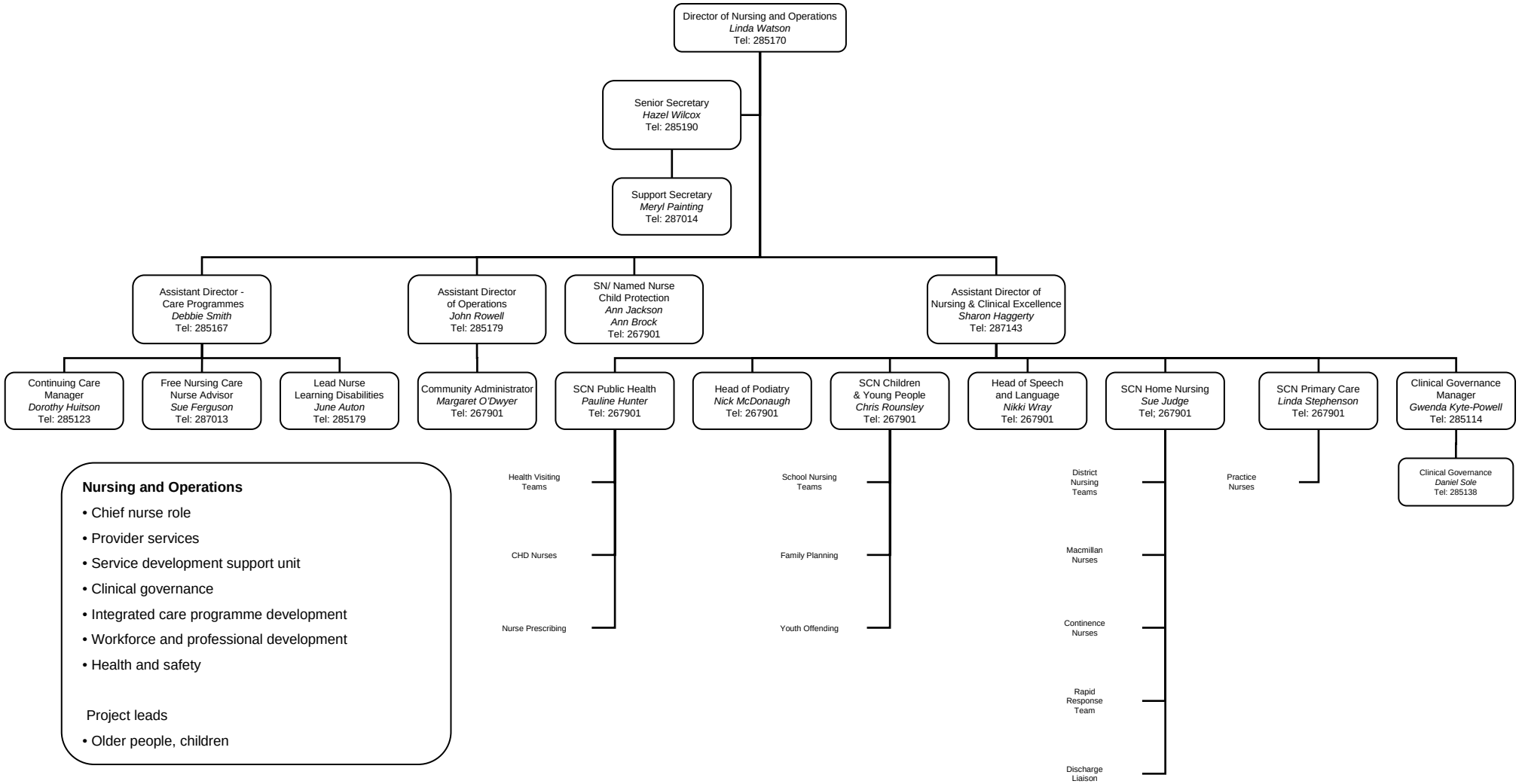
Chief Executive



Directorate of Finance and Performance Management



Directorate of Nursing and Operations



Directorate of Planning

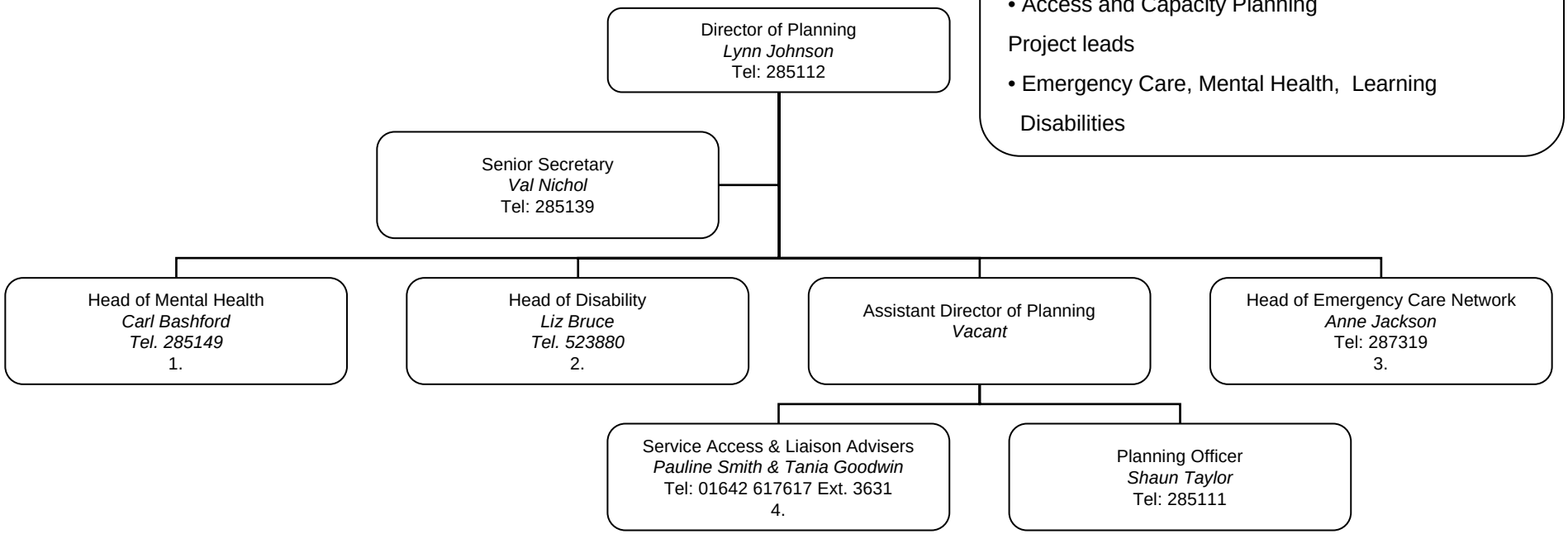
1. Joint Post funded by PCT
2. Joint Post funded by Social Services
3. Funded by four PCT's (Tees)
4. Joint appointments with North Tees PCT funded through ABC and Access Transformation Funds

Planning

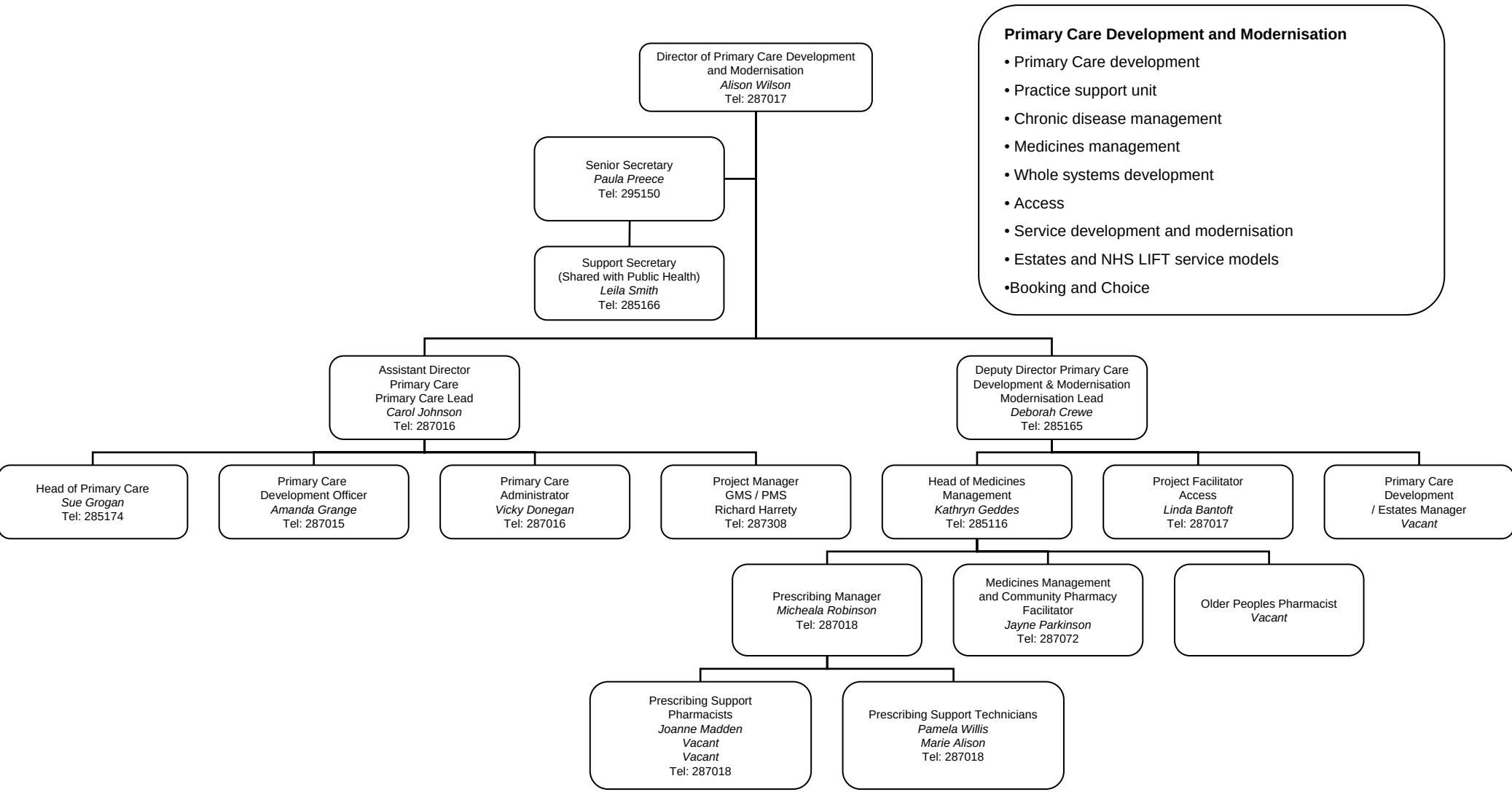
- LDP
- Secondary, tertiary and specialised services
- Continuing care
- Access and Capacity Planning

Project leads

- Emergency Care, Mental Health, Learning Disabilities



Directorate of Primary Care Development and Modernisation



Directorate of Public Health

Denotes permanent posts in the structure

Denotes posts which have time-limited funding

Public Health
- **Public Health**
- **Health Promotion and Development**
- **Community Development**
- **Effectiveness and the Evidence Base**
- **Major Incident Planning**

Project leads
- **CHD, Cancer, Substance Misuse, Sexual Health**

Director of Public Health and Well-being
Peter Price
Tel: 285172

Senior Secretary
Sharon Ross
Tel: 287316

Sure Start Manager
Gill Butler
Tel: 285137

Assistant Director Public Health
Vacant
Tel: 287316

Health Development Team Leader
Carole Johnson
Tel: 239928

Health Theme Co-ordinator - *Maureen Taylor* Tel: 287002
Play, Learning & Childcare Co-ordinator - *Julie Morgan* Tel: 287004
Community Development Co-ordinator - *Julie Fletcher* Tel: 287008
Finance & Admin Co-ordinator - *Richard Duffy* Tel: 287001

Health Development Worker – Young People
-*Siobhan Farmer* Tel: 239923
Health Development Facilitator
-*Bill Johnson* Tel: 239920
Resources Officer
-*Pat Duffy* Tel: 231248

Lead Nurse – Contraception/Sexual Health Services (Nursing & Operations)
- *Julie Maddison*

Teenage Pregnancy Co-ordinator
-*Deborah Gibbin* Tel: 239927
Drug Prevention Co-ordinator
-*Sharon Robson* Tel: 239922
New Deal Health Theme Co-ordinator
-*Vacant* Tel: 894046
New Deal Health Development Worker
-*Melanie Weeks* Tel: 287376
New Deal Apprentice Health Development Worker (h/t)
-*Steve Gaffney* Tel: 287376
New Deal Apprentice Health Development Worker (h/t)
-*Claire Boddy* Tel: 287376
Sure Start Health Development Worker
-*Sarit Carlebach* Tel: 239924
Dyke House Health Development Worker
-*Amanda Wilks* Tel: 424259
Owton Rossmere Health Development Worker
-*Steven Carter* Tel: 288130
Sure Start Plus Advisor
-*Liz Hipwell* Tel: 239926
Sure Start Plus Support Worker
-*Hayley Pratt* Tel: 239926
Boys and Young Men's Health Worker
- *John Fletcher* Tel: 239929