ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM AGENDA

HARTLEPOOL
BOROUGH COUNCIL

Tuesday 25th July 2006

at 10.00 am

in Committee Room "B"

MEMBERS: ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM:

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

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 23rd June 2006 *(attached)*

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 Joint Section 7 Consultation Committee (Acute Services Review) – Update Report – *Scrutiny Support Officer*

7.2 PCT reconfiguration – *Scrutiny Support Officer (to follow)*

7.3 Scrutiny Investigation into Social Prescribing – *Scrutiny Support Officer*

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

ITEMS FOR INFORMATION

i) Date of next meeting Wednesday 6th September 2006, commencing at 2.00 pm in Committee Room "B".

ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM

MINUTES

23rd June 2006

Present:

Councillor: Gerald Wistow (In the Chair)

Councillors: Councillors Caroline Barker, Jonathan Brash, Mary Fleet, Sheila Griffin, Geoff Lilley, Pat Rayner and David Young

In accordance with paragraph 4.2 (ii), of the Council's procedure rules, Councillor Carl Richardson attended as a substitute for Councillor Stephen Belcher.

Resident Representatives:
Mary Green and Evelyn Leck

Also present:
Stephen Wallace, Chair, Hartlepool PCT

Officers: Paul Walker, Chief Executive
Nicola Bailey, Director of Adult and Community Services
Sajda Banaras, Scrutiny Support Officer
Angela Hunter, Principal Democratic Services Officer

12. Apologies for Absence

Apologies for absence were received from Councillors Stephen Belcher and Gladys Worthy.

13. Declarations of interest by Members

None.

14. Minutes of the meeting held on 13th June 2006 (*Director of Adult and Community Services*)

Confirmed.

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

No items.

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

No items.

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

No items.

18. Reconfiguration of PCTs *(Chief Executive and Director of Adult and Community Services)*

The Chief Executive and Director of Adult and Community Services presented a report informing Members 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.

After consultation with the Tees Valley Local Authorities and PCTs, the Secretary of State announced that there would be 12 PCTs in the north east region including four PCTs in the Tees Valley that were co-terminous with their corresponding Local Authority boundaries. As a result of this, the Strategic Health Authority (SHA) wrote to all Local Authority and PCT Chief Executive's requesting that they respond to the SHA by the 5th June with some initial proposals on how those savings could be made across the PCT cluster, i.e. Tees Valley (in our case). The PCT Chief Executives submitted their ideas to the SHA without any formal consultation with the Local Authorities, therefore the report presents a series of options that we assume the PCT Chief Executives may have suggested which incorporates greater integration across the PCT cluster. However one further option was included which involved greater integration with the Local Authority, although no discussion had taken place in relation to this.

The Director of Adult and Community Services detailed the options that were included within the report along with the risk implications for each option and they were:

Option 1 – Retain a Hartlepool PCT as it currently stands with its own management team, Board and Professional Executive Committee (PEC).

Option 2 – Each PCT to have its own Trust Board with a corresponding PEC, but with a range of options that involved a sharing of the PCT management team across the Tees Valley area.

Option 3 – An option that encompasses greater integration in a variety of forms such as:

- Complete integration of the Adult and Community Services management arrangements with the PCT in relation to both commissioning and provision
- the creation of an adult provider trust that encompasses all of the PCT community health services, and
- the development of a Commissioning Partnership working with/for the Practice Based Commissioning Group.

An additional risk to be considered was the new Fitness for Purpose assessment that all PCTs and their management team have to undergo. This was a national assessment that was co-ordinated on a regional basis by the SHA. This assessment would include an internal self assessment followed by a formal challenge session to both the Board and management team by the SHA. If the PCT was not deemed 'fit for purpose' the SHA may intervene to work with the PCT board to ensure adequate arrangements were put in place to remedy the situation. Any arrangement jointly considered by the Local Authority and PCT would be subject to this assessment.

A discussion followed in which the following points were raised.

Some integrated services were already operating, ie the rapid response team – The Director of Adult and Community Services indicated that there were already some integrated services although this was mainly on a frontline staff basis. Although the management of these services was not yet integrated, the local authority was continuing to progress this.

Could any agreements made incorporate a level of protection for each organisation's own budgets? – The Director of Adult and Community Services responded that more formal integration with the PCT could be done in a range of ways regarding budgets whilst ensuring that statutory requirements were still met. Each organisation would be responsible for their own tolerance level within their respective budgets. It was also likely that a process of aligning budgets would be put in place as opposed to formal pooling of budgets.`

- **Chair of Hartlepool PCT**

The Chair of the PCT outlined their position with regard to the proposals. He added that the PCT's proposals had not been shared with the PCT Chairs or non-executive members either. However, the Tees PCT chairs wished to maintain their independence and sovereignty. Ian Wright had approached the Secretary of State who had indicated she would not look favourably on proposals which did not include a chief executive and other executive

directors. The Chair of the PCT indicated that Hartlepool PCT was generally in a healthy financial position with a robust recovery plan in place over the next 2 years to deal with the current £6m debt. This plan would ensure that the debt was repaid without affecting services and commissioning and without enforcing redundancies. A Public Interest Report was now being prepared on the PCT's financial position. For a long time, the auditor had said he was not planning to write such a report but had suddenly changed his mind. It was not clear what had caused this change of mind. However, in response to the Chief Executive's report that the SHA Chief Executive had said that morning that he expected the PIR report to be 'damning', the Chair of the PCT said he would be extremely surprised if that were the case.

The Chair of the PCT indicated that the criteria where the required 15% savings could be made were extremely tight. However, the required savings figures were difficult to establish. They changed every time he went into the office. He added that the PCT and Local Authority were natural partners and it would be useful to merge back office functions with the aim of reaching these targeted savings. The Chair of the PCT felt that it was imperative that a Hartlepool PCT was maintained to ensure that decisions were taken and carried out in Hartlepool for the benefit of Hartlepool residents.

A further discussion followed in which the following points were raised.

What would the procedure be if the PCT was found to be not fit for purpose? The Chair of the PCT indicated that a turn around team would not be instigated if the PCT was found not fit for purpose. He added that an improvement plan would need to be put in place which would be monitored by the SHA.

Are the restrictions on the savings too tight? The Chair of the PCT indicated that he felt that the required savings could be met by the PCT if the restrictions were widened, for example, joint working with the Local Authority. This could also be done without affecting front line services.

What does the recovery plan currently in place include? The Chair of the PCT responded that the plan included a reduction in overheads, a proportion of disinvestment, putting some projects on hold and operating with some vacancies.

If the Local Authority and PCT merged, what would be the knock-on effect to council tax payers? The Chief Executive indicated that the savings must be made from management and administration costs. He added that there was some duplication across these areas but that this would not be enough. If as part of the merger the PCT were to lose a Director, the Local Authority may be able to cover this post with its own staff (but to the detriment of its own services) but this would not be counted within the savings.

There was concern that the Local Authority responsibilities were moving away from what they should be and becoming too wide? The Chief Executive indicated that the boundaries between all public sector bodies were

becoming blurred with integration being the way forward. The ability to pool budgets has been available to PCT's and Councils since 1999 although few had undertaken to do this as they must be disaggregated in order to be audited.

Local Authority Members are not voted for if they do not perform, what influence would we have over the PCT? The Chief Executive responded that the people appointed to the PCT would ultimately be responsible to the Secretary of State. The Chair of the PCT added that the SHA Chief Executive would appoint the Chief Executive for the PCT.

Would option 3 be the better option if the restrictions on the savings could be overcome? The Chair of the PCT indicated that he would prefer the option of a Hartlepool PCT but would appeal for the restrictions on where the savings could be achieved to be widened.

Is the concept of making the required savings from a small pot whilst integrating with the Local Authority viable? The Chief Executive replied that the if the PCT and Local Authority work together in an imaginative way it may be achieved but at a cost to the Council as our current services must be protected. These may be efficiencies to be made through joint arrangements for management and administration. Similarly for joint commissioning, although it is difficult to see how this could take place if the government follows through with its invitation for large companies (American?) to undertake this work. Government also seems to favour this approach to service provision which may be better served in Hartlepool through some form of social enterprise. The government's presumption for back office functions is that they will be organised on a regional or national basis in the future.

A Member stated that the first decision for the Council must be whether or not they are prepared to fund national health functions.

Members thanked the Chair of the PCT for his attendance at this meeting and for answering Members questions.

Decision

i) That Hartlepool PCT and the Local Authority must build on current partnership arrangements, including the Local Area Agreement already established.
ii) That a strong locality focus must be retained and where necessary, locality structures should be put in place.
iii) That the Local Authority, PCT and Strategic Health Authority work together to establish the best option for Hartlepool.

GERALD WISTOW

CHAIRMAN

ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM REPORT

25 July 2006

HARTLEPOOL BOROUGH COUNCIL

Report of: SCRUTINY SUPPORT OFFICER

Subject: JOINT SECTION 7 CONSULTATION COMMITTEE (ACUTE SERVICES REVIEW) – UPDATE REPORT

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1. PURPOSE OF REPORT

1.1 To inform Members of the Adult and Community Services and Health Scrutiny Forum about the recommendations made by the Joint Section 7 Consultation Committee in relation to the Acute Service Review proposals.

2. UPDATE

2.1 The Joint Section 7 Consultation Committee (Joint Scrutiny Committee) that was established to scrutinise the Acute Services Proposals, following the review carried out by Professor Darzi formalized its views in relation to the proposals at a meeting held on 16 June 2006.**(See Appendices 1- 3)**

2.2 The Acute Services Review made recommendations to reconfigure the following services:-

a) Upper Gastro Intestinal Services
b) Vascular Services

2.3 Following the Joint Scrutiny Committee's investigation into the two above proposal areas, it should be noted that the County Durham & Tees Valley Strategic Health Authority decided against implementing those proposals. Through the Joint Scrutiny Committee evidence gathering process, these proposals were demonstrated as a backward step and would actually constitute a worse set of services.

2.4 The Acute Service Review also made recommendations in respect of;

c) Maternity provision

d) Paediatric provision
e) Trauma
f) Elective Orthopaedics
g) Breast Surgery
h) Gynaecology

2.5 In relation to maternity and paediatric services, the Joint Scrutiny Committee held the view that the proposals are not in the interests of the local health service, the communities they serve and the communities that the Joint Scrutiny Committee represents. Consequently, under the powers granted to it[1], the Joint Scrutiny Committee referred the disputed matters to the Secretary of State for consideration and determination.

2.6 The Joint Scrutiny Committee opposed the proposals pertaining to maternity and paediatrics on the basis of four key principles.

(i). The Joint Scrutiny Committee does not believe that the proposals pertaining to maternity and paediatric services are in the interests of the local community, nor in the interests of the local health services.

(ii). The Joint Scrutiny Committee does not believe that the proposals are consistent with the ethos of the key NHS Policy document *Keeping the NHS Local*.

(iii). The Joint Scrutiny Committee has consistently noted the lack of detailed information pertaining to the financial ramifications of the proposals on the local health economy. As a result of this, the Joint Scrutiny Committee is unable to conclude as to whether the proposals are sustainable or not, as it has had to work in something of a financial information vacuum.

(iv). The Joint Scrutiny Committee holds the view that the communities of Stockton- on-Tees, Hartlepool and the associated parts of East Durham are substantial communities in their own right. As such, they reasonably expect a certain level of District General Hospital service provision within their vicinities, as is presently provided.

2.7 The voting was 7:5 in favour of the Referral. Representatives from Stockton-on-Tees Borough Council and Hartlepool Borough Council voted against the matter being referred according to the four principles outlined above.

2.8 Stockton Borough Council's representatives expressed a wish to refer the matter to the Secretary of State, according to a different rationale which the Authority would pursue independently. It is understood that the Stockton Health Select Committee referral urges the Secretary of State to retain the Women and Children's Centre of Excellence at North Tees

[1] In Section 4.7 of the Local Authority (Overview & Scrutiny Committees Health Scrutiny Functions) Regulations 2002, Statutory Instrument 2002 No. 3048

and continuing all paediatric and emergency gynaecology there. **(See Appendix 4)**

2.9 Hartlepool Borough Council has previously expressed its support for the full implementation of the Darzi proposals. **(See Appendix 5)** The referral by both the Joint Scrutiny Committee and Stockton's Health Select Committee could potentially impact on this and therefore Members may wish to consider reaffirming that position.

3. RECOMMENDATIONS

3.1 That Members determine what, if any action the Forum would wish to take in response to the referral by the Joint Committee and the unilateral referral from Stockton Health Select Committee.

BACKGROUND PAPERS

The following background papers were used in the preparation of this report:-

(i). Joint Section 7 Consultation Committee Referral Letter, dated 7 July 2006.- Appendix 1
(ii). Joint Section 7 Consultation Committee Referral Report – Appendix 2
(iii). Joint Section 7 Consultation Committee Final Report – Appendix 3
(iv). Press Article – Appendix 4
(v). Hartlepool Borough Council position statement – Appendix 5

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7 July 2006

Dear Secretary of State

Re: Review of Acute Services on Teesside

I write to you as the Chairman of the Joint Section 7 Consultation Committee (Joint Scrutiny Committee), established to scrutinise proposals contained in The Acute Service Consultation Document[1]. This followed Professor Sir Ara Darzi's study (Acute Services Review, Hartlepool & Teesside, July 2005[2]) of the Acute Provision that services the communities of Teesside, North Yorkshire and East Durham.

The Acute Services Review made recommendations to reconfigure the following services

a) Upper Gastro Intestinal Services
b) Vascular Services

Following the Joint Scrutiny Committee's investigation into the two above proposal areas, it should be noted that the County Durham & Tees Valley Strategic Health Authority decided against implementing those proposals. Through the Joint Scrutiny Committee evidence gathering process, these proposals were demonstrated as a backward step and would actually constitute a worse set of services. This decision by County Durham & Tees Valley Strategic Health Authority is in itself evidence that the recommendations contained within the review need to be examined and justified individually.

The Acute Service Review also made recommendations in respect of;

c) Maternity provision
d) Paediatric provision
e) Trauma
f) Elective Orthopaedics
g) Breast Surgery
h) Gynaecology

[1] The Consultation Document was entitled "The Right Treatment, in the Right Place, at the Right Time: Taking Hospital Services across Teesside and parts of North Yorkshire into the future – Have your say about local hospital services"
[2] Can be found on www.countydurhamandteesvalley.nhs.uk

In relation to maternity and paediatric services. The Joint Scrutiny Committee holds the view that the proposals are not in the interests of the local health service, the communities they serve and the communities that the Joint Scrutiny Committee represents. Consequently, under the powers granted to it[3], the Joint Scrutiny Committee wishes to refer the disputed matters for your consideration and determination.

The Joint Scrutiny Committee opposes the proposals pertaining to maternity and paediatrics on the basis of four key principles.

1. The Joint Scrutiny Committee does not believe that the proposals pertaining to maternity and paediatric services are in the interests of the local community, nor in the interests of the local health services.

2. The Joint Scrutiny Committee does not believe that the proposals are consistent with the ethos of the key NHS Policy document *Keeping the NHS Local*.

3. The Joint Scrutiny Committee has consistently noted the lack of detailed information pertaining to the financial ramifications of the proposals on the local health economy. As a result of this, the Joint Scrutiny Committee is unable to conclude as to whether the proposals are sustainable or not, as it has had to work in something of a financial information vacuum.

4. The Joint Scrutiny Committee holds the view that the communities of Stockton- on-Tees, Hartlepool and the associated parts of East Durham are substantial communities in their own right. As such, they reasonably expect a certain level of District General Hospital service provision within their vicinities, as is presently provided.

As evidenced by the enclosed documentation, the Joint Scrutiny Committee has conducted a thorough scrutiny of the Acute Services Proposals, taking evidence from a wide range of stakeholders. The process included nineteen meetings all open to the public and local media, as well as 'Question Time' style Public Meetings held in Stockton and Hartlepool and considered evidence from in excess of fifty sources including chief clinical staff, chief non-clinical staff, Patients Forums, Support Groups, a Health Economist, local community activists and Local Medical Committees.

For clarity, the Joint Scrutiny Committee does not wish to make any significant comment of the local NHS' consultation process. The Joint Scrutiny Committee felt that the consultation process was of sufficient length and communicated the proposals in appropriate detail and the Joint Scrutiny Committee was furnished with senior clinical and managerial staff when necessary.

The Joint Scrutiny Committee agreed the text of a Final Report on 6 February 2006 and the report was presented to the local NHS on 14 February 2006. A formal response from the local NHS was received within the specified 28 days timeframe. The subsequent discussions between the Joint Scrutiny Committee and local NHS, failed to reach agreement on the proposals pertaining to maternity and paediatric services.

[3] In Section 4.7 of the Local Authority (Overview & Scrutiny Committees Health Scrutiny Functions) Regulations 2002, Statutory Instrument 2002 No. 3048

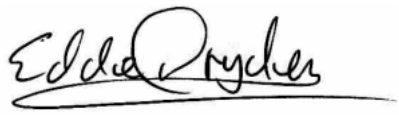
Accordingly, the Joint Scrutiny Committee feels it has exhausted all other avenues and duly refers the matter for your attention and direction. In support of the referral, I enclose a referral document and a copy of the Joint Scrutiny Committee's Final Report.

In the interests of probity, I would like to bring to your attention that the Joint Scrutiny Committee refers the matter to you by a majority vote. The original Final Report, which was agreed on 6 February 2006, had unanimous support of the Joint Scrutiny Committee. At the concluding meeting the Joint Scrutiny Committee's representatives from Stockton-on-Tees Borough Council and Hartlepool Borough Council voted against the matter being referred according to the four principles outlined above. Stockton Borough Council's representatives also expressed a wish to refer the matter, although according to different rationale, which they expressed a desire to pursue independently. For your information the voting was 7:5 in favour of the Referral.

As Chair of the Joint Scrutiny Committee, I believe the process has been thorough and fair and the conclusions reached are balanced and reasonable and based upon the weight of evidence and representations received. I conclude by pointing out that the review into the services has been ongoing for a considerable length of time and I believe that this has created a degree of uncertainty for health professionals and local communities and I would urge a speedy consideration and conclusion to this process.

As a final comment, I would like to commend the Government on the introduction of the Health Scrutiny powers for local authorities. The Members of the Joint Scrutiny Committee, representing six local authorities and made up of the major political parties and independents, feel it is entirely appropriate that local elected representatives have a responsibility to review health services and proposals to change them, on behalf of the local communities that elected them to office. I believe that the working of this Joint Scrutiny Committee has demonstrated how well health scrutiny can work, with elected representatives working in partnership to review services, for the common good of the communities they represent. The scrutiny process is also good for the National Health Service.

Yours sincerely



Councillor Eddie Dryden
Chair, Section 7 Joint Consultation Committee

Referral to the Secretary of State of Health in relation to the Acute Services Proposals

A report of the Joint Section 7 Consultation Committee relating to the Section 7 Scrutiny Review into the Acute Services Proposals, following the review carried out by Professor Sir Ara Darzi.

A brief history of Acute Services Review in the Tees Valley

1. A Tees Service Review was launched on 13 June 2003 to address a series challenges faced by primary and secondary health care in Tees Valley and parts of County Durham. Its terms of reference was to:

2. "Review services across health and social care across Teesside, in order to ensure sustainable solutions to managing service demand, delivery of NHS plan targets and Modernisation, while taking account of the need to maintain services, now and for the future."

3. A steering group was formed to formulate possible solutions to the challenges. The core membership of the steering group consisted of: Ken Jarrold, Chief Executive of County Durham and Tees Valley Strategic Health Authority (SHA) (Chair), Chief Executives of PCTs and NHS Trusts, Professional Executive Committee (PEC), Chairs of PCTs, Medical Directors of NHS Trusts, Directors of Social Services.

4. The challenges they faced were considered to be:

4.1 The increase in specialisation (e.g. in Upper Gastrointestinal (GI) cancer, vascular services), with the recommendation that Doctors only with specialist skills should be undertaking specialist procedures to ensure the best outcomes for patients and that they need to see a critical mass of patients to ensure their experience is kept up to date. This in turn is leading to greater centralisation of specialists

4.2 junior Doctors training and the introduction of the European Working Time Directive

4.3 the NHS Plan which sets out challenging targets for all NHS Trusts particularly in relation to access to outpatient and inpatient treatment and capacity in health care settings

4.4 shortages of key clinical staff in many specialities with difficulties in recruitment retention and also numbers available in the field

4.5 an ageing population and growing numbers of people with chronic disease who are living longer

4.6 Increasing patient demand.

5. There was also concern about a piecemeal approach to planning and previously unsuccessful attempts at a Tees wide review of services but despite that, significant service change occurring or being planned across Teesside included:

5.1 Implementation of changes to vascular services following a report by Professor Wood which recommended centralisation of complex work on in South Tees Hospital Trust (STHT). This was well advanced with complex vascular work moving to the James Cook University Hospital (JCUH) site from north of the Tees

5.2 Proposals for the centralisation of some more complex aspects of Upper GI cancer surgery at JCUH following the Allum report and York Health Economic Consortium recommendations in order to meet Improving Outcomes national guidance on Upper GI cancer services

5.3 Proposals for centralisation of North of the Tees cancer surgery at the University Hospital of North Tees and the establishment of an Arthroplasty centre at the University Hospital of Hartlepool, following the Higgins Review of services

5.4 The creation of a single acute hospital site in Middlesbrough, with the centralisation of South Tees' secondary services and tertiary services at the James Cook University Hospital (JCUH).

5.5 The relationship between the Friarage Hospital and JCUH and clarity as to the services provided by the Friarage particularly in terms of capacity

5.6 Initiatives by the PCTs and Acute Trusts to improve demand management and in particular the planned repatriation of patients from North and South Tees and the impact on local services.

6. It was proposed that the Review should focus on the following workstreams:

6.1 Hospitals south of the Tees, addressing the role of the James Cook University Hospital in terms of the development of tertiary services and the provision of District General Hospital (DGH) services and repatriation of DGH type referrals to local hospitals and the relationship with the Friarage Hospital

6.2 Hospitals north of the Tees, addressing two-site delivery across North Tees and Hartlepool Trust, considering options for and sustainability of services into the future

6.3 future primary and community care service provision

6.4 the need to redesign Emergency Care Services across the patch including Out of Hours services, the role of the ambulance service and NHS Direct.

Review Process and Timetable

6.5 The programme of work to support the review was as follows:

Outline paper and draft Terms of Reference	March 2003
Preparation and Briefing work complete	June 2003
Launch of the Review	13 June 2003
Workstreams to complete	November 2003
Review of Proposals by 'expert' panel	December 2003
Development of proposals complete	December 2003
Consultation / Scrutiny Committee	January-March 2004

7. Delays occurred which meant that public consultation was due to take place mid-2004. Since June 2003 a great deal of detailed work had taken place involving patients and members of the public, doctors, nurses and other staff, Primary Care Trusts, NHS Trusts, Local Authorities and a distinguished External Panel.

8. The members of the External Panel, which included leading doctors and other nationally recognised professionals, visited Teesside twice in order to review the work that had been done. Following a visit in July 2004 the Panel supported the proposals that were being developed and confirmed that the options for change had been explored and evaluated and that the case for change was robust. The Panel offered valuable advice on the draft consultation documents, which were re-written to take account of the Panel's views. The final decision on the proposals for consultation would have been made by the four Primary Care Trusts involved – Hartlepool, North Tees (Stockton), Easington and Sedgefield.

9. The proposals that were to be consulted on included:-

Hospital services

North of the Tees

9.1 Proposals were being developed for a limited number of service changes to the University Hospitals of Hartlepool and North Tees, in essential areas that could no longer be sustained at both hospitals safely and reliably due to the pressures of increasing specialisation and changes in medical staffing.

9.2 The service changes proposed would have centralised emergency surgery and trauma services for the most seriously ill patients, consultant led maternity services and inpatient children's services on

the University Hospital of North Tees site and planned surgery services on the University Hospital of Hartlepool site.

9.3 Both hospitals would have continued to provide a wide range of services including Accident and Emergency, a full General Medical service including emergency admissions for heart problems and strokes, day surgery, out patients and extended day services for children including day beds. The options for maternity services at Hartlepool included a midwife led unit and out patient service with deliveries at North Tees. Under both options antenatal and post natal care would be provided in Hartlepool.

9.4 If the proposals that were being discussed had been implemented, both the Hartlepool and North Tees Hospitals would have been maintained with a wide range of services and a high standard of care at both hospitals. The great majority of people who used the existing hospitals would have continued to do so. 94% of patients would have continued to use the hospital in Hartlepool. Only 6% would have been affected by the changes. For some forms of treatment, a small number of patients would have used specialist centres at their neighbouring hospital to make sure that they received the standard of care they required.

9.5 It had been recognised that for those people who are affected by the changes, travelling to and from hospitals was a major concern.

10. One of the results of the Tees Review process was that transport problems were already being given a higher priority. It was clear that visitors and patients already had problems in getting to the existing hospitals. The group working on transport had already secured £1.3 million over three years for hospital transport schemes. This included a hospital shuttle bus between Hartlepool and North Tees hospitals, and upgrading two other services so that patients could get to the two hospitals on more frequent buses and can also travel to James Cook University Hospital from both hospitals North of the Tees. It also included the provision of a minibus service to hospital from rural areas.

11. Transport was already an important issue even with the present location of services and the NHS was now more involved in these issues than ever before.

South of the Tees

12. The population south of the Tees are served by the new James Cook University Hospital and no changes were proposed to these services.

13. It was not anticipated that the service changes north of the Tees would have any impact on people living south of the Tees.

14. Public consultation was due to commence in September 2004. However the NHS was not allowed to consult during an election. A date for the public consultation was to be set after the Hartlepool by-election which was held on 30 September 2004.

The involvement of Professor Sir Ara Darzi in reviewing Acute Services.

15. In a House of Commons debate on Foundation Hospitals (8 June 2004) the following undertaken was given in response to a statement from the MP for Hartlepool, in respect of the Tees Review:

16. **Dr. Reid:** My right hon. Friend is right to say that a review is under way. In respect of the application for foundation trust status, I shall say only that an initial failure does not mean that reapplication cannot be made in the relatively near future. I do not wish to prejudge matters, but I can tell him that Hartlepool will still have a full and proper hospital service after the review has taken place.[1]

17. Following the Parliamentary by-election caused the sitting MP, Mr Mandleson appointment to the European Union as Trade Commissioner John Bacon, Group Director, Health and Social Care Delivery, wrote to Ken Jarrold (16 August 2004) stating that "…in the light of the Secretary of State's undertaking I would like you to undertake further work to see how the fullest possible range of services can be maintained in Hartlepool, including for example maintaining accident and emergency services and consultant led maternity provision."

18. It was at this time that John Bacon introduced Professor Sir Ara Darzi to work with the steering group to providing independent advice.

19. The terms of reference to govern Professor Darzi's work were set as:

19.1 To consider how the fullest possible range of services can be maintained at Hartlepool Hospital

19.2 Taking into account work already undertaken in the course of the Tees Services Review

19.3 Taking into account the wider context of proposed provision of primary and secondary care services, both north and south of the Tees

19.4 With the aim of reporting back to the Department of Health by the end of October 2004

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[1] Can be accessed at http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040608/debtext/40608-02.htm and in paper format at Hansard **8 Jun 2004 : Column 132**

Additional terms of reference added in December 2004

19.5 The work under way by the Hambleton and Richmondshire PCT and South Tees Hospitals Trust in relation to Friarage Hospital.

19.6 The impact of the centralisation of specialist services at the James Cook University Hospital on the other hospitals in County Durham and Tees Valley and on the capacity at the James Cook University Hospital.

PRESENTATION OF PROFESSOR DARZI'S RECOMMENDATIONS

20. On 8 July 2005, Professor Ara Darzi presented his conclusions and recommendations to an invited audience in Hartlepool. The summary of Professor Darzi's recommendations are:

20.1 University Hospital Hartlepool (UHH) should continue to provide a doctor-led accident and emergency service and acute medicine. It should host a new *Centre of Excellence in Women's and Children's Services*, including consultant led maternity, paediatric services, gynaecology, and breast surgery. It should increase its inpatient elective surgery portfolio, in particular orthopaedics. Major trauma and emergency surgery out of hours should move to University Hospital North Tees (UHNT).

20.2 The UHNT should become the main centre north of the Tees for emergency surgery, including trauma, with expanded intensive care facilities. It should continue to provide a full accident and emergency service and acute medicine. It should develop as a centre for major complex surgery, including hosting a new *North Tees Complex Surgical Centre*, providing upper gastro-intestinal cancer services for the whole Teesside area. Vascular surgery should be developed at the UHNT as part of a clinical network with the JCUH. An endo-luminal vascular service should also be developed at the UHNT serving the whole Teesside area. A 24-hour midwife-led maternity unit should be developed. Consultant-led maternity, high-risk obstetrics and paediatric services should be centralised in the UHH.

20.3 James Cook University Hospital (JCUH) should retain its full range of district general hospital-type services and its range of tertiary and supra-regional services. The proposed move of upper gastro-intestinal cancer services to UHNT should free up a modest amount of capacity. Work should also be intensified to improve integration with and make full use of capacity at the Friarage Hospital, for example in orthopaedics and ophthalmology, to reduce capacity pressures at JCUH.

PUBLIC CONSULTATION PERIOD

21. The local NHS accepted Professor Darzi's recommendations and the decision to consult on such proposals was taken. The statutory

consultation period of public consultation was launched by the local NHS on 23 September 2005 and ran until 23 December 2005.

SCRUTINY INVOLVEMENT

22. A Joint Consultation Committee (also referred to as the Joint Scrutiny Committee) was formed to comply with Section 7 of the Health and Social Care Act 2001 with representation from all affected local authority areas (Borough Councils – Hartlepool; Middlesbrough; Redcar and Cleveland; Stockton-on-Tees; and County Councils – Durham; North Yorkshire). The Joint Committee asked Stockton's Councillors to conduct more detailed investigative work regarding the proposals as they affected maternity and paediatric services.

23. In December 2005 Stockton-on-Tees Council's Health and Social Care Select Committee published its findings which were endorsed by, and appended to, the Joint Consultation Committee report published in February 2006. In addition to this and also in December 2005, the North Yorkshire County Council Scrutiny of Health Committee met and came to exactly the same conclusions as outlined in 23.1-23.4. The Joint Consultation Committee's (unanimously agreed) Final Report recommended to the NHS Joint Primary Care Trust Committee that it not implement Professor Darzi's recommendations relating to:

23.1 The establishment of a Tees wide upper gastro-intestinal service at UHNT

23.2 The establishment of a Tees wide endo-luminal vascular service and the establishment of a vascular network with JCUH

23.3 Maternity Services

23.4 Paediatric Services

24. County Durham and Tees Valley Strategic Health Authority (SHA) Board informed the Joint Consultation Committee on 6 March 2006 that the proposed changes to upper gastro-intestinal and vascular services were not supported by the SHA and would therefore not go ahead, although proposed changes to maternity and paediatric services had been supported and would still go ahead.

25. On 5 April 2006 a report to the SHA Board proposed to identify other possible services that would be relocated from South Tees Hospitals NHS Trust to North Tees and Hartlepool NHS Trust instead of the proposed move of Upper GI and vascular services which was not supported. Collaborative work between local Trusts is ongoing to identify service areas that could be moved more appropriately. The recently identified possible services are:

25.1 Urology

25.2 Vascular – whole service relocation, not the split service previously suggested
25.3 Reconstructive Plastic Surgery and Burns
25.4 Maxillo Facial Surgery

The Evidence gathered by the Joint Scrutiny Committee in relation to Maternity & Paediatric services

26. A meeting of the Joint Scrutiny Committee took place on 19 October 2005. The purpose of the meeting was to consider the proposed establishment of a Centre of Excellence in Women's & Children's services at Hartlepool. This includes Consultant led Maternity, Paediatric services, Gynaecology and Breast Surgery.

27. The Joint Scrutiny Committee heard from around the table that it was largely accepted by both organisations, including the clinical bodies that changes to current service provision and organisation are needed. The only real issue for debate is that of location of the services concerned.

28. It was stated that under the original Tees Review proposals, the specialist, complex centre was going to be based at the UHNT. The difference with Professor Darzi's report is that he recommends the specialist centre should be at UHH. The rationale for Professor Darzi's recommendation on this topic was based on Patient Choice. If the Consultant led Maternity service was based at UHH, Stockton residents have a choice of accessing Consultant led services at UHH, JCUH, Darlington Memorial Hospital or Midwife led services at UHNT. Alternatively, if the situation were reversed, Hartlepool residents would only be able to access Consultant led services at JCUH, UHNT or Sunderland City Hospital.

29. The Joint Scrutiny Committee heard that in recent years, there has been great difficulty in the recruitment of midwives and meeting the working time directive for junior doctors. As a result of these problems, the Joint Scrutiny Committee heard that both units have closed from time to time, which impacts on the quality of care offered, but also breeds confusion for staff and service users.

30. The Joint Scrutiny Committee enquired as to whether, with two units still open under the proposals, would you not just have the same problems? It was said that the same problem would not persist, as the two units proposed would be of a very different nature, as opposed to now where they are very similar. The unit at UHNT would be significantly smaller than UHH and would be aiming for around 500 births per annum. The UHH unit would be aiming for around 3000 per annum.

31. The Joint Scrutiny Committee enquired as to whether this would create a greater pressure on Maternity facilities at JCUH. The thinking behind this was that if mothers to be preferred the idea of giving birth in a Consultant led environment, for a significant proportion of Stockton (Ingleby Barwick, Yarm and Thornaby) JCUH is significantly nearer than UHH. The Joint Scrutiny Committee learned that there was a difference in medical opinion as to how many extra births the proposals may mean for JCUH. The North Tees & Hartlepool Trust felt it might be around 1000 as a worst case scenario, whereas the South Tees Hospitals NHS Trust felt that 1000 was a reasonable forecast.

32. Nonetheless, what is accepted is that the proposals as they are mapped out for maternity services, would mean an increase in the amount of births at JCUH. As to whether the JCUH would be able to cope with this mooted increase would remain to be seen. From the South Tees perspective, JCUH would have a better chance in coping if the rise was planned for and not laid at the door as a result of a gradual drift of mothers-to-be.

33. It was added that on an anecdotal level, there was evidence of such a drift starting to occur now there was a perceived 'public uncertainty' about the future of UHNT's Maternity function.

34. Either way, The Joint Scrutiny Committee noted that Prof. Darzi does not appear to have taken into account where mothers-to-be from parts of North Tees would go and the assumption that all would attend UHH seems rather simplistic. The Royal College of Paediatrics and Child Health, as referenced at footnote 6 also makes this point.

35. It was noted, however, that the public (mis) conception was an important consideration, as there was a lot of mis-information out in the public domain about the future of the Maternity function at UHNT. The Joint Scrutiny Committee heard that under the Proposals there would definitely be a Maternity function at UHNT and this was an important point to remember.

36. The Joint Scrutiny Committee enquired as to whether there were parallels with the proposed Midwife led unit and what has happened with the Guisborough Maternity facility, where it has suffered from under usage by the community it stands to serve.

37. It was said that it was very difficult to predict such a situation and certainly the hope was that any midwife led unit at UHNT would be a vibrant aspect of the local health service. Indeed, the Joint Scrutiny Committee was advised that such midwife units as proposed were wholly consistent with the prevailing national policy.

38. The Joint Scrutiny Committee also heard that the existence of a Midwifery led unit, was by no means a guarantee of low birth figures per se. The example of Bishop Auckland was invoked where the

Midwife led unit has, in it's first year, administered around 300 births, when 250 would have been considered a 'good year'.

39. It was added that a lot of women from the North Tees PCT area already have Midwife led births, so what was proposed was not a big as departure as may appear prima facie.

40. The Joint Scrutiny Committee discussed further the two sites currently in operation North of Tees. Members were advised that the overriding clinical wish would be for one site north of the Tees, offering a full range of services. As, however, Professor Darzi has seemingly removed that possibility from the equation; the proposed split of services over the two sites is the best option, with the levels of staff available.

41. The Joint Scrutiny Committee heard that the emphasis in the proposals was on giving Mothers to be a safe choice and despite fears regarding safety, The Joint Scrutiny Committee was advised that midwives would never be party to a service that was unsafe.

42. The Joint Scrutiny Committee heard further that if the Darzi proposals were not implemented, there would inevitably be an emergency failing of services and over time, both North Tees sites would 'wither on the vine', as the duplication of services would mean that both hospitals were unsustainable.

43. The Joint Scrutiny Committee enquired as to the amount of patient transfers which would need to be undertaken from UHNT to the Consultant led service at UHH, for medical reasons. It was estimated at between 10% and 15%, although the Joint Scrutiny Committee acknowledged that clinical skill would be key in assessing a woman throughout a pregnancy, spotting any potential problems and arranging the most appropriate venue.

44. In relation to the proposals affecting maternity and paediatric services, the Joint Committee authorised its Members from Stockton Borough Council, to conduct some more detailed investigative work on the topic within Stockton's own Health Scrutiny Committee (SHSC). The information gathered was then fed into the Joint Scrutiny Committee processes for consideration as evidence, when it came to taking a view on the proposals. The Joint Scrutiny Committee supports the findings in Stockton Borough Council's report which is attached (see appendix 1) and these should be considered in totality with the conclusions and recommendations contained in this joint report.

45. Prof. Darzi's proposals include the establishment of a women's centre of excellence similar to that which already exists at UHNT, at UHH, whilst at the same time proposing to reduce the consultant-led provision at UHNT. The Joint Scrutiny Committee agrees with SHSC that it is unsafe to assume that a centre of excellence can be

developed simply by providing the accommodation required, it will require the appropriate specialists to be employed and teamwork to be established. The Joint Scrutiny Committee does not wish to see either Stockton or Hartlepool Residents to be disadvantaged and therefore believes that both sites should be centres of excellence.

46. As a reading of this report will demonstrate, the Joint Committee has received a quantity of evidence to suggest that, should the proposals be implemented as they currently stand, a significant amount of North Tees PCT residents would choose to access JCUH for consultant led maternity care as opposed to travelling to UHH.

47. This point was expanded upon by the Chair of the North Tees & Hartlepool NHS Trust PPI Forum, who said that of UHH's intended patient pool for consultant led maternity a substantially higher amount lived in the North Tees PCT region and accordingly, if they attended JCUH as predicted, there would be significant knock on effects for the long term viability of UHH's consultant led maternity function.

48. This concept has been supported by figures collected by the SHSC. They indicate that there are more than double the amount of women of child bearing age[2] in the North Tees PCT (39,025) area than in the Hartlepool PCT area (18,364)[3]. This would indicate, therefore, that if a significant amount of the North Tees PCT residents access JCUH, questions would be posed over the viability of a consultant led maternity service at UHH. The SHSC also puts forward the view that the amount of women from the Easington PCT area who use UHH is negated by the amount of women from the Sedgefield PCT area who use UHNT.

49. Whilst the local NHS recognises the Transport problems affecting the accessibility of some services, it is not in a position to divert NHS monies to pay for public transport. On this point, The Joint Scrutiny Committee understood that whilst the NHS was a key partner, it was not it's role to arrange public transport and this should not be expected of the local NHS, nor should it be expected to fund transport solutions out of NHS budgets. It is evident, therefore, that the lack of public transport is a vital point to consider.

50. On the subject of Paediatrics, the Joint Scrutiny Committee spoke at some length with witnesses. Under the proposals, the UHH would be the main centre north of the Tees for Paediatric care. The UHNT will have a time specific paediatric unit, opening from 9am until 9pm, although the proposals are unclear as to whether this means five or seven days of the week. This would have a consultant and junior doctor presence. The Joint Scrutiny Committee heard that one-hour

[2] For the purposes of this exercise child bearing age is from 15 years old to 44 years old.
[3] This is also supported in the birth rates for the two local authority areas which indicate that in a given year, 2115 live births occurred involving women from Stockton and 1065 with women from Hartlepool. www.statistics.gov.uk/downloads,theme_population/FM1_32/Table7.1.xls

before the unit closes, the Consultant would assess each patient and make a judgement as to whether they can go home or have to be transferred to Hartlepool for an inpatient stay. The unit at UHNT would be nurse led at night and Consultant staff would be on call at UHH.

51. The Joint Scrutiny Committee was told that at present, the split site working for paediatrics was proving to be very difficult, whilst it was also proving to be problematic in efforts to entice new staff to the area. It was felt that if the caseload were condensed into one unit, there would be a larger pool of cases to work with and, therefore, prove more tempting to those who may be recruited to the area.

52. Once again, the Joint Scrutiny Committee was told that the ideal solution to such problems would be the opening of a single site hospital north of the Tees. Professor Darzi, however, has dismissed that, and in taking 8-10 years to build, would not be a solution for the problems currently experienced.

53. At this stage, the Joint Scrutiny Committee heard from the Clinical Director of Paediatrics at the South Tees Trust that the Proposals were not in the interests of Paediatric care. The views expressed during the meeting were also supported and expanded upon in a written submission sent to the Joint Scrutiny Committee by the same person. The reason for this view is the fact that, for north of the river, the trauma centre will be at UHNT 24 hours a day, whilst the specialist paediatric base will be UHH. In essence, the proposals would create a situation where emergency surgery and trauma care will take place at UHNT without resident children's doctors. The Joint Scrutiny Committee heard, to its concern, that this is against Royal College of Surgeons Guidance[4] and a draft working paper from the Department of Health[5].

54. To clarify, the view expressed to the Joint Scrutiny Committee is that, it is against clinical governance principles and it is not safe to have a paediatric emergency surgery and trauma service, where there is no paediatric team. Further, that it is a serious risk to any paediatric patient deemed to need critical care for them to be in a hospital without a paediatrician[6]. Indeed, this view has been supported by a further written submission received by The Joint Scrutiny Committee from a practising consultant paediatrician employed at JCUH[7]. That submission states that there are "clinical governance issues" arising from having sick children receiving surgical services in a hospital without continuing paediatric services.

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[4] *Children's Surgery – a first class service*, Royal College of Surgeons 2000, reviewed in 2005.
[5] *The acutely or critically sick or injured child in the District General Hospital*, See www.dh.gov.uk Gateway reference 4758.
[6] Please see submitted correspondence to Joint Committee from Dr Fiona Hampton, Referenced in bibliography.
[7] Please see submitted correspondence from Dr Geoffrey Wyatt, Referenced in Bibliography.

55. The Joint Scrutiny Committee appreciates that the science of medicine creates, if not demands, differences of opinion between its exponents. Nonetheless, to have two senior clinicians express such similar concerns over an aspect of the proposals is of great concern. This is especially so, given the fact that those expressing the concerns will not be working within the facilities affected and can therefore, afford a degree of dispassion when considering the topic. Further to this, the Joint Scrutiny Committee has not, as yet, heard any arguments that sufficiently dismiss the above concerns.

56. Some time after the meeting was held; the Joint Scrutiny Committee received correspondence from the Royal College of Paediatrics and Child Health, outlining its views on the proposals in relation to paediatrics.[8]

57. The document makes the point that

> "The College strongly recommends that there should be an on-site paediatric presence, both medical and nursing, where surgery is being undertaken on children. This has been recognised by the DH in its guidance of ISTCs. The Darzi proposals pose an unacceptable danger for children where surgery is concerned"

58. It was noted that the Children's National Service Framework states at Standard 7:

> "Children and young people receive care that is integrated and co-ordinated around their particular needs and those of their family…"[9]

59. With consideration of the views expressed above about a lack of 'ready to go' paediatric input in a trauma setting at UHNT, the Joint Scrutiny Committee is unclear as to how this represents integrated care for children and has grave concerns over the safety of the service configuration proposed. At this stage of the investigation, those concerns have not being allayed.

60. The SHSC also gathered evidence which indicates that consultants feel the proposals are not in the best interests of patients and contradict clinical governance principles. The evidence received indicates that it is not safe to have paediatric emergency and trauma at UHNT when it is planned not to have a paediatric team overnight, as it will operate as a nurse-led facility.

61. The Joint Scrutiny Committee also heard evidence from the Clinical Director of Paediatrics at South Tees, on the topic of paediatric

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[8] Please see submitted correspondence from Professor Craft at Royal College of Paediatrics and Child Health of 20th December 2005. Referenced in Bibliography.

[9] *National Framework for Children, Young People and Maternity Services*, Department for Education & Skills and Department of Health, October 2004.

emergency medical care and the potential impact on JCUH. The letter referenced above also expands upon these views. It was said that the Proposals assumed that people in the catchment area of UHNT would be prepared to attend UHH. In child medical emergencies (e.g. suspected meningitis), The Joint Scrutiny Committee heard that it is far more likely that a significant amount of North Tees PCT residents from the areas of Yarm, Ingleby Barwick and Thornaby, would find it easier to travel straight to JCUH. It was said that this idea of patient drift is not just the view of the team at JCUH, but is supported by A&E attendance records. The Joint Scrutiny Committee heard that already, people from those areas access JCUH by choice. It was stated that this would only increase should the proposals be implemented.

62. The Joint Scrutiny Committee heard that this may represent a increase in patronage of JCUH in this field of around 33%, assuming that half of the North Tees PCT area population finds it easier to get to JCUH than UHH.

63. The Joint Scrutiny Committee heard that the impact on such a shift in patient flow dynamics could very difficult to sustain and may mean around another 1700 cases per year at JCUH, coming into a unit which is already stretched. The Joint Scrutiny Committee learned that patients would be handled on a 'first come' basis, which may mean that depending on patient flows, a significant number of patients from South of Tees (for whom JCUH is the DGH) would not be able to access such services and could be displaced across Teesside. In addition, it was proposed that if JCUH was heavily used by the UHH's natural patron base, would UHH become sustainable in the long term, especially when one considers the advent of payment by results.

64. The points outlined above are supported in a written submission referenced footnote 7. In that submission it is stated that should the increase in footfall to JCUH occur, there might be a change in the professional activities within the paediatric department of JCUH. The Joint Scrutiny Committee heard there might be a situation where there is a shift from a department trying to provide a full range of children's services to a department where the acute service is reacting to the increased workload from the children of Stockton. This would, therefore, have implications for recruitment, training and relationships with surgical staff and nursing staff.

65. The Joint Scrutiny Committee has noted that, should a significant amount of residents from the North of Tees areas, as outlined above, attend JCUH, it may have repercussions for the viability of the centre at UHH. This would be especially so given the advent of Patient Choice. In addition to this, a reduced case throughput at UHH would result in the questioning of the presence of a consultant body and the opportunities for consultants to maintain and develop skills. Further, given the advent of payment by results, it would leave the UHH unit open to financial uncertainty. The likelihood of an increased paediatric

patient flow to JCUH from North Tees PCT area has also been raised in the evidence received by SHSC and fed back into the Joint Scrutiny Committee.

66. The Joint Scrutiny Committee has been told in written evidence that the best option would be to centralise paediatric services on the JCUH site. In effect, therefore, it is the views of witnesses that Prof. Darzi has not "gone far enough" in relation to paediatric services.

67. On this point, the Joint Scrutiny Committee realises that the call for a centralised paediatrics centre has come from employees of one acute trust and weights that evidence as such. In addition to this view, however, the Royal College of Paediatrics (referenced at footnote 9) has advised along similar lines that:

"In the future there will need to probably only be one inpatient unit and the logical place for this would probably be James Cook".

68. In relation to surgery, the same correspondent advises The Joint Scrutiny Committee that

69. "General paediatric surgery should be concentrated on one site for the Tees Valley. There is huge national concern at the loss of expertise in this area. Until recently adult general surgeons with a special interest have undertaken it. Most of these are to retire imminently and current surgical trainees do not wish to undertake this work. There are similar issues for anaesthesia for children. The Tees Valley has a big enough population to sustain a really excellent service for both paediatric surgery and anaesthesia but scarce manpower resources need to be concentrated and must have appropriate paediatric backup."

70. Further, the Joint Scrutiny Committee realises that it is its role of The Joint Scrutiny Committee to scrutinise the proposals, which are put in front of it. It does not wish to be seen to be disrespectful to the health service planners it has met, nor step outside it's remit by attempting to direct health service configuration across Teesside. Nor does it presume to possess more expertise than it does. Nonetheless, it feels it is appropriate to ask the question as to how feasible would a centralised paediatric unit be for Teesside, irrespective of location.

71. It was confirmed again to the Joint Scrutiny Committee within the meeting that the general ethos in the proposals had gained significant clinical support and it was widely accepted that doing nothing was not a feasible option, the matter causing a significant amount discussion was the location of the services concerned.

72. The Joint Scrutiny Committee stressed that it was integral that when considering the matter, it dealt with the facts of the cases in hand and not emotions or emotive messages.

73. At the same meeting, the Joint Scrutiny Committee studied the centralisation of Women's services at UHH. It was stated that within the field of breast surgery, the only substantive change for patients, would be that major breast surgery would now take place exclusively at UHH. Women's pre and postoperative appointments would continue to be held at UHNT, should that be the most appropriate place to visit.

74. The stated aim of the Proposals was to create a Centre for excellence, which afforded equality of care and access to care. The Joint Scrutiny Committee heard that a short time ago following a regular peer review into Breast Cancer, the clinical staff said there was nothing in the Darzi report that concerned them.

75. As far as this element of the proposals was concerned, the Joint Scrutiny Committee found nothing to take exception with a fully recognised the need to centralise surgical expertise north of the river. The Joint Scrutiny Committee thought it was particularly pleasing that, for Stockton residents, the only time they would need to use UHH would be for surgery. The fact that check-ups, assessments and such like would take place at people's local hospital was a positive aspect.

Position of the Joint Committee on maternity & paediatrics

Proposal

76. The Establishment of a Centre of Excellence in Women's & Children's services at UHH (includes Consultant Led Maternity, Paediatric Services, Gynaecology and Breast Surgery)

77. The Joint Scrutiny Committee feels that in terms of maternity services, this recommendation is not consistent with the ethos of Keeping the NHS Local. The Joint Committee recognises the importance of a consultant led maternity services at UHH serving the communities of Hartlepool and East Durham, although this should not be at the expense of the services currently on offer at UHNT or the wider Tees Valley community. On the weight of evidence received, the Joint Scrutiny Committee has concerns over the impact on JCUH's services and existing body of patients, of the migration of patients from the North Tees area, choosing to access JCUH. Accordingly, the proposal in relation to maternity services is not supported.

78. With reference to the paediatric proposals, the Joint Scrutiny Committee is minded to take on board the advice of the Royal College of Surgeons in document "Children's surgery: a First class service", which is quoted in the body of the report and bibliography. The Joint Scrutiny Committee notes how the document states that trauma and paediatrics should be housed together, for patient safety reasons and as a result, recommends that proposals for paediatric provision should be at the level outlined in the above report, whilst recognising local

need. Accordingly, the Joint Scrutiny Committee does not support the proposal for paediatric services, as it stands.

79. In terms of Breast Surgery, the Joint Scrutiny Committee is in support of the proposal. The Joint Scrutiny Committee is pleased to note that all preoperative and postoperative checks and assessments will take place at the woman's local hospital. Attendance at UHH will only be necessary for surgery.

80. In terms of gynaecological services, the Joint Scrutiny Committee's original position was that it understood and accepted the rationale for the proposal and was accordingly in support of this element of the proposal. Since that position was publicised, the Joint Scrutiny Committee has been advised that it is not clinically advisable to have a consultant led inpatient gynaecological service and consultant led maternity on two different sites, due to the clinical links between the two subject areas. Consequently, the Joint Scrutiny Committee has resolved its position is that consultant led inpatient gynaecology should be provided on both sites north of the Tees.

81. The Joint Scrutiny Committee would like to make specific reference to the lack of financial information, which the Joint Scrutiny Committee has asked for on six different occasions in open, public meetings. Indeed, on one occasion (16 January 2006) following another request for financial information relating to the proposals, the Joint Scrutiny Committee was told that individual business cases would be prepared should the proposals be approved. As a result, there was no detailed financial information presently available to demonstrate the financial implications and ramifications of the proposed service changes. In the absence of this information it was not possible for the Joint Committee to reach any conclusion as to the appropriateness, viability and sustainability of the recommendations.

Conclusion

82. The Joint Scrutiny Committee, having considered a substantial amount of evidence, as detailed above, does not support the proposals in relation to maternity and paediatric services. Its rationale for not supporting the proposals is essentially fourfold.

83. Firstly, the Joint Scrutiny Committee does not believe that the proposals pertaining to maternity and paediatric services are in the interests of the local community, nor in the interests of the local health service.

84. Secondly, the Joint Scrutiny Committee does not believe that the proposals are consistent with the ethos of the key NHS Policy document *Keeping the NHS Local*.

85. Thirdly, the Joint Scrutiny Committee has consistently noted the lack of detailed information pertaining to the financial ramifications of the proposals on the local health economy. As a result of this, the Joint Scrutiny Committee is unable to conclude as to whether the proposals are sustainable or not.

86. Fourthly, the Joint Scrutiny Committee holds the view that the communities of Stockton on Tees, Hartlepool and the associated parts of East Durham are substantial communities in their own right and as such, should be able to expect a certain level of District General Hospital service provision within their vicinities, as is presently provided.

87. The Joint Scrutiny Committee therefore refers the matter to the Secretary of State for Health, for ultimate determination. A copy of the full Final Report of the Joint Committee is attached for completeness.

88. For the sake of probity, you are asked to note that the decision to refer the matter to the Secretary of State is a majority decision of the Joint Scrutiny Committee. The representatives from Hartlepool Council and Stockton on Tees Borough Council voted against referring matter to the Secretary of State according to the four principles outlined above. Stockton Borough Council's representatives also expressed a wish to refer the matter, although according to different rationale, which they expressed a desire to pursue independently. For your information the voting was 7:5 in favour of the Referral.

SECTION 7 JOINT CONSULTATION COMMITTEE (ACUTE SERVICES REVIEW 2005/06)

SECTION 7 SCRUTINY REVIEW INTO THE ACUTE SERVICES PROPOSALS, FOLLOWING THE REVIEW OF PROFESSOR SIR. ARA DARZI: FINAL REPORT

Membership of the Joint Scrutiny Committee

Middlesbrough Borough Council

Hartlepool Borough Council

Durham County Council

North Yorkshire County Council

Redcar & Cleveland Borough Council

Stockton Borough Council

February 2006

Executive Summary

1. On 23 September 2005, a public consultation was launched by the local NHS in relation to proposals for changes to Acute Services based across Teesside and North Yorkshire.

2. The proposals came about following Professor Sir Ara Darzi's investigation into hospital based services across Teesside and North Yorkshire, which he was asked to complete by the Department of Health in October 2004. The reason for his study was to investigate how the sustainability of all hospitals across Teesside could be arrived at, whilst continuing to deliver first class services.

3. He presented his findings in Hartlepool on 8 July 2005, which form the basis of the proposals, which have been consulted upon.

4. When such a consultation is launched, Overview & Scrutiny has a unique role to play. The local NHS is legally obliged to formally consult with Overview & Scrutiny about the proposed changes and is legally obliged to provide information and attend meetings when reasonably requested to do so.

5. Overview & Scrutiny also has responsibilities. All of the local authorities whose population will be materially affected by the proposals, are obliged to form a Joint Committee to consider the proposals. It is then The Joint Scrutiny Committee that has the power to formally request attendance and information and ultimately refer a disputed matter to the Secretary of State for Health, if necessary.

6. Accordingly, a Joint Committee was formed to scrutinise the proposals and this Final Report is a record of process.

7. At the outset of the exercise The Joint Scrutiny Committee agreed a Remit and Terms of Reference to direct its investigation, which has provided The Joint Scrutiny Committee with the opportunity to scrutinise in detail every major aspect of the proposals.

8. The Joint Scrutiny Committee spoke with a very wide-ranging group of people in its investigation and considered a significant amount of verbal and documentary evidence. Full details are in the report although as an example, The Joint Scrutiny Committee spoke with NHS Managers, Doctors, Midwives nurses, Patient Groups, University academics and Independent Transport Consultants.

9. The Joint Scrutiny Committee decided to scrutinise the proposals by separating out each different aspect of the proposals and considering each subject area in turn.

10. Following the scrutiny of the proposals, the Joint Scrutiny Committee believes the following statements to be true and would request that the full Final Report is read with these in mind.

11. Current service configuration is unsustainable. Accordingly, doing nothing is not a viable option, but the amount of service reconfiguration should vary at each hospital, In line with "Keeping the NHS Local", services should be located as close to people's homes as is safely possible, taking into account the expectations of local communities to have key services available at its local hospital.

12. Any change to service configuration should also bring about improvements in the patient experience and patient outcomes. This is especially so if the changes require additional expenditure to be realised.

13. There is also a realistic requirement for services to be configured in such a way that will be attractive to medical staff, thereby improving recruitment and retention.

Conclusions

14. Following its investigation into the proposals, The Joint Scrutiny Committee has reached the following conclusions.

Proposal

The Establishment of a Centre of Excellence in Women's & Children's services at UHH (includes Consultant Led Maternity, Paediatric Services, Gynaecology and Breast Surgery)

15. The Joint Scrutiny Committee feels that in terms of maternity services, this recommendation is not consistent with the ethos of Keeping the NHS Local. The Joint Committee recognises the importance of a consultant led maternity services at UHH serving the communities of Hartlepool and East Durham, although this should not be at the expense of the services currently on offer at UHNT or the wider Tees Valley community. On the weight of evidence received, the Joint Scrutiny Committee has concerns over the impact on JCUH's services and existing body of patients, of the migration of patients from the North Tees area, choosing to access JCUH. Accordingly, the proposal in relation to maternity services is not supported.

16. With reference to the paediatric proposals, the Joint Scrutiny Committee is minded to take on board the advice of the Royal College of Surgeons in document "Children's surgery: a First class service", which is quoted in the body of the report and bibliography. The Joint Scrutiny Committee notes how the document states that trauma and paediatrics should be housed together, for patient safety reasons and as a result, recommends that proposals for paediatric provision should be at the level outlined in the above report, whilst recognising local need. Accordingly, the Joint Scrutiny Committee does not support the proposal for paediatric services, as it stands.

17. In terms of Breast Surgery, the Joint Scrutiny Committee is in support of the proposal. The Joint Scrutiny Committee is pleased to note that all

preoperative and postoperative checks and assessments will take place at the woman's local hospital. Attendance at UHH will only be necessary for surgery.

18. In terms of gynaecological services, the Joint Scrutiny Committee understands and accepts the rationale for the proposal and accordingly is in support of this element of the proposal.

Proposal

- **The concentration of elective orthopaedics in UHH**
- **The establishment of a major trauma and emergency surgery facility at UHNT**
- **The increased use of the Friarage for orthopaedics**

19. The Joint Scrutiny Committee understands the rationale for the above proposals and supports their implementation. The Joint Scrutiny Committee understands the intention of, to a large extent, divorcing elective orthopaedics from emergency surgery. This is because, the Joint Committee fully accepts and understands that the former can often be disrupted, depending upon the emergency workload. Given that national targets for such elective work will soon be in force, the Joint Scrutiny Committee agrees that the proposal is a sensible approach to providing the best possible service to two distinct patient groups.

20. In relation to the increased use of the Friarage, the Joint Scrutiny Committee is in full support of this element of the proposal. In the view of the Joint Scrutiny Committee it provides greater choice to patients, contributes to making the Friarage (and its associated support services) more sustainable and potentially frees up some capacity at JCUH.

Proposal
The Establishment of a Tees wide Upper Gastro Intestinal service at UHNT
The establishment of a Tees wide endo-luminal vascular service and the establishment of a vascular network with JCUH

21. The Joint Scrutiny Committee was informed at a meeting on 19 December 2005, that the recommendations in relation to vascular services have been dropped in response to a national confidential enquiry into deaths associated with vascular services, which asserted that the existing service configuration across Teesside was the optimum.

22. The Joint Scrutiny Committee welcomes the agreement reached by the two acute trusts, and would wish to see similar co-operation between the respective agencies replicated. The Joint Scrutiny Committee would, however, like to state that should these proposals had remained, on the strength of evidence received the Joint Scrutiny Committee would not have supported the proposal.

23. In relation to the proposal pertaining to Upper GI services – The Joint Scrutiny Committee, on the weight of the evidence received, strongly opposes the proposal on the following grounds.

24. The Joint Scrutiny Committee has received evidence, which states that the proposed move of such services would have detrimental impacts upon the safety of patients accessing the service and would, therefore represent a retrograde step. The Joint Scrutiny Committee does not feel that there has been sufficient evidence-led rebuttal of this perspective to assuage the Joint Scrutiny Committee's concerns.

25. The Joint Scrutiny Committee has also heard that if the proposal were to be implemented, there would be unnecessary duplication of services between UHNT and JCUH. The finances for which could be better spent.

26. The Joint Scrutiny Committee has received a substantial amount of evidence to indicate that presently at JCUH, the upper GI service has access to a wide variety of support services on the same site. These are services such as Renal, cardiothoracic, radiotherapy and chemotherapy, which the upper GI service often has reason to call upon. The Joint Scrutiny Committee has learned that a significant proportion of those support services will not be provided at UHNT and patients would face a hypothetical wait for expertise to arrive or a journey to JCUH. Given the lack of support services at UHNT, the Joint Scrutiny Committee cannot possibly envisage how patients will benefit from such a proposal.

27. The Joint Scrutiny Committee has also noted that the upper GI unit at JCUH is held in very high esteem nationally and viewed as an example of best practice. The Joint Scrutiny Committee cannot see any logical, patient centred rationale as to why this should be moved to UHNT, which presently, is only able to express the ambition of replicating the current service on offer at JCUH.

28. The Joint Scrutiny Committee has also noted that the current service configuration in relation to upper GI services is supported by two detailed reports by independent authorities (please see para 128). The Joint Scrutiny Committee has received no evidence to indicate that thinking on the topic has changed to such a degree, as to render the conclusions of both reports out of date or 'defunct'. Accordingly, the Joint Scrutiny Committee questions the lack of clear, available medical rationale as to the proposed move of the service.

29. The Joint Scrutiny Committee has also received evidence to indicate that the loss of three upper GI surgeons will also have a significant impact on general surgical capacity at both JCUH and the Friarage. Given the accepted dearth of suitably qualified surgeons nationally, this is a consequence of the proposal that the Joint Scrutiny Committee finds unacceptable.

30. It is for reasons above, which the Joint Scrutiny Committee strongly opposes the proposed move of upper GI services.

Workforce

31. On the weight of the evidence received, the Joint Scrutiny Committee believes that Professor Darzi did not involve staff sufficiently in his work before arriving at his recommendations.

32. Nonetheless, the Joint Scrutiny Committee is pleased to see the Trusts now engaging with staff in considering the proposals and how they would be staffed, should they be accepted. The Joint Scrutiny Committee has received no evidence to indicate that any staffing issues brought about by the proposals are insurmountable. The Joint Scrutiny Committee, therefore, does not wish to raise any objections with reference to the proposals and their staffing.

Financial Planning

33. The Joint Scrutiny Committee is deeply concerned that it has not received any evidence, despite numerous requests within meetings, regarding the financial implications of the proposals published. The Joint Scrutiny Committee notes that at a meeting of the Stockton Health Scrutiny Committee, a figure of £15m was quoted for capital costs to fund the reconfiguration. Yet, this information was not forthcoming to the Joint Scrutiny Committee.

34. The Joint Scrutiny Committee feels that the absence of this information has severely impeded it in taking a view regarding the sustainability, feasibility and value for money of the proposals.

Consultation

35. The Joint Scrutiny Committee feels that as a whole, the consultation process was largely well attempted, whilst it may have been more effective in the urban regions than in rural areas, especially in relation to the distribution of consultation literature.

36. In terms of consultation with the Joint Scrutiny Committee, it is felt that it has been good and the Joint Scrutiny Committee would like to place on record its thanks for the level of assistance offered and its commitment in engaging with Overview & Scrutiny. The Joint Scrutiny Committee has gained the impression, however, that during the latter period of the consultation period, there has been a reluctance to fully inform the Joint Scrutiny Committee on financial information and public feedback.

Transport

37. The Joint Scrutiny Committee is of the view that, on the weight of evidence received, there is not sufficient integration between the planning of health services and the planning of public transport schedules.

38. The Joint Scrutiny Committee, whilst understanding it is not the primary role of the NHS to provide public transport, it would wish to see improved joint planning between agencies at the earliest possible opportunity.

39. On the strength of the evidence received, the Joint Scrutiny Committee wishes to express its concern over evidence it received from both Ambulance Trusts. This stated that due to the proposed changes, particular cohorts of patients would take longer to transport, which therefore means that ambulance vehicles and crews will be out of circulation for longer.

40. From evidence gathered by Durham County Council, the Joint Scrutiny Committee would also like to raise the issue of disparity between the amount of disabled car parking at the different hospital sites concerned, as well as the disparity of free disabled car parking.

41. Further to that, the Joint Scrutiny Committee wishes to raise that the hospital travel cost scheme for those who may have difficulty funding travel to hospital does not seem to be particularly well publicised. The Joint Scrutiny Committee feels the scheme would benefit from better publicity.

42. In addition, the Joint Scrutiny Committee feels it would be beneficial to patients and their carers if a consistency of car parking charges across the different hospital sites was applied.

Additional Observations of the Joint Scrutiny Committee

43. The Joint Scrutiny Committee would like to bring attention to the fact that it has received a significant amount of evidence from clinicians, which would support the designing, building and opening of a single site for North of the Tees. The Joint Scrutiny Committee is, however, aware of differing public opinions on the topic.

44. Further to that, the Joint Scrutiny Committee would like to bring attention to the fact that the overwhelming majority of paediatricians, who have engaged with the Joint Scrutiny Committee, have advocated the opening of a Tees wide paediatric inpatient unit, for improved outcomes and better concentration of expertise. Whilst the Joint Scrutiny Committee is not in a position to make a clinical judgement on the validity of this concept, it does feel it appropriate to ask the questions as to how desirable and/or achievable this is.

45. As change needs to happen, although the form of change is the subject of much debate, the Joint Scrutiny Committee commends the local NHS to work together in order to pursue possible alternatives to provide sustainable hospital services in the future.

46. The Joint Scrutiny Committee wishes to place on record its view that the overall timeframe for completion of a service review, which was launched in July 2003, has been too long and unhelpful. It seems to have created uncertainty, had a negative impact on public confidence and morale of staff.

Recommendations

47. Following the consideration of the evidence, the Joint Scrutiny Committee makes the following recommendations.

48. The Joint Scrutiny Committee recommends to the NHS Joint Committee that it agrees to implement the proposals as consulted upon, pertaining to:

a) Gynaecology
b) Breast surgery
c) The concentration of elective orthopaedics at UHH
d) The establishment of a major trauma and emergency surgery facility at UHNT
e) The increased use of the Friarage for orthopaedics

49. The Joint Scrutiny Committee recommends to the NHS Joint Committee that it does not implement the proposals as consulted upon, pertaining to:

a) The establishment of a Tees wide upper gastro intestinal service at UHNT
b) The establishment of a Tees wide endo-luminal vascular service and the establishment of a vascular network with JCUH
c) Maternity services
d) Paediatric services

50. The Joint Scrutiny Committee does not believe the proposals at 49 to be in the interests of local health services and the people the Joint Scrutiny Committee represents.

51. As a result of this, if the NHS Joint Committee accepts any of the proposals above from 49(a) to 49(d), the Joint Scrutiny Committee will refer the disputed matter to the Secretary of State for Health for determination under powers granted to it.[1]

[1] Please see p.30 of Overview & Scrutiny of Health – Guidance. Published by Dept of Health, July 2003. Please see www.dh.gov.uk

SECTION 7 JOINT CONSULTATION COMMITTEE (ACUTE SERVICES REVIEW 2005/06)

SECTION 7 SCRUTINY REVIEW INTO THE ACUTE SERVICES PROPOSALS, FOLLOWING THE REVIEW OF PROFESSOR SIR. ARA DARZI: FINAL REPORT

Membership of the Joint Scrutiny Committee

Middlesbrough Borough Council

Hartlepool Borough Council

Durham County Council

North Yorkshire County Council

Redcar & Cleveland Borough Council

Stockton Borough Council

February 2006

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SECTION 7 SCRUTINY REVIEW INTO THE ACUTE SERVICES PROPOSALS, FOLLOWING THE REVIEW OF PROFESSOR SIR. ARA DARZI: FINAL REPORT

PURPOSE OF THE REPORT

1. To present the findings of the Section 7 Scrutiny Review into the Acute Services Proposals, put forward following Professor Sir Ara Darzi's investigation.

BACKGROUND

2. In June 2003, the Tees Review was launched and started to look at the future of all health services across Teesside. There was a great deal of discussion with a significant amount of people involved. The review came about, as the local NHS felt it was becoming clear that some action was needed to make sure patients continued to receive the best possible health care, which could mean changing the way services are provided.

3. The local NHS felt the review was needed because:

3.1 People want to get care as close to their home as possible.
3.2 To get the best care, some people need to be treated in bigger more specialist hospitals. Here, doctors see large numbers of patients with certain conditions which makes sure they can remain experts at their job, work with the latest equipment and highly experienced and trained staff.
3.3 There is a national shortage of some staff, such as doctors and nurses. The time people have to wait for care and treatment needs to be reduced and people want more choice about where and how they are treated.
3.4 People are living longer, needing more care and more people are living with long term illnesses such as diabetes, chest or heart conditions.
3.5 The European Working Time Directive will mean that junior doctors will work fewer hours.
3.6 Thanks to new medical technology, people who used to stay in hospital for several days for an operation can now have this done in a day.
3.7 Some tests can now be done in a person's local hospital, or even at the family doctor's which in the past, would have meant a visit to a specialist hospital.

4. In 2004, County Durham & Tees Valley Strategic Health Authority asked Professor Sir Ara Darzi, a distinguished surgeon who has carried out a number of reviews of hospital services around the country on behalf of the Department of Health, to look at the result of the discussions which took place in the Tees Review. He was also asked

to consider how the fullest possible range of services could be maintained at the University Hospital of Hartlepool.

5. In December 2004, the Strategic Health Authority asked Professor Sir Ara Darzi to extend his review and also look at:

5.1 The work underway by the Hambleton & Richmondshire Primary Care Trust and South Tees Hospitals NHS Trust in relation to making the Friarage Hospital a thriving hospital in the long term.

5.2 What had happened as a result of very specialist services being brought together at the James Cook University Hospital and what happened to the other hospitals in County Durham and Tees Valley as a result.

5.3 The space and resources available at the James Cook University Hospital, Middlesbrough.[2]

6. Following his research and associated work, Professor Darzi presented his report in Hartlepool, on 8 July 2005. His report is available from local NHS Trusts and also as a background paper to this report. Professor Darzi's recommendations, which are the proposals being consulted on, are as follows:

7. **The University Hospital of Hartlepool** should continue to provide a consultant-led accident and emergency service and acute medicine. It should host a new Centre of Excellence in Women's and Children's Services, including consultant-led maternity, paediatric services, gynaecology and breast surgery. It should increase its inpatient elective surgery portfolio, in particular orthopaedics. Major trauma and emergency surgery out of hours should move to the University Hospital of North Tees.

8. **The University Hospital of North Tees** should become the main centre north of Tees for emergency surgery, including trauma, with expanded intensive care facilities. It should continue to provide a full accident and emergency surgery and acute medicine. It should develop as a centre for major complex surgery, including hosting a North Tees Complex Surgical Centre, providing upper gastro-intestinal cancer services for the whole of the Teesside area. Vascular surgery should be developed at the University Hospital of North Tees as part of a clinical network with the James Cook University Hospital. An endo-luminal vascular service should also be developed at the University Hospital of North Tees serving the whole Teesside area. A 24-hour midwife-led maternity unit should be developed. Consultant-led maternity, high-risk obstetrics and paediatric services should be centralised in the University Hospital of Hartlepool.

9. **The James Cook University Hospital** should retain its full range of district general hospital-type services and its range of tertiary and supra regional services. The proposed move of upper gastro-intestinal cancer

[2] Please see Executive Summary on Page 4 of Full Length Consultation Document. Fully referenced in the bibliography.

services to the University Hospital of North Tees should free up a modest amount of capacity.

10. Work should also be intensified to improve integration with and make full use of capacity at the **Friarage Hospital**, for example in orthopaedics and ophthalmology, to reduce capacity pressures at the James Cook University Hospital.

HOSPITAL INFORMATION

11. The proposals out to public consultation have material effects on four local hospitals. Information on these four facilities is outlined below to add context to this final report.

12. **The University Hospital of Hartlepool** provides a wide range of district general hospital services including accident and emergency, maternity and children's services, care for critically ill patients and other support and partner services such as radiology, pathology and physiotherapy. Most of the hospital was built in the 1970's. It has:

    12.1 421 beds
    12.2 five operating theatres
    12.3 seven critical care beds
    12.4 three medical high dependency beds
    12.5 day case, day care and outpatient facilities

13. **The University Hospital of North Tees** provides a wide range of district general hospital services including accident and emergency, maternity and children's services, care for critically ill patients and other support and partner services. It was built in the 1960's. It has:

    13.1 560 beds
    13.2 six operating theatres
    13.3 six critical care beds (which are due to be expanded to eight)
    13.4 day case, day care and outpatient facilities

14. **The James Cook University Hospital** provides district general hospital services primarily for people living in Middlesbrough and Redcar & Cleveland and a wide range of specialist services across Teesside, North Yorkshire, South Durham and parts of Cumbria. These specialist services include operations and treatment for patients with heart and lung disease, spinal cord injuries, cancer, vein, artery and general circulation problems, ear, nose and throat and eye problems such as cataracts.

15. The original South Cleveland Hospital was built in the 1980'a and expanded under the government's private finance initiative. The £155m James Cook University Hospital opened its doors in August 2003 when services at Middlesbrough General Hospital, the North Riding Infirmary and the neuro rehabilitation ward at West Lane Hospital were transferred onto the site. It has:

15.1 1,070 beds
15.2 19 main operating theatres, an accident and emergency theatre for patients who have had serious accidents, specialist day cases and obstetric theatres for women who need a caesarean section
15.3 A wide range of adult intensive care, critical care, high dependency care and children's intensive care
15.4 Day case, day care and outpatient facilities.

16. The work done in the hospital has grown substantially since the original plans for expansion were agreed.

17. **The Friarage Hospital** became part of the South Tees Hospitals NHS Trust in April 2002. It provides district general hospital services including accident and emergency, emergency surgery, acute medicine, day case and inpatient surgery, maternity and children's services, care for critically ill patients and other support and partner services, including mental health inpatients.

18. It is undergoing a £21m redevelopment to replace the wooden huts and other old buildings from which some of its services have been provided for many years. It has

18.1 254 beds
18.2 Six operating theatres
18.3 Four intensive care beds
18.4 One high dependency bed
18.5 Day case, day care and outpatient facilities

INTRODUCTION

19. Under current legislative arrangements, it is the role of Overview & Scrutiny to consider the proposals and take a view on their suitability. In forming a view, Overview & Scrutiny should talk to key stakeholders and consider evidence received carefully. There is a series of key questions that Overview & Scrutiny should ask, to aid its understanding of the proposals. These are questions such as:

19.1 Whats proposed to change?
19.2 Why do things have to change?
19.3 What does the local NHS want to get out of these changes?
19.4 How do the measures proposed deliver on these aims?

20. To formally scrutinise the Acute Services Proposals, it was necessary to form a Joint Committee constituted from the affected local authorities. The local authorities that made up The Joint Scrutiny Committee were:

20.1 Middlesbrough Council (Chair)
20.2 Hartlepool Borough Council (Vice Chair)
20.3 Durham County Council

20.4 North Yorkshire County Council
20.5 Redcar & Cleveland Borough Council
20.6 Stockton Borough Council

21. To inform the Scrutiny Review, it operated within a clear, defined remit and terms of reference. These were:

22. **Remit: -**

'To act as the statutory overview and scrutiny consultee in relation to the proposals put forward as a result of the Acute Services Review. The Joint Scrutiny Committee will take evidence from appropriate ranges of stakeholders. The Joint Scrutiny Committee will consider the suitability of the proposals in relation to the local health need and the associated consultation methodology practised by the local NHS. Following evidence gathering and deliberations, The Joint Scrutiny Committee will produce a final report'

23. **Terms of Reference**

'To examine the proposals put forward for developments to Acute Service provision and the affected area and their evidence base.

Specifically

a) To what extent is the transport infrastructure in the affected area adequate, to ensure reliable access to services?

b) To what extent are the proposals consistent with prevailing national policy including Strengthening Accountability and Keeping the NHS Local?

c) To what extent have the developments as proposed been informed by views expressed by stakeholders during section 11 consultation?

d) To what extent do the developments as proposed, ensure equality of access to and quality of services for residents from the affected areas?

e) How do the proposals ensure greater stability for acute services across the affected area?

f) How do the proposals improve upon exisiting patient care and associated care pathways?

METHODS OF INVESTIGATION

24. The Joint Scrutiny Committee met on numerous occasions to consider the Acute Services proposals between late September 2005 and January 2006. The evidence gathering meetings took the form of witnesses attending to present their views, followed by a question & answer / debate period. A detailed record of the meetings, including the supporting papers to every meeting are accessible through the Middlesbrough Council website. Further to that, copies are available by contacting the support staff for The Joint Scrutiny Committee, as an annex to this report.

25. During the work of The Joint Scrutiny Committee, evidence was received from the following people:

25.1 **North Tees Primary Care Trust**
C Willis, supporting Officer to Acute Services Review Joint Committee and Chief Executive Officer North Tees PCT

25.2 **County Durham &Tees Valley Strategic Health Authority**
E Criddle, Project Manager to Acute Services Review Joint NHS Committee
P Frank, PPI & Equality Manager

25.3 **Hartlepool PCT**
K Aston, PPI Lead, Hartlepool PCT
A Jackson, Deputy Director of Public Health

25.4 **South Tees Hospitals NHS Trust**
F Toller, Division Manager
J Moulton, Director of Facilities & Planning
S Hutchison, Chief of Service
J Wiles, Children's Services Manager
F Hampton, Consultant
H Simpson, Consultant
Prof. R Wilson, Chief of Service, Surgery
P Davis, Upper G I Surgeon
M Toase, Trade Union representative
A Parry, Vascular Surgeon
D Wilson, Clinical Oncologist

25.5 **North Tees & Hartlepool Hospitals NHS Trust**
Prof. A Mullan, Deputy Chief Executive/Director of Nursing
Dr K Agrawol, Clinical Director of Paediatrics
Dr A Ryall, Clinical Director, Obstetrics & Gynaecology
J Mackie, Head of Midwifery
Dr I L Rosenberg, Consultant Director, Surgery
Dr P Gill, Medical Director
A Lamb, Deputy Chief Executive Officer and Director of Acute Services
Dr Broadway, Clinical Director of Anaesthetics
J Atkinson, Head of PPI/Health Record Management
J Henderson
K Lynford, UNISON

P Holroyd, Royal College of Midwives
D Emerton, Clinical Director A & E
Dr N Wadd, Oncologist

25.6 **Oesophagi Support Group**
N Laking, Specialist Nurse and Support Officer
E Drabble
K Caswell

25.7 **South Tees Patient & Public Involvement Forum**
A Raw

25.8 **North Tees & Hartlepool Patient & Public Involvement Forum**
L Shields
D Froggatt

25.9 **North Yorkshire Local Medical Committee**
Dr D Rogers

25.10 **Easington PCT**
R Bolas, Chief Executive
C Sullivan, Deputy Director of Public Health

25.11 **North East Ambulance Service NHS Trust**
R French
L Matthias

25.12 **Tees, East & North Yorkshire Ambulance Service NHS Trust**
P Bainbridge
P Summerfield

25.13 **Hartlepool Borough Council**
I Jopling

25.14 **Stockton Borough Council**
R Farnham

25.15 **Independent Transport Consultants**
P Hardy
R Higgins

25.16 **Cleveland Local Medical Committee**
Dr J T Canning, Secretary

25.17 **University of Teesside**
J Gray, Health Economist

EVIDENCE CONSIDERED
&
FINDINGS OF THE JOINT SECTION 7 CONSULTATION COMMITTEE (ACUTE SERVICES REVIEW)

Chapter 1

EVIDENCE IN RELATION TO CONSULTATION PRACTICE BY THE LOCAL NHS

26. Following the establishment of the Joint Scrutiny Committee under Section 7 of the Health & Social Care Act and Health Scrutiny Regulations, it held its first meeting on 6 October 2005. The purpose of this meeting was to hear about the NHS Joint Committee's consultation plan, i.e. who it intended to engage with over the proposals and how it was going to do that.

27. The Joint Scrutiny Committee heard that the consultation planned for the Acute Services proposals would last just over twelve weeks, in line with Cabinet Office and Overview & Scrutiny of Health Guidance.[3] The Joint Scrutiny Committee was advised it was important to view the latest consultation activity, as an extension of the Patient & Public Involvement (PPI) work carried out over the last two years, since the inception of the Tees Review.

28. In handling the consultation process, the Joint Scrutiny Committee was told the local NHS was committed to working with the Community & Voluntary Sector, in ensuring as many people as possible participated, thereby attempting to avoid the trap of consulting with the 'usual suspects'.

29. Reference was made to a Consultation Activity Log, being kept as part of the local NHS' commitment to a transparent consultation process. It would also serve as a useful tool in directing consultation as the process developed.

30. The Joint Scrutiny Committee heard that the consultation plan had taken account of known best practice and lessons learnt from previous NHS public consultation activities around the country in recent times, including a Health Scrutiny Committee's observations from the Bristol area.

31. It was agreed with the NHS representatives that holding public meetings alone was not enough, to ensure a thorough and worthwhile consultation exercise. To that end, the Joint Scrutiny Committee was advised that the local NHS had written to in excess of 500 associations and groups, concerning the proposals and inviting them to comment. It was noted that sometimes, public attendance at public meetings was disappointing.

32. The Joint Scrutiny Committee heard that the local NHS would be happy to go and engage with any group to discuss the proposals and did not expect people to rely on public meetings or making written submissions

[3] Please see Overview & Scrutiny of Health, Published by the Department of Health, July 2003.

to contribute to the consultation. Whilst the Joint Scrutiny Committee was pleased to hear this, it did note that this offer was not explicitly articulated in the consultation document. This left the question of how community groups who had not been part of the initial contact would be in a position to know that such an offer existed. The only reason the Joint Scrutiny Committee knew of it was due to the fact that it was in the privileged position of scrutinising the proposals. It was, therefore, felt that was a weakness of the consultation document.

33. On the subject of public meetings, the Joint Scrutiny Committee heard that a series of meetings had been arranged and they would be taking place in all of the affected PCT areas. It was said that there would be two public meetings per PCT, although following consideration of the consultation document, this appeared to not be the case. There were only three meetings planned between Middlesbrough PCT and Langbaurgh PCT. (This concern was, later rectified, when the NHS held a further meeting in Saltburn) Further to that, there was only one public meeting advertised for the North Yorkshire region.

34. In addition to that, it was noted that the meeting in North Yorkshire was very early in the consultation process. It was felt in public consultation; it can often take a while for issues of concern to be teased out. If this was the case, having one consultation meeting in an area as vast as North Yorkshire, very early in the process was not deemed to be best practice. Further to that, the Joint Scrutiny Committee also noted that all of the public meetings to be held in Middlesbrough PCT and Langbaurgh PCT were to be held during the day (Again, this concern was to some extent allayed later in the process by the Saltburn meeting, as it was an evening meeting). It was felt that the lack of an evening meeting would also have an impact on who could attend the meetings and, therefore, the range of views which would be presented at these meetings.

35. The Joint Scrutiny Committee heard that the public meetings would be recorded by an independent company, based in Middlesbrough called 'Rocket Science' and that a detailed account of the meetings would be produced and placed in the public domain. In addition, it heard that the consultation leaflets had been sent to around 370,000 addresses in the affected area.

36. In relation to the topic of people contributing to the proposals, it was noted that the comments were expected to be free form, as there was no template or set questions to answer to structure people's response. It was felt that in this type of 'free form' approach, the less articulate or confident in the community might feel unable to respond, despite possibly having perfectly legitimate and useful views to put forward. The Joint Scrutiny Committee enquired as to whether some form of structured questionnaire could be considered to elicit responses from people other than those who are most confident and articulate.

37. The Joint Scrutiny Committee enquired as to the impact the consultation process can have on the content of the proposals. It heard that the NHS Joint Committee is legally obliged to listen to views

expressed during the consultation. There does, however, come a point when the NHS Joint Committee is required to consider the totality of the proposals. Potentially, the Joint Scrutiny Committee was told that, there is a danger linked to picking and choosing from the Proposals, in that that you may unravel it all. It was said that there is a need to consider the health and health services of the whole Teesside area and not consider one specific patch's situation excessively.

38. The Joint Scrutiny Committee held a meeting on 17 November 2005 to receive further evidence on the consultation practice of the local NHS over the proposals and to hear some stakeholder views on the proposals.

39. In relation to consultation, the Joint Scrutiny Committee heard that the local NHS had at that point, attended around 150 public meetings to discuss the proposals, in addition to the 12 statutory meetings advertised in the consultation documentation. It was also confirmed that PPI leads within each affected PCT were also arranging additional local meetings, if it was felt necessary.

40. The Joint Scrutiny Committee heard that there was no set audience at public meetings and that 'everybody and anybody' could request local NHS attendance at meetings about the proposals. Further to that, the Joint Scrutiny Committee was impressed to hear that the local NHS had responded to every request for a meeting and the local NHS "have not turned anyone down". It was felt this record of responsiveness reflected well on the local NHS.

41. The Joint Scrutiny Committee heard that the local NHS, which was distributed at public meetings, had drafted a pro-forma. The purpose of the proformas is to check the understanding of the public who are attending meetings. The proformas were to be analysed by Rocket Science.

42. Mention was made of the consultation and how despite the Joint Scrutiny Committee being generally complimentary about the consultation document, it was felt to be lacking in some key details, such as impacts of proposals and why exactly the review had taken place. It was acknowledged that the consultation document was drafted in fairly basic terms, to ensure the understanding of the widest possible cross section of the community. Nonetheless, it was agreed that there was, therefore, a lack of clear opportunities for people to receive slightly more in depth information about the proposals and their ramifications, unless they were in the fortunate position of being a Member of the Joint Scrutiny Committee. By its nature, the consultation document did not give a detailed picture and as a result, the Joint Scrutiny Committee felt that to an extent, the wider public was being asked to comment on something, which they had not had an adequate opportunity to understand. This is especially so given the absence within the literature produced of an offer to go and talk with groups, despite that offer being aired at the Joint Scrutiny Committee on 6 October 2005.

43. It was stated that every public consultation meeting is started with the same PowerPoint presentation, outlining the methodology and rationale of Professor Darzi and his study. It was said that this is a deliberate move, to ensure that the messages given out are consistent across the affected area and that it is vital it remains consistent throughout the consultation period.

44. The Joint Scrutiny Committee heard that the local NHS considered feedback they received during the consultation period, with a view to refining practice during the remainder of the consultation period. Examples of this include additional consultation documents being sent out, special interest groups being proactively engaged with and additional public meetings being staged with a wider variety of times and locations. The Joint Scrutiny Committee was pleased to see that additional meetings had been arranged, and felt this reflected well on the local NHS willingness to respond to comments.

45. In response to Member's queries, it was confirmed to the Joint Scrutiny Committee that as yet, there had been no changes to services, irrespective of what had come out of the consultation process so far. It was felt to be very important by the NHS Joint Committee that any service changes are only implemented, if at all, following the completion of a full consultation period, once all options had been considered.

46. It was stated that people in the Yorkshire Dales, who rely on JCUH for specialist services, had not received copies of the consultation paper. The NHS representatives undertook to ensure copies were sent out to the said area.

47. The Joint Scrutiny Committee enquired as to whether the consultation process will actually make an impact and change the proposals. The Joint Scrutiny Committee heard that "it is not inconceivable" that changes to Darzi may occur, although that will only happen, if at all, once the NHS Joint Committee has had the opportunity to consider the consultation results and makes a judgement on the viability of possible options.

48. The Joint Scrutiny Committee met on 16 January 2006, to take evidence in relation to the methodology employed to direct the consultation process and the available feedback from the consultation process.

49. The Joint Scrutiny Committee received a presentation from the account director of Rocket Science, an independent market research company who had been commissioned by the NHS Joint Committee to document the consultation and provide an analysis of the feedback received.

50. The Joint Scrutiny Committee heard that there had been 18 statutory public meetings, held across the affected area to discuss the proposals. It was confirmed that proceedings at these meetings had been recorded in a verbatim format. In addition to those public

meetings, there had also been in excess of 350 meetings with stakeholders.

51. In relation to the consultation document, it was confirmed that 377,000 properties were targeted to receive the consultation document and those properties were selected by postcode. All of the 'TS' postcodes received the paper and a proportion of 'DL', 'YO', 'SR' and 'DH' postcodes receiving the paper, depending upon the level of proximity to the proposals.

52. The papers were distributed through a variety of means, between 25 & 29 September 2005 and 97% of properties received the paper. The Joint Scrutiny Committee heard that quality checks performed indicated that 100% of people telephoned indicated they had received the document.

53. The Joint Scrutiny Committee heard that the bulk of information received, which would be analysed, was received in the statutory public meetings. Further to that, it was confirmed that the vast majority of comments were freehand and open-ended. As a result of this, the responses were more numerous and lengthy and made the analysis rather labour intensive.

54. The Joint Scrutiny Committee heard that the process of analysis had created six themes which comments were received on, these were service provision, finance, transport, process, non-Darzi related specifically and other.

55. The Joint Scrutiny Committee also learned about a questionnaire, which was used at 17 out of the 18 statutory public meetings. It asked a series of questions. Preliminary results indicated that around 50% of people who completed the questionnaire accepted that there was a need to do something to change the way some services were configured. It was noted that around 75% of those completing the questionnaire felt that Prof. Darzi's recommendations were not the best way to provide sustainable services at all four hospitals concerned. Finally, it was noted that around 75% of those responding to the questionnaire felt that Prof. Darzi was wrong to discount the options he did in arriving at his recommendations.

56. On the whole, it was stated that the biggest issue coming from the consultation was that of concern over service provision, following that was the topic of transport and then finance and process.

57. It was confirmed to the Joint Scrutiny Committee that the most written responses to the consultation came from the North Tees PCT area, with the Hartlepool PCT area being second. The least number of responses came from the Easington PCT area.

58. As a final point, it was felt important to note that 90% of the population in the area affected had not responded to the consultation. Consequently any summation of the consultation would be based on the comments of the 10% who had engaged.

Chapter 2

Proposal – The Establishment of a Centre of Excellence in Women's & Children's services at Hartlepool. (Includes Consultant Led Maternity, Paediatric services, Gynaecology and Breast Surgery)

59. A meeting of the Joint Scrutiny Committee took place on 19 October 2005. The purpose of the meeting was to consider the proposed establishment of a Centre of Excellence in Women's & Children's services at Hartlepool. This includes Consultant led Maternity, Paediatric services, Gynaecology and Breast Surgery.

60. The Joint Scrutiny Committee heard from around the table that it was largely accepted by both organisations, including the clinical bodies that changes to current service provision and organisation are needed. The only real issue for debate is that of location of the services concerned.

61. It was stated that under the original Tees Review proposals, the specialist, complex centre was going to be based at the UHNT. The difference with Professor Darzi's report is that he recommends the specialist centre should be at UHH. The rationale for Professor Darzi's recommendation on this topic was based on Patient Choice. If the Consultant led Maternity service was based at UHH, Stockton residents have a choice of accessing Consultant led services at UHH, JCUH, Darlington Memorial Hospital or Midwife led services at UHNT. Alternatively, if the situation were reversed, Hartlepool residents would only be able to access Consultant led services at JCUH or Sunderland City Hospital.

62. The Joint Scrutiny Committee heard that in recent years, there has been great difficulty in the recruitment of midwives and meeting the working time directive for junior doctors. As a result of these problems, the Joint Scrutiny Committee heard that both units have closed from time to time, which impacts on the quality of care offered, but also breeds confusion for staff and service users.

63. The Joint Scrutiny Committee enquired as to whether, with two units still open under the proposals, would you not just have the same problems? It was said that the same problem would not persist, as the two units proposed would be of a very different nature, as opposed to now where they are very similar. The unit at UHNT would be significantly smaller than UHH and would be aiming for around 500 births per annum. The UHH unit would be aiming for around 3000 per annum.

64. The Joint Scrutiny Committee enquired as to whether this would create a greater pressure on Maternity facilities at JCUH. The thinking behind this was that if mothers to be preferred the idea of giving birth in a Consultant led environment, for a significant proportion of Stockton

(Ingleby Barwick, Yarm and Thornaby) JCUH is significantly nearer than UHH. The Joint Scrutiny Committee learned that there was a difference in medical opinion as to how many extra births the proposals may mean for JCUH. The North Tees & Hartlepool Trust felt it might be around 1000 as a worst case scenario, whereas the South Tees Hospitals NHS Trust felt that 1000 was a reasonable forecast.

65. Nonetheless, what is accepted is that the proposals as they are mapped out for maternity services, would mean an increase in the amount of births at JCUH. As to whether the JCUH would be able to cope with this mooted increase would remain to be seen. From the South Tees perspective, JCUH would have a better chance in coping if the rise was planned for and not laid at the door as a result of a gradual drift of mothers-to-be.

66. It was added that on an anecdotal level, there was evidence of such a drift starting to occur now there was a perceived 'public uncertainty' about the future of UHNT's Maternity function.

67. Either way, The Joint Scrutiny Committee noted that Prof. Darzi does not appear to have taken into account where mothers-to-be from parts of North Tees would go and the assumption that all would attend UHH seems rather simplistic. The Royal College of Paediatrics and Child Health, as referenced at footnote 6 also makes this point.

68. It was noted, however, that the public (mis) conception was an important consideration, as there was a lot of mis-information out in the public domain about the future of the Maternity function at UHNT. The Joint Scrutiny Committee heard that under the Proposals there would definitely be a Maternity function at UHNT and this was an important point to remember.

69. The Joint Scrutiny Committee enquired as to whether there were parallels with the proposed Midwife led unit and what has happened with the Guisborough Maternity facility, where it has suffered from under usage by the community it stands to serve.

70. It was said that it was very difficult to predict such a situation and certainly the hope was that any midwife led unit at UHNT would be a vibrant aspect of the local health service. Indeed, the Joint Scrutiny Committee was advised that such midwife units as proposed were wholly consistent with the prevailing national policy.

71. The Joint Scrutiny Committee also heard that the existence of a Midwifery led unit, was by no means a guarantee of low birth figures per se. The example of Bishop Auckland was invoked where the Midwife led unit has, in it's first year, administered around 300 births, when 250 would have been considered a 'good year'.

72. It was added that a lot of women from the North Tees PCT area already have Midwife led births, so what was proposed was not a big as departure as may appear prima facie.

73. The Joint Scrutiny Committee discussed further the two sites currently in operation North of Tees. Members were advised that the overriding clinical wish would be for one site north of the Tees, offering a full range of services. As, however, Professor Darzi has seemingly removed that possibility from the equation; the proposed split of services over the two sites is the best option, with the levels of staff available.

74. The Joint Scrutiny Committee heard that the emphasis in the proposals was on giving Mothers to be a safe choice and despite fears regarding safety, The Joint Scrutiny Committee was advised that midwives would never be party to a service that was unsafe.

75. The Joint Scrutiny Committee heard further that if the Darzi proposals were not implemented, there would inevitably be an emergency failing of services and over time, both North Tees sites would 'wither on the vine', as the duplication of services would mean that both hospitals were unsustainable.

76. The Joint Scrutiny Committee enquired as to the amount of patient transfers which would need to be undertaken from UHNT to the Consultant led service at UHH, for medical reasons. It was estimated at between 10% and 15%, although the Joint Scrutiny Committee acknowledged that clinical skill would be key in assessing a woman throughout a pregnancy, spotting any potential problems and arranging the most appropriate venue.

77. In relation to the proposals affecting maternity and paediatric services, the Joint Committee authorised its Members from Stockton Borough Council, to conduct some more detailed investigative work on the topic within Stockton's own Health Scrutiny Committee (SHSC). The information gathered was then fed into the Joint Scrutiny Committee processes for consideration as evidence, when it came to taking a view on the proposals. The Joint Scrutiny Committee supports the findings in Stockton Borough Council's report which is attached (see appendix 1) and these should be considered in totality with the conclusions and recommendations contained in this joint report.

78. Prof. Darzi's proposals include the establishment of a women's centre of excellence similar to that which already exists at UHNT, at UHH, whilst at the same time proposing to reduce the consultant-led provision at UHNT. The Joint Scrutiny Committee agrees with SHSC that it is unsafe to assume that a centre of excellence can be developed simply by providing the accommodation required, it will require the appropriate specialists to be employed and teamwork to be established. The Joint Scrutiny Committee does not wish to see either Stockton or Hartlepool Residents to be disadvantaged and therefore believes that both sites should be centres of excellence.

79. As a reading of this report will demonstrate, the Joint Committee has received a quantity of evidence to suggest that, should the proposals be implemented as they currently stand, a significant amount of North Tees PCT residents would choose to access JCUH for consultant led maternity care as opposed to travelling to UHH.

80. This point was expanded upon by the Chair of the North Tees & Hartlepool NHS Trust PPI Forum, who said that of UHH's intended patient pool for consultant led maternity a substantially higher amount lived in the North Tees PCT region and accordingly, if they attended JCUH as predicted, there would be significant knock on effects for the long term viability of UHH's consultant led maternity function.

81. This concept has been supported by figures collected by the SHSC. They indicate that there are more than double the amount of women of child bearing age[4] in the North Tees PCT (39,025) area than in the Hartlepool PCT area (18,364)[5]. This would indicate, therefore, that if a significant amount of the North Tees PCT residents access JCUH, questions would be posed over the viability of a consultant led maternity service at UHH. The SHSC also puts forward the view that the amount of women from the Easington PCT area who use UHH is negated by the amount of women from the Sedgefield PCT area who use UHNT.

82. Whilst the local NHS recognises the Transport problems affecting the accessibility of some services, it is not in a position to divert NHS monies to pay for public transport. On this point, The Joint Scrutiny Committee understood that whilst the NHS was a key partner, it was not it's role to arrange public transport and this should not be expected of the local NHS, nor should it be expected to fund transport solutions out of NHS budgets. It is evident, therefore, that the lack of public transport is a vital point to consider.

83. On the subject of Paediatrics, the Joint Scrutiny Committee spoke at some length with witnesses. Under the proposals, the UHH would be the main centre north of the Tees for Paediatric care. The UHNT will have a time specific paediatric unit, opening from 9am until 9pm, although the proposals are unclear as to whether this means five or seven days of the week. This would have a consultant and junior doctor presence. The Joint Scrutiny Committee heard that one-hour before the unit closes, the Consultant would assess each patient and make a judgement as to whether they can go home or have to be transferred to Hartlepool for an inpatient stay. The unit at UHNT would be nurse led at night and Consultant staff would be on call at UHH.

84. The Joint Scrutiny Committee was told that at present, the split site working for paediatrics was proving to be very difficult, whilst it was also proving to be problematic in efforts to entice new staff to the area.

[4] For the purposes of this exercise child bearing age is from 15 years old to 44 years old.

[5] This is also supported in the birth rates for the two local authority areas which indicate that in a given year, 2115 live births occurred involving women from Stockton and 1065 with women from Hartlepool. www.statistics.gov.uk/downloads,theme_population/FM1_32/Table7.1.xls

It was felt that if the caseload were condensed into one unit, there would be a larger pool of cases to work with and, therefore, prove more tempting to those who may be recruited to the area.

85. Once again, the Joint Scrutiny Committee was told that the ideal solution to such problems would be the opening of a single site hospital north of the Tees. Professor Darzi, however, has dismissed that, and in taking 8-10 years to build, would not be a solution for the problems currently experienced.

86. At this stage, the Joint Scrutiny Committee heard from the Clinical Director of Paediatrics at the South Tees Trust that the Proposals were not in the interests of Paediatric care. The views expressed during the meeting were also supported and expanded upon in a written submission sent to the Joint Scrutiny Committee by the same person. The reason for this view is the fact that, for north of the river, the trauma centre will be at UHNT 24 hours a day, whilst the specialist paediatric base will be UHH. In essence, the proposals would create a situation where emergency surgery and trauma care will take place at UHNT without resident children's doctors. The Joint Scrutiny Committee heard, to its concern, that this is against Royal College of Surgeons Guidance[6] and a draft working paper from the Department of Health[7].

87. To clarify, the view expressed to the Joint Scrutiny Committee is that, it is against clinical governance principles and it is not safe to have a paediatric emergency surgery and trauma service, where there is no paediatric team. Further, that it is a serious risk to any paediatric patient deemed to need critical care for them to be in a hospital without a paediatrician[8]. Indeed, this view has been supported by a further written submission received by The Joint Scrutiny Committee from a practising consultant paediatrician employed at JCUH[9]. That submission states that there are "clinical governance issues" arising from having sick children receiving surgical services in a hospital without continuing paediatric services.

88. The Joint Scrutiny Committee appreciates that the science of medicine creates, if not demands, differences of opinion between its exponents. Nonetheless, to have two senior clinicians express such similar concerns over an aspect of the proposals is of great concern. This is especially so, given the fact that those expressing the concerns will not be working within the facilities affected and can therefore, afford a degree of dispassion when considering the topic. Further to this, the Joint Scrutiny Committee has not, as yet, heard any arguments that sufficiently dismiss the above concerns.

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[6] *Children's Surgery – a first class service*, Royal College of Surgeons 2000, reviewed in 2005.

[7] *The acutely or critically sick or injured child in the District General Hospital*, See www.dh.gov.uk Gateway reference 4758.

[8] Please see submitted correspondence to Joint Committee from Dr Fiona Hampton, Referenced in bibliography.

[9] Please see submitted correspondence from Dr Geoffrey Wyatt, Referenced in Bibliography.

89. Some time after the meeting was held; the Joint Scrutiny Committee received correspondence from the Royal College of Paediatrics and Child Health, outlining its views on the proposals in relation to paediatrics.[10]

90. The document makes the point that

"The College strongly recommends that there should be an on-site paediatric presence, both medical and nursing, where surgery is being undertaken on children. This has been recognised by the DH in its guidance of ISTCs. The Darzi proposals pose an unacceptable danger for children where surgery is concerned"

91. It was noted that the Children's National Service Framework states at Standard 7:

"Children and young people receive care that is integrated and co-ordinated around their particular needs and those of their family…"[11]

92. With consideration of the views expressed above about a lack of 'ready to go' paediatric input in a trauma setting at UHNT, the Joint Scrutiny Committee is unclear as to how this represents integrated care for children and has grave concerns over the safety of the service configuration proposed. At this stage of the investigation, those concerns have not being allayed.

93. The SHSC also gathered evidence which indicates that consultants feel the proposals are not in the best interests of patients and contradict clinical governance principles. The evidence received indicates that it is not safe to have paediatric emergency and trauma at UHNT when it is planned not to have a paediatric team overnight, as it will operate as a nurse-led facility.

94. The Joint Scrutiny Committee also heard evidence from the Clinical Director of Paediatrics at South Tees, on the topic of paediatric emergency medical care and the potential impact on JCUH. The letter referenced above also expands upon these views. It was said that the Proposals assumed that people in the catchment area of UHNT would be prepared to attend UHH. In child medical emergencies (e.g. suspected meningitis), The Joint Scrutiny Committee heard that it is far more likely that a significant amount of North Tees PCT residents from the areas of Yarm, Ingleby Barwick and Thornaby, would find it easier to travel straight to JCUH. It was said that this idea of patient drift is not just the view of the team at JCUH, but is supported by A&E attendance records. The Joint Scrutiny Committee heard that already, people from those areas access JCUH by choice. It was stated that this would only increase should the proposals be implemented.

[10] Please see submitted correspondence from Professor Craft at Royal College of Paediatrics and Child Health of 20th December 2005. Referenced in Bibliography.
[11] *National Framework for Children, Young People and Maternity Services*, Department for Education & Skills and Department of Health, October 2004.

95. The Joint Scrutiny Committee heard that this may represent a increase in patronage of JCUH in this field of around 33%, assuming that half of the North Tees PCT area population finds it easier to get to JCUH than UHH.

96. The Joint Scrutiny Committee heard that the impact on such a shift in patient flow dynamics could very difficult to sustain and may mean around another 1700 cases per year at JCUH, coming into a unit which is already stretched. The Joint Scrutiny Committee learned that patients would be handled on a 'first come' basis, which may mean that depending on patient flows, a significant number of patients from South of Tees (for whom JCUH is the DGH) would not be able to access such services and could be displaced across Teesside. In addition, it was proposed that if JCUH was heavily used by the UHH's natural patron base, would UHH become sustainable in the long term, especially when one considers the advent of payment by results.

97. The points outlined above are supported in a written submission referenced footnote 7. In that submission it is stated that should the increase in footfall to JCUH occur, there might be a change in the professional activities within the paediatric department of JCUH. The Joint Scrutiny Committee heard there might be a situation where there is a shift from a department trying to provide a full range of children's services to a department where the acute service is reacting to the increased workload from the children of Stockton. This would, therefore, have implications for recruitment, training and relationships with surgical staff and nursing staff.

98. The Joint Scrutiny Committee has noted that, should a significant amount of residents from the North of Tees areas, as outlined above, attend JCUH, it may have repercussions for the viability of the centre at UHH. This would be especially so given the advent of Patient Choice. In addition to this, a reduced case throughput at UHH would result in the questioning of the presence of a consultant body and the opportunities for consultants to maintain and develop skills. Further, given the advent of payment by results, it would leave the UHH unit open to financial uncertainty. The likelihood of an increased paediatric patient flow to JCUH from North Tees PCT area has also been raised in the evidence received by SHSC and fed back into the Joint Scrutiny Committee.

99. The Joint Scrutiny Committee has been told in written evidence that the best option would be to centralise paediatric services on the JCUH site. In effect, therefore, it is the views of witnesses that Prof. Darzi has not "gone far enough" in relation to paediatric services.

100. On this point, the Joint Scrutiny Committee realises that the call for a centralised paediatrics centre has come from employees of one acute trust and weights that evidence as such. In addition to this view, however, the Royal College of Paediatrics (referenced at footnote 9) has advised along similar lines that:

"In the future there will need to probably only be one inpatient unit and the logical place for this would probably be James Cook".

101. In relation to surgery, the same correspondent advises The Joint Scrutiny Committee that

102. "General paediatric surgery should be concentrated on one site for the Tees Valley. There is huge national concern at the loss of expertise in this area. Until recently adult general surgeons with a special interest have undertaken it. Most of these are to retire imminently and current surgical trainees do not wish to undertake this work. There are similar issues for anaesthesia for children. The Tees Valley has a big enough population to sustain a really excellent service for both paediatric surgery and anaesthesia but scarce manpower resources need to be concentrated and must have appropriate paediatric backup."

103. Further, the Joint Scrutiny Committee realises that it is its role of The Joint Scrutiny Committee to scrutinise the proposals, which are put in front of it. It does not wish to be seen to be disrespectful to the health service planners it has met, nor step outside it's remit by attempting to direct health service configuration across Teesside. Nor does it presume to possess more expertise than it does. Nonetheless, it feels it is appropriate to ask the question as to how feasible would a centralised paediatric unit be for Teesside, irrespective of location.

104. It was confirmed again to the Joint Scrutiny Committee within the meeting that the general ethos in the proposals had gained significant clinical support and it was widely accepted that doing nothing was not a feasible option, the matter causing a significant amount discussion was the location of the services concerned.

105. The Joint Scrutiny Committee stressed that it was integral that when considering the matter, it dealt with the facts of the cases in hand and not emotions or emotive messages.

106. At the same meeting, the Joint Scrutiny Committee studied the centralisation of Women's services at UHH. It was stated that within the field of breast surgery, the only substantive change for patients, would be that major breast surgery would now take place exclusively at UHH. Women's pre and postoperative appointments would continue to be held at UHNT, should that be the most appropriate place to visit.

107. The stated aim of the Proposals was to create a Centre for excellence, which afforded equality of care and access to care. The Joint Scrutiny Committee heard that a short time ago following a regular peer review into Breast Cancer, the clinical staff said there was nothing in the Darzi report that concerned them.

108. As far as this element of the proposals was concerned, the Joint Scrutiny Committee found nothing to take exception with a fully recognised the need to centralise surgical expertise north of the river. The Joint Scrutiny Committee thought it was particularly pleasing that, for Stockton residents, the only time they would need to use UHH

would be for surgery. The fact that check-ups, assessments and such like would take place at people's local hospital was a positive aspect.

Chapter 3

Proposals –
The concentration of elective orthopaedics in UHH
The establishment of a major trauma and emergency surgery facility at UHNT
The increased use of the Friarage for orthopaedics

109. At its meeting on 24 October 2005, the Joint Scrutiny Committee considered the elements of the Proposals around the concentration of elective orthopaedics at UHNT, the increased use of the Friarage for orthopaedics and the establishment of a major trauma and emergency surgery facility at UNHT.

110. As far as orthopaedics is concerned, the Joint Scrutiny Committee heard that the idea of centralising of elective orthopaedics was not a new idea and it had been raised as an issue in the Higgins Report. The Joint Scrutiny Committee learnt that when all orthopaedic services are provided on one site, it is often the case that elective procedures can be cancelled due to emergency surgical priorities and that this potential scenario can hang over elective work.

111. The Joint Scrutiny Committee heard that it would be far more beneficial for patients accessing the services and the services themselves to be separated into, in effect, 'hot' and 'cold' sites. This would, therefore, mean that first rate emergency orthopaedics could be provided north of the Tees (at UNHT), without disrupting the effectiveness of the elective orthopaedic workload (at UHH).

112. It was noted by the Joint Scrutiny Committee that a key driver behind securing an effective elective orthopaedic function was to satisfy central Government targets around waiting times and to meet the demands of the Patient Choice Agenda. For waiting lists in elective orthopaedics to be reduced, the unit needs to have 82% occupancy. Aside from Government targets, there is also an additional need for waiting lists to be reduced. Under the Patient Choice agenda, patients are not able to 'choose' a hospital that has a waiting list of six months or longer. There is, therefore, a financial motivation for the reduction of waiting lists, as otherwise, hospitals may lose out on income.

113. As far as the proposals impact on local people, the Joint Scrutiny Committee heard that all inpatient elective orthopaedic work would be handled at UHH, under the proposals. The vast majority of the cases would be hip and knee replacements and would necessitate a stay in hospital of around 4 days. Postoperative care, check ups and physiotherapy would take place at the hospital nearest to where the patient was from.

114. The Joint Scrutiny Committee enquired as to the level of resistance this element of the proposals has been met with. It was said that there had been little public resistance, especially when compared to other elements of the proposals. The Joint Scrutiny Committee heard that clinicians had aired concerns, although it was felt that those concerns

were more to do with changes to working practices and had not been able to put forward any objections based in clinical matters.

115. The Joint Scrutiny Committee enquired as to impact *Keeping the NHS Local* had had in this element of the proposals. Members were advised that whilst such guidance was very important in shaping services, at the current stage, it was of a higher importance that waiting lists were reduced. Elective care would be separated from emergency care to aid this. It was also noted that a future demand would be that, the NHS was moving toward a national target of an 18-week period from GP referral to surgery in such fields. This target comes on stream in 2008; therefore increasing the urgency needed to deal with such backlogs.

116. On this element of the proposals, The Joint Scrutiny Committee heard that Professor Darzi's recommendations made a lot of sense and put the local NHS in a better position to address backlogs and reduced the risk of elective care being cancelled or suspended to meet the needs of emergency work. On the basis of the evidence heard, The Joint Scrutiny Committee found very little to disagree with in this element of the proposals and felt that they represented a sensible and logical way forward in addressing very real problems being encountered by services in these fields. In addition, however, The Joint Scrutiny Committee also recognised that despite being ruled out by Professor Darzi following his study, the majority of the clinical community in this field felt that a single site, north of the River Tees would be a more suitable way forward.

Chapter 4

Proposal –
The Establishment of a Tees wide Upper Gastro Intestinal service at UHNT
The establishment of a Tees wide endo-luminal vascular service and the establishment of a vascular network with JCUH.

117. At its meeting on 8 November 2005, The Joint Scrutiny Committee considered the topics of the establishment of a Tees wide Upper Gastro Intestinal service at the UHNT and the establishment of a Tees wide endo-luminal vascular service and the establishment of a vascular network with JCUH. Prior to the meeting, the South Tees Trust had circulated a briefing paper, presenting its views on the above topic[12]. The discussion started with the upper GI element of the proposals.

118. The Joint Scrutiny Committee heard from the Chief of Surgery at JCUH, that the proposals would have a significant impact on both upper GI surgery and general surgical capacity at JCUH.

119. The Joint Scrutiny Committee heard that when considering making proposals to change or move services, one should start with the central premise that no one will be disadvantaged by the move. The Joint Scrutiny Committee was told that the witness struggled to believe that to be true in this respect.

120. In respect of Upper GI, The Joint Scrutiny Committee heard that a principal effect of the proposed move would be the loss of three surgeons out of a current compliment of eight. This loss would either come about through direct transfer of staff to UHNT or by surgeons moving to other centres where they can continue to pursue their subspecialty interest.

121. The Joint Scrutiny Committee heard that a loss of three surgeons out of a compliment of eight would result in a loss of capacity of 3/8, which equates to 37%. Further to that, in a briefing paper supplied by the Trust, it details how there is relatively speaking a small volume if upper GI work undertaken by the Trust. Accordingly, the two established surgeons undertake a substantial volume of 'general' surgical workload for the Trust of around 2170 cases per annum or 25% of the total general surgical activity of the Trust. The briefing paper asserts that for each oesphago-gastric resection undertaken, these two surgeons perform 33 general surgical procedures. The Joint Scrutiny Committee was concerned by such figures, especially given the well-documented difficulty in recruiting such professionals. Further to that, The Joint Scrutiny Committee was unclear as to how the move of Upper GI would create capacity at JCUH if the move of Upper GI resulted in the loss of surgical expertise. In essence, there is surely no benefit in having spare capacity if there are not enough surgeons to make use of that capacity. The point of a loss of capacity in general surgery is also

[12] Please see briefing paper circulated by South Tees Trust with Committee papers of 8 November 2005. Referenced in Bibliography.

identified by David Clarke[13], who calls the potential reduction in capacity of emergency surgery through the proposed changes to upper GI as "devastating".

122. Further on this point, The Joint Scrutiny Committee has heard from two written contributions that Upper GI surgery only takes up 5/6 beds in a Hospital of 1070 beds, so the question of how much capacity this frees up needs to be asked. Indeed, the written submission referenced at footnote 12 has advised The Joint Scrutiny Committee, that the capacity that would be created by the proposed move of upper GI could be created by the opening of a vacant ward on level 3 of the new building. The ward is currently closed due to the difficult financial position of the South Tees Trust.

123. In so far as the upper GI unit at JCUH is concerned, The Joint Scrutiny Committee has been advised by the witness referenced at footnote 12 that the results of the unit are comparable with the 'best' centres in the UK.

128. The Joint Scrutiny Committee has been advised that the decision to centralise upper GI services at JCUH, was made following the recommendations of 2 detailed reports. One of the reports was chaired by Mr. W. Allun, the then Chair of the U.K. Upper GI Surgeons Association. The University of York's Health Economics Dept conducted the other report. The Joint Scrutiny Committee noted the evidence, therefore, that on the basis of two rather brief visits to area, Prof Darzi went against two detailed pieces of work, without any clear or transparent rationale for doing so. In his written submission, the above witness makes the further point that, in his view, he cannot see any demonstrable benefit to patient care in moving upper GI services to UHNT.

129. In summary to the written submission, it is said "the only purpose that I can see to be served by transferring both services (upper GI and vascular) would be to somehow improve the status of UHNT, or give it more kudos. It would have no benefit to patients (surely the most important result of any recommendation)."

130. The Joint Scrutiny Committee was told further of clinical concerns from South Tees that the move to Upper GI would impact on patient safety, as the current level of medical infrastructure enjoyed at JCUH was not available at UHNT for upper GI patients suffering additional problems, such as renal or heart related. This point is explored further later in this paper.

131. The point was made to The Joint Scrutiny Committee that the South Tees Trust had very little idea what Professor Darzi was going to propose and therefore had very little opportunity if at all to influence the content of the report, before it was unveiled to the public on 8 July 2005.

[13] Please see correspondence received by Joint Committee from Mr. David Clarke of 9/11/05, recently retired consultant surgeon. Referenced in bibliography.

132. In respect of vascular services, The Joint Scrutiny Committee heard that the current system of operation, based at JCUH as a hub and spoke across Teesside, was reflective of best practice guidance issued by the Vascular Society of Great Britain & Ireland in 1998. Further to that, other services around the country are currently moving towards centralisation and in the view of the South Tees Trust, this remains the best practice model. Indeed, The Joint Scrutiny Committee heard that other centres are currently contacting JCUH to research its methodology in centralising the service, wanting to replicate the approach. The Joint Scrutiny Committee heard, therefore, that in the view of the witnesses, there are no sound medical reasons for disrupting the service.

133. The submission referenced at footnote 12 also covers vascular services. The Joint Scrutiny Committee is advised by the written submission that the service was centralised on JCUH in April 2002, following the recommendation of a report commissioned by the two Acute Trust Chief Executives, written by Professor Richard Wood of Sheffield. The written submission advised The Joint Scrutiny Committee that of the hospitals considered (JCUH, UHH and UHNT) only JCUH possessed the associated specialities deemed essential by the Vascular Surgical Society (large ITU, large diabetic care centre, limb fitting centre, acute haemodialysis and cardiothoracic surgery). In conclusion in relation to this service area, the submission reads "movement of the service to UHNT would have no significant impact on capacity at JCUH and would not benefit patients".

134. On this matter, The Joint Scrutiny Committee considers it appropriate to ask, what exactly has exchanged in best practice regarding these two specialist areas to go against independent reports stating they should be sited at JCUH.

135. As part of the debate regarding the moving of the specialist services as outlined above, The Joint Scrutiny Committee also heard the views of medical and managerial staff from the North Tees & Hartlepool Acute Trust.

136. The Joint Scrutiny Committee heard that there has been a historical paucity of services north of the Tees, with UHNT and UHH very much concentrating on sustaining their viability. It was said that it has been plain since the bringing together of the two hospitals under one Trust heading in 1999, that UHNT and UHH were not viable as stand alone entities in their own right.

137. On this point, it was pointed out to the Joint Scrutiny Committee that the preferred clinical option was a single site, although this had not been very popular with local people.

138. The point was made that Professor Darzi's role was to assess services across the Tees Valley and not just any one given district. It was the view of the witnesses that the proposals were in the best interests of the sustainability of health services across the Tees Valley. Further to

that, it was stated that a key element in Prof. Darzi's work would be to address a perceived drift of services from north of the river to the south of the river.

139. The Joint Scrutiny Committee considered the view from South of Tees representatives regarding loss of staff and uncertainty over some services. The Joint Scrutiny Committee heard from north of Tees acute representatives, that it was only what acute services north of the river had had to tolerate for a number of years. Whilst The Joint Scrutiny Committee understood the feeling behind such a view, it felt it slightly inappropriate that it was brought into the debate. The Joint Scrutiny Committee did not view the seeming willingness to 'redress the balance' as a legitimate rationale in the debate and would have preferred to hear more about the improvements to patient care that the proposed moves would bring.

140. The Joint Scrutiny Committee heard further from north of Tees acute services representatives that should the transfer of such services not go ahead, they were very concerned over the implications of the "continual downgrading" of services in the area.

141. The Joint Scrutiny Committee heard that the clinicians from north of the Tees would strongly contest the reduced patient safety argument which was put forward by South Tees clinicians in relation to the proposed move of upper GI services. At this point it was acknowledged that a difference of opinion existed between the two Trusts on the subject of patient safety, which could not be settled in an easily demonstrable fashion. On the subject of balance, between the two trusts, at this point South Tees made the point that if the proposals were to go ahead, there would be a situation whereby South Tees would have 5 surgeons and the North Tees & Hartlepool Trust would have 14.

142. The Joint Scrutiny Committee heard that the South Tees Trust was quite sure that the North Tees & Hartlepool Trust could provide a first class upper GI service over time, although made the point that there would be a substantial lead in time, whilst the service was being established. As a result of this, the South Tees Trust expressed concern over what would happen to patients and their care during that lead in period. The Joint Scrutiny Committee felt this was a legitimate question to ask of the local NHS and would ask the question at a later stage.

143. The debate around the pros and cons ensued and various points were put forward on behalf of both sides of the debate.

144. On the side of the upper GI services staying at JCUH, it was said that the surgeon involved would prefer to stay at JCUH, the service was established at JCUH, there was no guarantee the team would move to UHNT and that two independent, authoritative studies supported the notion of the service being housed at JCUH.

145. On the side of the service moving to UHNT, The Joint Scrutiny Committee heard that for long-term sustainability, the local health

economy needed to ask itself whether it was prepared to go through short-term disruption. Further to that, The Joint Scrutiny Committee heard that if no services were moved from the south of the patch to the north of the patch, it would be "disastrous" for the future viability of hospital services north of the Tees.

146. The point was made that UHNT would need significant levels of investment to take on such services as are mentioned in the proposals.

147. The Joint Scrutiny Committee heard it is in the entire Tees Valley health economy's interests that services north of the Tees are sustainable, although South Tees are concerned that in making that so, services south of the Tees would be disrupted.

148. At the meeting to discuss this matter, two senior clinicians from the North Tees & Hartlepool NHS Trust undertook to provide a written submission to The Joint Scrutiny Committee further outlining their views in relation to the proposed shift of services[14].

149. The briefing paper advises The Joint Scrutiny Committee that the southward specialist drift affect not only the specific service e.g. surgery but also the support specialities i.e. anaesthetics, critical care and radiology. It is a decline in these support services, which threatens the viability of the remaining surgical specialities.

150. The briefing paper argues that the reinstatement of upper GI and vascular services at UHNT would bring support to other work in the proposed Complex Surgical Centre.

151. The Joint Scrutiny Committee notes and accepts a point made by the briefing paper that such service's success at JCUH does not preclude them from being equally successful at UHNT. The briefing paper says that this would be especially so if the Trust relocated the successful teams.

152. The Joint Scrutiny Committee is advised by the briefing paper that whilst South Tees have drawn attention to the loss of three GI surgeons and the impact on the rota, it is rather disappointing that "little or no consideration has been given to using all the resources of the Trust, whilst taking a pessimistic view of future recruitment".

153. The Joint Scrutiny Committee is advised by the briefing paper that the original business case for establishing upper GI surgery at JCUH indicated that it should not be used to support the general surgical rota.

154. In conclusion to the briefing paper, The Joint Scrutiny Committee is advised

"Other comments from South Tees note the impact of transferring services on other specialities in the hospital. *This is the impact that the*

[14] Briefing paper from Mr. L Rosenberg – Consultant Surgeon and Dr P. Gill Medical Director. Referenced in Bibliography.

chronic drift of specialist services from north to south of the Tees has had on the North Tees and Hartlepool Trust for years (briefing paper's italics). It is Darzi's explicit intention to partially reverse that trend and to establish and stabilise a better balance between the hospitals across Teesside"

155. On this point, as written above, The Joint Scrutiny Committee is slightly unclear as to how the oft-repeated aim of making hospitals more sustainable north of the Tees, fits together with benefits to patients in the guise of improved services. Whilst acknowledging that patient flows and financial arrangements are important, The Joint Scrutiny Committee has noted a distinct lack of information as to the patient benefits that will be realised by the proposed moves. That lack of information, despite opportunities to put it forward, then poses the question of whether any tangible benefits to patients exist.

156. At the meeting on 8 November 2005, The Joint Scrutiny Committee also took evidence from the Oesophageal Support Group, established to support upper GI surgery patients and their carers.

157. The Joint Scrutiny Committee heard that the support group was founded in 1996, as it was felt that patients often felt isolated following their care. It was confirmed to The Joint Scrutiny Committee that the support group is open to any patient of the service and/or their carer(s) and the group has around 100 active members.

158. In so far as the activity of the support group, The Joint Scrutiny Committee heard that it provides support and information to patients and carers, advises clinicians when invited to and occasionally assists in the interviewing of potential clinical appointments. It was confirmed that the support group is made up of people from all parts of the geographical area served by upper GI services at JCUH.

159. In respect of consultation, it was confirmed to The Joint Scrutiny Committee that Prof. Darzi never contacted the oesophageal support group for their views, before proposing the moving of the service to UHNT. The Joint Scrutiny Committee was also advised by the support group that, in its view, the level of consultation with appropriate clinicians by Prof. Darzi left a great deal to be desired.

160. The Joint Scrutiny Committee heard that the support group severely doubted whether the same quality of service could be offered at UHNT. This was due to two factors. Firstly, the support group emphasised the importance of support services at JCUH such as Renal and Cardiothoracic, which would not be available with the same prevalence, if at all, at UHNT. Secondly, the support group spoke at some length and in glowing terms about the strength of the upper GI multidisciplinary team based at JCUH.

161. The Joint Scrutiny Committee heard that there is no guarantee all team members would move to UHNT and could not be compelled to do so. Accordingly, the fear of the support group was that if some team

expertise was 'lost in the move', the service would, by definition, be weaker at UHNT.

162. The Joint Scrutiny Committee was advised by the support group that, in their view, there was no clear rationale as to why upper GI had been "picked on" by the Review and the support group put forward its view that it may be a high profile service to replace what UHNT was "losing" to UHH.

163. To emphasise this point, the support group queried to what extent the proposals were about soothing political concerns over the future of certain hospitals, as opposed to securing improvements in patient services and patient outcomes.

164. As a final point, the support group advised The Joint Scrutiny Committee that, this was the first occasion they had been contacted to officially its views in relation to the proposals. The Support group emphasised again, that Professor Darzi had not contacted them at any time, or by the local NHS to feed into the consultation process. The Joint Scrutiny Committee felt that as a recognised patient support group, this fact was unfortunate and raised questions over the wider consultation process.

165. Following the meeting, a representative of the support group wrote to The Joint Scrutiny Committee reaffirming the views put forward and offering additional views. That correspondence is part of The Joint Scrutiny Committee's bibliography.[15]

[15] Correspondence from Mrs. E. Drabble of 11/11/05 and 17/12/05, received by Joint Committee and referenced in bibliography.

Chapter 5

Views of Stakeholders

Patient & Public Involvement Forums

166. At a meeting on 8 November 2005, The Joint Scrutiny Committee took evidence from the Chairs of the Patient & Public Involvement Forums (PPIFs) attached to the South Tees Hospitals NHS Trust and the North Tees & Hartlepool NHS Trust.

167. The Joint Scrutiny Committee enquired as to the level of involvement the PPIFs have had with the Acute Services proposals, either when the proposals were being drafted or since the consultation period has commenced.

168. The Joint Scrutiny Committee heard that both Forums have had no involvement in either the drafting of the proposals or consultation on the proposals. Individual members of the PPIFs have attended public consultation meetings and contributed their views and comments as members of the public, although the PPIFs, as entities created by statute had not been formally consulted at either the proposals drafting stage or the proposal consultation stage. The Joint Scrutiny Committee considered this to be a rather concerning testimony. It was acknowledged that PPIF members would and did attend public meetings to express views or comments and this is to commended, although The Joint Scrutiny Committee is of the view that PPIF members should not *have* to attend public consultation meetings to get their views across. PPIFs should be on the list of key stakeholders who are consulted as a matter of course, as entities in their own right. The fact that this was seemingly not the case concerned The Joint Scrutiny Committee. Indeed, it was also said that the only formal invite the PPIFs had had to date to proffer a view as entities in their own right, was the one afforded to them by the Joint Scrutiny Committee.

169. Nonetheless, as a whole, the PPIFs were of the view that their under involvement aside, the public consultation process seemed to be fairly comprehensive. Having made that point, the PPIF's were more critical of Professor Darzi, stating that they felt he had researched and drafted his report in a "PPI vacuum".

170. The Joint Scrutiny Committee was informed that the South Tees PPIF had taken it upon themselves to compile a report outlining their views on the proposals and the level of its involvement, which it is submitting to the consultation. The Joint Scrutiny Committee has since being supplied with a copy of the report[16], which has informed the content of this section.

[16] *Acute Services Review – Hartlepool and Teesside Consultation*. South Tees Patient and Public Involvement forum's response to the consultation exercise. Can be obtained from Supporting Organisation, Age Concern Teesside.

171. As regards the views of the South Tees PPIF on the actual proposals, it was pleased to see the increased emphasis on using the Friarage in service provision. The Joint Scrutiny Committee heard that as far as the South Tees PPIF was concerned, the biggest area of concern was the proposed move of Upper GI services to be based at the UHNT. It was stated that the unit at JCUH had been built up over recent years through a lot of hard work from Trust staff and considerable financial investment.

172. The PPIF informed The Joint Scrutiny Committee that Upper GI services had been centralised at JCUH as a result of clinical rationale, which was supported by an external expert report. The reason for this is that Upper GI surgery, by its nature, often calls upon other support services such as renal medicine and Cardiothoracic, which are also located at JCUH. The Joint Scrutiny Committee heard from the PPIF that as those services would not be available at UHNT, it was clearly not in the interests of patients to perform upper GI surgery on one site, and then face the journey with a fragile patient to JCUH to access important support services which are needed as a matter of urgency. In turn, it led to the PPIF asking what exactly is "the point" of the proposed move? On this matter, The Joint Scrutiny Committee felt there was a great deal of logic in the PPIF's observation and resolved to pursue the issue of support services at a later date.

173. Further to the above concerns, the PPIF indicated that in their view, the move of Upper GI to UHNT would not free up much capacity at JCUH, as the amount beds used at JCUH by Upper GI (around 4-6) versus the overall bed capacity at JCUH (around 1080) was negligible. The PPIF also expressed concern over the length of time the move would take and asked the question of what would happen to patients who needed the service during the lead in period. Again, on this point The Joint Scrutiny Committee resolved to ask this question of the NHS Joint Committee in a later meeting.

174. The Joint Scrutiny Committee heard from the PPIF that the move of upper GI services would also reduce the number of surgeons at JCUH and would, therefore, reduce the general surgical capacity of the South Tees Trust, as well as in upper GI. In a further written submission sent by the PPIF, The Joint Scrutiny Committee was advised that the departure of three surgeons would result in the surgical rota increasing from 1:8 to 1:5. In summary on the upper GI topic, the PPIF informed The Joint Scrutiny Committee that it does not feel the increased capacity of around six beds should upper GI move is worth having. Especially so if it means the departure of three established surgeons.

175. The PPIF expressed concern over other aspects of the proposals, which were in relation to maternity services north of the Tees. The Joint Scrutiny Committee was told that under the proposals, consultant led maternity for north of the Tees would be provided at UHH. The Joint Scrutiny Committee heard that a likely impact of this, would be that mothers to be from the Ingleby Barwick, Yarm and Thornaby areas of North Tees were more likely to access JCUH for consultant led maternity care. If this were so, it would create an additional burden on

Maternity services at JCUH into hundreds of extra births. At this stage, it was not clear as to how this additional footfall, if it came, would be accommodated.

176. The same sorts of fears were articulated in relation to paediatric services. Again, under the proposals, 24-hour paediatrics would be housed at UHH. The fear of the PPIF was articulated to The Joint Scrutiny Committee that parents from the same parts of North Tees as above, may look to JCUH as the first port of call and therefore most sensible location of services. Again, the fear of the PPIF was that JCUH would not have the capacity to absorb additional patient flow and was concerned about the ramifications this would bring for south of Tees residents, who access JCUH as their natural District General Hospital (DGH).

177. The South Tees PPIF felt that if one was to combining the additional footfall outlined above with the already challenging transport and parking arrangements at JCUH, there was considerable scope for significant problems to ensue.

178. The Joint Scrutiny Committee also heard the views of the North Tees & Hartlepool PPIF in relation to the Acute Services Proposals. The Joint Scrutiny Committee heard that the PPIF's concerns also centred on maternity provision. The Joint Scrutiny Committee was told that there was a fear that if a lot of North Tees residents opted to use JCUH for Maternity provision, the consultant led maternity service at UHH would 'wither on the vine', due to under usage.

179. This point was especially pertinent when The Joint Scrutiny Committee heard that, across north of Tees, a higher proportion of births take place with women living in the Yarm, Thornaby and Ingleby Barwick area. As a result, this would increase the impact of a lack of footfall to UHH for consultant led maternity services.

180. The PPIF also highlighted their view that, as it was decided the Trust should continue to operate on two sites, the transport infrastructure linking the two sites and the infrastructure linking the two sites with their primary patient base, was not of a sufficient quality and required a large amount of developmental work.

Evidence from Local Medical Committees

181. There now follows evidence gathered by The Joint Scrutiny Committee from Cleveland Local Medical Committee and North Yorkshire Local Medical Committee. The Joint Scrutiny Committee has also received an emailed response to a number of preliminary questions from the Durham Local Medical Committee. This is referenced in the Bibliography.

182. At the meeting, The Joint Scrutiny Committee also heard the views of the Northallerton Sub Committee of the North Yorkshire Local Medical Committee (NYLMC).

183. The Joint Scrutiny Committee was told that Prof. Darzi did not consult the NYLMC during his study, nor had the NYLMC being approached/consulted by the local NHS on the proposals as published, which The Joint Scrutiny Committee found rather concerning. Under national developments such as *Commissioning a Patient Led NHS*,[17] General Practice is to be a central building block of the 'new' NHS. Consequently, The Joint Scrutiny Committee found it ironic that Prof. Darzi had not sough the views of such a recognised body as the NYLMC, nor had the local NHS approached the NYLMC proactively for their views on such an important set of proposals.

184. The Joint Scrutiny Committee heard that the NYLMC was pleased with Prof. Darzi's recommendations regarding the Friarage, as the proposals seemed to give the Friarage a higher status than it has previously had.

185. As regards the proposed move of services to UHNT, it was said that medical links between primary care in North Yorkshire and secondary care north of the Tees did not really exist and consequently would need to be developed quite swiftly to avoid any problems in service delivery.

186. The Joint Scrutiny Committee also heard that the NYLMC is concerned over patient safety for those accessing upper GI services should the services move to UHNT. The Joint Scrutiny Committee heard that the proposed move of upper GI services would result in less support services being available on the same site for patients, which could not be beneficial for patient care. The NYLMC told The Joint Scrutiny Committee that it felt the proposal affecting upper GI was "change for change's sake".

187. The Joint Scrutiny Committee heard that in the view of NYLMC, if there was a rationale for the moving of upper GI, it was financial as opposed to a clinically led decision.

188. It was added further that in the view of the NYLMC, the consultation document had not really been seen in the Northallerton area, and on the basis of the witness' experience, patients were not very conversant with the Acute Services Proposals in that area.

189. The Joint Scrutiny Committee met on 12 December 2005 to take further evidence in relation to the Acute Services Review and the proposals put forward. The first contributor to the meeting was the Secretary of the Cleveland Local Medical Committee (CLMC). In advance of the meeting, The Joint Scrutiny Committee supplied the CLMC with a list of initial questions, the purpose of which was to indicate to the CLMC the particular areas which The Joint Scrutiny Committee would be interested in pursuing. As a result of that briefing, The Joint Scrutiny Committee was supplied with a written submission from the CLMC[18], which outlined its initial views.

[17] *Commissioning a Patient Led NHS*, Department of Health, 28 July 2005. Please see www.dh.gov.uk, Gateway Reference number: 5312

[18] A copy of the CLMC briefing can be obtained by contacting the Joint Committee Support Staff.

190. The Joint Scrutiny Committee heard that the CLMC has been consulted over many years in relation to the provision of secondary care services. It added further that the CLMC has been able to add its views on the proposals by attending a formal consultation meeting, which was open to all general medical practitioners and members of the public on 18 October, together with informal briefings by PCT Chief Executives at regular liaison meetings. In addition to this, it has been confirmed to The Joint Scrutiny Committee subsequently in writing that the CLMC, was not consulted by the local NHS in relation to the proposals. The Joint Scrutiny Committee, therefore, finds it rather troublesome that both NYLMC and CLMC[19] have not been approached directly for their views, as bodies created under statute to represent the views of GPs within any given locality. It is noted that individual practitioners had an opportunity to attend public meetings, although The Joint Scrutiny Committee feels that such organisations should have to resort to such an approach to get their view across.

191. The Joint Scrutiny Committee heard it was the view of the CLMC, that current healthcare arrangements in Teesside were not sustainable in the long term and doing nothing was not really an option, especially when one considered the resources (or lack of) available. The Joint Scrutiny Committee heard that this is especially so when one considers increased sub-specialisation of medical and surgical specialities, changes in acceptable working patterns for both senior and junior doctors and the need to balance service delivery with professional training and development. Further to that, The Joint Scrutiny Committee heard that in general terms the proposals outlined would deliver improvements in patient care, but only when introduced actually provide for a real shift in resources from secondary to primary care.

192. The CLMC also had a series of observations on specific elements of the proposals, which now follow. It was noted that with the proposed changes to consultant led maternity provision north of the Tees, it was likely that an increased number of mothers-to-be would prefer to access JCUH for their care, as opposed to travelling to UHH for Consultant led care. The Joint Scrutiny Committee heard that this would be especially so for women from the Ingleby Barwick, Yarm and Thornaby areas. As to whether JCUH would be able to cope with the increased patronage was rather unclear and to some extent, depended on the timing and frequency of such increased patronage. What was established, however, was that it was uncertain as to whether JCUH would be able to cope.

193. The Joint Scrutiny Committee heard that this potential state of affairs might have repercussions for the Consultant led unit at UHH. If the unit at UHH does not deliver its 'fair share' of babies as result of potential service users accessing JCUH, it may become unsustainable. Further to that, if a certain critical mass of births is not reached at UHH, it could have implications for the status of the unit, in terms of retaining

[19] See email from CLMC, referred to in Bibliography

clinicians and retaining clinical skills, should a low patient flow mean they are not able to practice them sufficiently.

194. On an anecdotal level, The Joint Scrutiny Committee heard that if this was the case, the CLMC had been told by a GP based in Hartlepool that they would be perfectly willing to recommend consultant led services at JCUH to pregnant women, as opposed to services at UHH. Whilst The Joint Scrutiny Committee fully accepts that this is anecdotal, if this feeling is replicated amongst other GPs, it does not bode well for the future vitality of the UHH unit, as put forward by the proposals.

195. The CLMC also expressed a concern in relation to Ambulance services. The Joint Scrutiny Committee heard that a reduction in the availability of paediatric inpatient care at UHNT has been raised as a concern. This is due to the increase in travelling time for patients north of the Tees in attending UHH. The CLMC told The Joint Scrutiny Committee that there is concern that this may mean there is less availability in ambulances to respond to emergency and urgent GP cases. The Joint Scrutiny Committee noted that the concept of increased journey times and, therefore, reduced capacity had also been raised by both Ambulance Trusts in evidence to The Joint Scrutiny Committee.

196. The Joint Scrutiny Committee was told of a concern that the CLMC had in relation to pregnant women accessing Accident & Emergency. That concern was the absence of an obstetric registrar in the A&E Department of UHNT, despite the confidential enquiry into maternal deaths recommendation that all pregnant women who attend A&E should be seen by a doctor of at least that level. This was a theme that The Joint Scrutiny Committee undertook to ask further questions of the NHS at a later date.

197. Finally, the CLMC advised The Joint Scrutiny Committee that it expected emergency attendances from north of the Tees to increase at JCUH, as a result of the proposed changes.

198. Following the conclusion of the evidence gathering process, the Joint Scrutiny Committee secretariat also received an emailed response from the Durham Local Medical Committee (DLMC). That response confirmed that, in the view of the DLMC, the proposals would deliver real improvements in patient care and are therefore in the interests of the health of local people. The rationale for this is that the proposals will concentrate specialisms under one roof and, therefore, increase expertise. The DLMC also confirm that it attended two public meetings during the consultation period and that its views were sought when the issue was considered, before the proposals were drafted.

Chapter 6

Evidence in Relation to Transport

199. On 28 November 2005, The Joint Scrutiny Committee met to take evidence on the topic of transport, which included the sub topics of patient and public transport. Consequently, The Joint Scrutiny Committee took evidence from the Transport & Health Partnership Group and the two Ambulance Trusts, which serve the affected area, Tees East & North Yorkshire Ambulance Service (TENYAS) and the North East Ambulance Service (NEAS).

200. The Joint Scrutiny Committee heard that the Transport & Partnership Group has been in existence since the Tees Services Review, which started in summer 2003. The Group includes health, local authority, bus company and customer representation. The Joint Scrutiny Committee heard that the Group is investigating "the travel implications of the proposed recommendations in the Acute Services Review – Hartlepool and Teesside, to assess the potential changes to patient flows against current and future transport provision."[20]

201. It was stated that it was actually an opportune time to be considering transport issues in relation to healthcare, as local authorities' Local Transport Plans (LTPs) were currently being revised ahead of March 2006. In addition to this, The Joint Scrutiny Committee heard that as a recent development, one of the standards that LTPs are assessed against is how effective they are in delivering access to healthcare. It was felt that this might concentrate minds further in making the links between public transport and health services. In connection with this, The Joint Scrutiny Committee heard that the extent to which public bodies were working together on this matter was better than it had been for a long time. It was told there was confidence that the issues could be addressed through a compliment of approaches, as more was known about the problems and how they could be addressed.

202. On the subject of bus providers, The Joint Scrutiny Committee heard that ultimately, they are commercial companies who are in existence to make a profit. It therefore followed that routes that did not yield profits would always be susceptible to being removed from the schedule. The Joint Scrutiny Committee was advised that where this could be influenced by the local NHS was, in understanding patient flows to the extent that they could be planned to make such journeys profitable and, therefore, significantly more sustainable.

203. In so far as Ambulance services, The Joint Scrutiny Committee heard that they had been heavily involved in the drafting of the proposals and had been afforded ample opportunity to put forward views as part of the consultation. The Joint Scrutiny Committee heard that there were no major problems for Teesside anticipated as a result of the proposals. It

[20] See *Transport to Health – Final Version*. See Page 1. Can be obtained by contacting Joint Committee Secretariat.

was said that if there were a concern, it would be around increased journey times for patients accessing particular services. This would, therefore, mean that any given ambulance would be out of circulation for longer dealing with the same patient. It was said to The Joint Scrutiny Committee that these increased journeys may affect around 1,900 people from the NEAS area and around 1,500 people from the TENYAS area.

204. Queries were made by The Joint Scrutiny Committee in relation to the affect that possible Ambulance service re-organisation would have on the quality of services provided. The Joint Scrutiny Committee heard that since April 2005, PCTs have had the responsibility over patient transferrals, so in effect, the quality of services should not be adversely affected by organisational changes as the PCTs would guard against such an outcome.

205. On the question of public transport provision, The Joint Scrutiny Committee agreed that it would probably never be as good as people would like it to be. Having said that, it was also inextricably linked to a key public policy question as to how much exactly is society willing for the state to pay towards public transport, as hypothetically, there is almost no limit.

206. The Joint Scrutiny Committee heard that in considering areas with poor public transport coverage, there are two separate and distinct cohorts, one with high car ownership and low car ownership. The Joint Scrutiny Committee proffered the view that it may be more appropriate to attempt to address the areas of need as opposed to geographical areas per se. The reason for this view being that, in more affluent areas where car ownership is high, public transport may not be patronised, even if provided. Consequently, The Joint Scrutiny Committee was quite firm in the view that work to develop better transport links should centre on areas of need, as opposed to geographical areas per se.

207. The Joint Scrutiny Committee enquired as to whether there were any notable gaps in current service provision around current hospital locations. Ironically, The Joint Scrutiny Committee heard that one such gap was for transport services between UHH and UHNT. It was added that this was a concern, given that there will be an increasing amount of interdependency between the two sites. The Joint Scrutiny Committee learned that work was underway to address that, but expressed a hope that such work would be expedited, given the relationship between the two hospitals, which would only increase if the Darzi proposals were implemented.

208. On a more positive note, The Joint Scrutiny Committee heard that the Darzi proposals were positive for transport in the area, as they had forced local agencies to confront the issue. Further to that, as national policy continues to place an increasing emphasis on treatment in primary care, this will also lessen the strain on hospitals and, therefore, the public transport systems serving them.

209. In response to a query, The Joint Scrutiny Committee heard that the impact of the Proposals on public transport would roughly be neutral. Increased movement out of one community to access a specialism would be off set by another cohort visiting their local hospital, when they would previously had to travel.

210. On the subject of transport, The Joint Scrutiny Committee felt that they got very few answers on the matter from the meeting. The Joint Scrutiny Committee is quick to point out, however, that this is not a criticism of those involved, although it is an unfortunate turn of events. The Joint Scrutiny Committee understands the rationale of planning services first in the interests of patients, and then developing a transport infrastructure to support the service reconfiguration. Further to that, The Joint Scrutiny Committee understands that as Prof. Darzi only revealed his proposals on 8 July 2005, there cannot possibly be answers to the transport considerations raised by the proposals. Nonetheless, The Joint Scrutiny Committee was interested to investigate how the transport system would support the Darzi proposals. Despite a significant amount of work being done by the Transport Group, The Joint Scrutiny Committee concluded that at this stage, there is not sufficient evidence to state that the transport system is fit for purpose in relation to supporting the proposed service changes.

Chapter 7

Evidence in Relation to National Policy

211. At the meeting of 12 December 2005, The Joint Scrutiny Committee also took evidence from a Health Economist from the University of Teesside.

212. The Joint Scrutiny Committee heard that there is quite a sound argument for service rationalisation north of the Tees as it was not cost effective (nor possible at times) to provide services in duplicate for the community the Trust serves.

213. The Joint Scrutiny Committee also heard that there is something of a trade off when trying to satisfy national policy requirements, as at times they can appear to be contradictory. As The Joint Scrutiny Committee is aware, a key element of government policy is the idea of *Keeping the NHS Local*, i.e. delivering more and more services in the community, nearer to where people live. On the other hand, another key element of national policy is also one of cost effectiveness and striving for more efficient services. The Joint Scrutiny Committee's attention was drawn to the fact that in considering these two topics and attempting to satisfy both, an inevitable degree of trade off was required. As an example, whilst it would be wholly consistent with Keeping the NHS Local to have most DGH services in every town, for obvious reasons, it would not be cost effective to do so.

214. The Joint Scrutiny Committee was told that, in the view of the Health Economist, there was not sufficient evidence in either the Consultation document or Professor Darzi's final report that a full and detailed local health needs assessment had been conducted before the recommendations were put forward. The Joint Scrutiny Committee was, therefore, told that there is no evidence (at least in the public domain) which indicates that Professor Darzi's recommendations were prepared with the health of the specific localities in mind.

215. Further to that point, the Health Economist told The Joint Scrutiny Committee that there was no rationale in the report as to why particular specialist services at JCUH had been selected to move to different sites. The Joint Scrutiny Committee was told that without such rationale being explicitly articulated, it was impossible to tell as to whether the proposed service moves were for clinical, financial or political reasons or indeed a combination.

216. The Joint Scrutiny Committee heard that the emergence of *Choose & Book* within the NHS would be a major milestone and bring its own challenges for the local health economy. It was said that, *Choose & Book* essentially creates an internal market within the NHS, with acute trusts having to compete to perform work. A question that was posed to The Joint Scrutiny Committee was that, with the advent of Choose & Book, would most people choose to access JCUH as their preferred site, due to its reputation as a regional centre with a large number of

highly specialised services. It was said that JCUH would not feel able to 'turn work down', as under *payment by results*, to do so would have a detrimental impact on JCUH's income. In turn, if this happened, surely this raises the question of the viability of the two hospitals north of the Tees. As a logical extension of this argument, the health economist advised The Joint Scrutiny Committee that to avoid JCUH becoming a monopoly provider across the Tees Valley, a single site hospital was required north of the Tees to counteract the 'pull' of JCUH, by providing its own full range of services.

217. For this reason, The Joint Scrutiny Committee heard that Professor Darzi had, in the view of the health economist, been wrong to rule out the prospect of a new build, single site north of the Tees. Professor Darzi had ruled it out due to the time constraints of developing a new single site, although The Joint Scrutiny Committee heard that a number of the proposals would take a significant amount of time to implement anyway. In effect, The Joint Scrutiny Committee heard that Professor Darzi had conducted his review, without paying due attention to the upcoming roll out of Choose & Book agenda.

218. In conclusion The Joint Scrutiny Committee heard that the Health Economist challenged Prof. Darzi's methodology, the transparency of his review and the content of his recommendations in the light of recent government policy, as illustrated above in relation to Choose & Book. Ultimately, and considering the Choose & Book Agenda, The Joint Scrutiny Committee heard that Professor Darzi proposals were short-sighted and at best, medium term.

Chapter 8

Evidence in Relation to the Impact of the Proposals on Staff

219. At The Joint Scrutiny Committee meeting on 12 December 2005, The Joint Scrutiny Committee also spoke to staff representatives to obtain their views on the proposals and in an attempt to gather information on the proposals' impact on staff.

220. The Joint Scrutiny Committee heard that the two acute Trusts had established staff project groups, who were actively involved in considering the proposals' impacts to the working practices of the Trust, in partnership with the Trust.

221. It was confirmed to The Joint Scrutiny Committee that Prof. Darzi had not contacted Trade Unions and staff representative groups for their views at any time during his investigation and the production of his report. The Joint Scrutiny Committee heard that such groups would have liked to have being contacted, although they were not.

222. On the subject of the proposals, The Joint Scrutiny Committee heard that Trade Unions and staff groups present felt that Professor Darzi's recommendations did not adequately address the issues, which had precipitated the review. Nor did they feel, that the proposals took into account the area and people's likely behaviour when wanting to access healthcare.

223. The Joint Scrutiny Committee was interested to hear as to whether the proposals were deliverable in terms of staffing. The Joint Scrutiny Committee was told that they were deliverable, although it would not be easy to meet the staffing requirements of the proposals.

224. On the point of staffing, representatives from the South Tees Trust pointed out to The Joint Scrutiny Committee that the proposals would pose staffing concerns for the Trust. As previously stated, the South Tees Trust advised The Joint Scrutiny Committee that the proposals would mean that the Trust would lose the services of three surgeons, as a result of the upper GI proposals. The Joint Scrutiny Committee was told that when that was viewed against the backdrop on 200 national surgical vacancies going unfilled, it gave the South Tees Trust cause for concern.

225. In addition to the above, The Joint Scrutiny Committee heard that in the near future, staffing challenges would be exacerbated by the fact that in certain professions, a significant amount of the current cohort are nearing retirement age, which would increase pressure on services. The Joint Scrutiny Committee heard that midwifery was a particularly pertinent area of service where this scenario could be observed.

Chapter 9

Additional Evidence Gathering

226. As a result of the meetings and evidence gathering process The Joint Scrutiny Committee went through in considering the Acute Services Proposals, an additional meeting was diaried for 19 December 2005. The purpose of this meeting was to ask additional questions, on areas where The Joint Scrutiny Committee felt it needed further information/clarification.

227. A set of questions was prepared by The Joint Scrutiny Committee in advance of the meeting and sent to the local NHS representatives who would be attending the meeting. This was to allow the local NHS a reasonable notice period of the questions that would be asked and the areas The Joint Scrutiny Committee was interested in pursuing. A list of those questions can be found in the supporting papers to the meeting. At the meeting the questions were dealt with in the order they were prepared.

228. The Joint Scrutiny Committee heard that at JCUH, there are four inpatient beds that are dedicated to upper GI surgery, which are in constant use. There was also the possibility of one or two critical care beds being used from time to time by upper GI patients. In terms of surgical theatre capacity, The Joint Scrutiny Committee was advised that it equated to around three full day and 2 half-day slots.

229. Further to the above, The Joint Scrutiny Committee heard that there were doubts over the information used by Professor Darzi when considering JCUH as over capacity. The Joint Scrutiny Committee was advised that the information used was actually two years old and things had moved on substantially from then with services at JCUH.

230. The Joint Scrutiny Committee heard further that should upper GI work leave JCUH, the Trust would find it difficult to find the extra work to backfill the spare capacity created by the proposed move.

231. It was suggested that it was not as simple as simply moving a service, as a key element of the service was the work of the team involved in delivering the service. Concerns were raised as to whether all members of the team would be prepared to move and therefore would the moved service be as effective. The point was made by Members of The Joint Scrutiny Committee that it appeared insufficient thought had been given by Professor Darzi to the “unintended consequences” of the proposed move of upper GI services. Attention was drawn to two of those unintended consequences being the disruption of a team widely accepted as first class and a significant impact on the ability to deliver sufficient general surgical capacity at JCUH, primarily due to the loss of three surgeons.

232. The Joint Scrutiny Committee heard at this point that the North Tees & Hartlepool NHS Trust would be happy to assist the JCUH in attempting to address the surgical workload, by offering surgeon's time.

233. The Joint Scrutiny Committee heard that whilst the JCUH would be grateful for such an offer, it did not view it as a long term, sustainable solution to surgical deficits created at JCUH by the proposals. Further to that, The Joint Scrutiny Committee has heard evidence that split site working for surgeons is not viewed as the best way to organise a surgeon's working time due to inherent inefficiencies of this approach, i.e. travelling time between sites. Further to that, The Joint Scrutiny Committee heard that in the view of the South Tees Trust, it was reasonable to expect a hospital on the scale of JCUH to have sufficient surgeons 'of its own' to meet surgical demands.

234. The Joint Scrutiny Committee enquired as to the state of readiness that UHNT would be to accommodate upper GI services, as proposed by Prof. Darzi. It was agreed that presently, UHNT could not accommodate the services and a "tremendous amount" of work needed to be done to get UHNT up to level where it would be able to provide the service which JCUH provides.

235. That point was emphasised when The Joint Scrutiny Committee heard that no move could be sanctioned, until the environment was right. On this point, it was agreed by both Trusts that it could not happen now, such were the developments needed to the UHNT infrastructure.

236. As to how quickly the necessary capacity could be built up, this topic was the subject of debate between professionals in attendance at the meeting and The Joint Scrutiny Committee did not receive a definitive answer. Nonetheless, judging by the debate between clinicians in attendance at the meeting, it would take UHNT between two and four years to build up sufficient capacity.

237. At this stage of the meeting, the debate was widened to encompass other services, which play a part in upper GI treatment.

238. The Joint Scrutiny Committee heard from an oncologist working at JCUH that around 75% of upper GI patients did not undergo surgery, but went through a treatment of radiotherapy or chemotherapy and would therefore stay at JCUH, where those services would continue to be based. The point was, therefore, made that the service was being fragmented across two sites, which could not be in the interests of the service.

239. The point was made in addition to the above, that the proposals were chiefly concerned with making health services across the whole of Teesside viable and some redistribution was necessary.

240. The Joint Scrutiny Committee heard that the North Tees & Hartlepool Trust, once having moved the upper GI service to UHNT, hoped to build on its already excellent results and in the process of doing so, make the hospital more attractive to future generations of clinicians.

241. On this point, The Joint Scrutiny Committee heard from oncologists based at JCUH that the existing service configuration had been critical in attracting them to work in the area. If the proposed service configuration prevailed at the time they were looking for positions, they would probably have not been attracted to the area.

242. At this point, The Joint Scrutiny Committee heard from the Chief of Surgery at JCUH that it was not even clear as to whether the main purpose of the Prof. Darzi's review was to investigate the sustainability of services across the Tees Valley, or to ensure that UHH was kept open. Certainly the first of Prof. Darzi's terms of reference is concerned with the maximum amount of services being kept at UHH. In respect of the proposed move of upper GI, The Joint Scrutiny Committee was told that if the Acute Services Review had been chiefly concerned with having a patient focus, the move of upper GI would not have been proposed, as the proposal represents a risk to patient safety and ultimately, survival rates.

243. The Joint Scrutiny Committee discussed the impacts the proposals would have on the numbers of surgeons working at both sites and despite some professional disagreement on the exact numbers, it was agreed that the North Tees & Hartlepool NHS Trust would have more surgeons than the South Tees Trust. It was added that this reduction in surgeon numbers would have a detrimental effect on JCUH's waiting times and other associated targets.

244. It was queried at this point as to whether it would be possible for any other services to be moved, in the stead of upper GI to assist in the sustainability of services north of the Tees. The Joint Scrutiny Committee heard that whilst it was not outside the realms of possibility, it had not been properly considered and the consultation was on Prof. Darzi's proposals.

245. At this point, The Joint Scrutiny Committee enquired as to the range of support services, which would be available at UHNT to support the proposed move of upper GI. The Joint Scrutiny Committee heard that it was not essential that all services are on one site, although it is desirable as the requirement for such expertise is often urgent. Essentially, The Joint Scrutiny Committee heard that the absence of a full range of support services is a criterion in deciding whether or not it is a 'risk' to move a service.

246. It was confirmed to The Joint Scrutiny Committee that as far as support services to upper GI surgery were concerned, Cardiothoracic, radiotherapy and chemotherapy were not intended to be located at UHNT. Renal dialysis machines would be present at UHNT. Clinicians at UHNT advised The Joint Scrutiny Committee that they hoped that cross-hospital working would be developed to provide all necessary support services. The Joint Scrutiny Committee heard that the transportation of clinicians between sites for their expertise happens and is an accepted part of medical practice.

247. Accordingly, The Joint Scrutiny Committee was told that JCUH remained the optimum location for upper GI surgery, due to the proximity of such support services. Further to this point, The Joint Scrutiny Committee heard that, in the view of JCUH clinicians, the proposed move in light of the issues over support services represented a reduction in patient safety.

248. In conclusion to Upper GI, staff at JCUH feel that it should not be moved and would welcome reconsideration of the concept. The North Tees & Hartlepool NHS Trust are firmly of the view that they could, in time, deliver the service as well as JCUH and eventually build on it.

249. The Joint Scrutiny Committee enquired as to the financial ramifications of the proposals and exactly how much it would cost to implement the proposals. It was confirmed to The Joint Scrutiny Committee that the financial detail of the proposals was still being worked up and would be available for the NHS Joint Committee to consider, at the time of deciding whether or not to go ahead with the proposals. Nonetheless, it was confirmed that such detail was not available as yet. On this point, The Joint Scrutiny Committee was unsatisfied that it could not take a view on the financial implications of the proposals, especially given the fact that both acute trusts faced difficult financial situations. In addition, it was stated that the financial information, if completed, would not be released during the consultation, due to the fact that NHS consultations should not release 'new' information, once a consultation has started.

250. At the start of the meeting, Members of The Joint Scrutiny Committee wanted to ask a series of questions around the proposed changes to vascular services. As The Joint Scrutiny Committee started to ask the pre-prepared questions, The Joint Scrutiny Committee was advised that discussions had taken place between senior staff of both Acute Trusts. Those discussions had arrived at an agreement whereby both Trusts were apparently now in agreement that vascular services should remain at JCUH and not move to UHNT as proposed in the consultation document. It was said that the reason for this was that a recent Confidential Inquiry into Deaths related to vascular services, which had advocated that the current service configuration on Teesside was the optimum approach and that approach should be encouraged in other parts of the country. In the light of this evidence it was felt that the proposal to disrupt vascular services was in the best interests of the local health service or patients.

251. The Joint Scrutiny Committee was very interested to hear this and felt that this development begged the question of what else in Prof. Darzi's proposals could be challenged and would be not acted upon. Further to that, The Joint Scrutiny Committee was slightly puzzled as to why this had been revealed and new additional information in relation to finance referenced above was not able to be shared during the consultation, even if it was available as surely both represented new information. The Joint Scrutiny Committee felt that the meeting of the NHS Joint Committee to consider the consultation information and make a decision was the time to make any such decision, and felt it was

outside the proper processes for such a declaration to simply be announced at a Scrutiny Committee meeting.

252. The Joint Scrutiny Committee also asked a series of questions in relation to Paediatric services. It was confirmed that UHNT would provide 24-hour trauma for children and paediatric cover. It was said that this would not be a problem in terms of patient safety, as there would be a registrar overnight. Further to that, it was said that the amount of times that a child requires trauma other than orthopaedic assistance is less than once a year. Nonetheless, The Joint Scrutiny Committee heard that the arrangements under the proposals did not compromise patient safety and made the situation no worse or no better than it is currently.

253. The Joint Scrutiny Committee quoted standards outlined in a Royal College of Surgeons report (please see footnote 5) and asked as to how such standards fitted with the content of the proposals. The Joint Scrutiny Committee was told that such standards were aspirational a very few centres in the country would meet the standards described in them. Nonetheless, whilst The Joint Scrutiny Committee accepted this point, it begged the questions of why exactly have such standards if they were never going to be met. Further, whilst to some extent resources dictated this, The Joint Scrutiny Committee would like to think local services were striving to meet the standards.

254. The Joint Scrutiny Committee also asked a question as regards what would happen to a heavily pregnant woman needing obstetrics and trauma, given that they will be based at UHH and UHNT respectively. The Joint Scrutiny Committee was told that she would go to UHNT for her trauma needs, where she would also be assessed by the on call obstetrician. Again, The Joint Scrutiny Committee heard that this was a very rare occurrence, although if it was particularly severe, they could also go to JCUH.

Public Meetings held by the Joint Scrutiny Committee

255. In addition to the formal evidence gathering meetings described above, the Joint Scrutiny Committee held two public meetings to discuss the issues at hand. The meetings were orchestrated in a similar fashion to 'Question Time', in that the meetings were chaired by the Joint Scrutiny Committee Chair and were made up of a Panel of experts, who answered the questions of the audience.

256. The purpose of the meetings was not to consult per se, as it is not the Joint Scrutiny Committee's role to do so, but to gather themes and issues of concern from local people, which could then inform and direct The Joint Scrutiny Committee in its evidence gathering process. In addition, the meetings could also be used as a vehicle to get questions answered, factual information out into the public domain and clear up misconceptions that the public had about what the proposals meant.

257. This duly happened and a significant amount of additional questions prepared for the meeting on 19 December 2005, were generated at those meetings.

258. The meetings were held in Stockton on 7 December 2005 and Hartlepool on 12 December 2005. Full write-ups of the meetings are available as a background paper to this report.

Chapter 10

Views in Relation to County Durham

Context

259. Residents in the south of Easington and parts of Sedgefield in County Durham have traditionally been required to travel out of the county for hospital treatment to the Tees Valley. Easington District, in particular, has some of the most deprived wards in the country with some of the poorest health. 30% of the population in the Easington district consider themselves to have a long-term limiting illness. The death rate for circulatory disease is the highest in the northern region and the district has one of the highest rates for lung cancer.

260. In the Sedgefield District, there are also significant health challenges. For example, heart disease is well above the national average and deaths from cancer, are also significantly above the national average.

261. Because residents in the north of Easington traditionally receive hospital treatment in Sunderland and residents in the west of Easington are most commonly referred to the University Hospital North Durham in addition to those who are treated in the Tees Valley it can be difficult to monitor services. This can hinder health improvement initiatives.

262. In seeking views from patients, because of the way in which services are provided, sometimes the views of Easington and Sedgefield patients can be difficult to ascertain. For example, the Easington Patient Forum tends to leave issues about hospital treatment to the Patient Forums for the North Tees and Hartlepool and South Tees Trusts. The interests of Easington patients are not specifically represented on the South Tees Trust Patient Forum. It was, however, very encouraging to hear at The Joint Scrutiny Committee meetings, the North Tees and Hartlepool Forum strongly putting forward views on behalf of Easington residents.

Impact of the proposal

263. Because the impact of these proposals on residents of County Durham is, perhaps, somewhat different than the impact on those areas represented on The Joint Scrutiny Committee which have a hospital within their area, a meeting of the County Durham Health Scrutiny Sub-Committee was convened to consider the impact of the proposals specifically for County Durham residents.

264. This meeting took place on the 6th December 2005 and included Patient Forum representatives. In considering the public meetings that have taken place within County Durham at Shotton Hall, Trimdon and Sedgefield, it was noted that, predictably, the majority of comments from the public related to transport issues. In the discussion with

representatives of the Strategic Health Authority, the North Tees and Hartlepool Trust and the Easington Primary Care Trust who attended the meeting in Durham, the main focus of issues raised related to transport.

Patient Flows

265. The potential changes to patient flows as a result of the proposals were analysed across the eleven specialisms that will be affected. It was emphasised that approximately 75% of the treatment at North Tees and Hartlepool Hospitals related to out patient treatment. There would be no change for County Durham residents in relation to this area.

266. As far as in-patient treatment was concerned, the patient flow data illustrated that for residents within the major part of County Durham only small numbers would be affected. For Easington and Sedgefield PCT areas, the biggest impact would be a shift from University Hospital of Hartlepool to the North Tees Hospital of about 700 patients per year in relation to Accident and Emergency Services. The other significant impact would be a move from North Tees Hospital to Hartlepool Hospital of about 1,000 patients in respect of general surgery and about 450 in respect of orthopaedics per year.

267. It is, of course, unclear what the implications will be of the new Patient Choice that might have an impact on the current patient flows.

General issues

268. The overall view of the proposals seems to be that, on balance, there would be some benefits for County Durham residents compared to the current arrangements although there was a very strong theme from those representing patients that more services should be provided locally to avoid patients having to travel to distant hospitals. The role of Peterlee and Sedgefield Community Hospitals is particularly significant.

269. The overall strategy to reverse the shift of specialist services from the north of the Tees to the south of the Tees using networks to strengthen the relationship between hospitals should provide overall benefits for residents in County Durham. For the proposals in respect of the University Hospital of Hartlepool, there are perceived benefits in the proposed improvements in services.

270. In relation to the proposals for the University Hospital of North Tees the movement of specialist services from the south of the area to North Tees would enhance the services for residents within County Durham. In terms of upper gastro intestinal cancer services the statistics shows that this has minimal effect on Durham although the concern about losing the integrity of the current service is recognised as an important issue to address.

271. In relation to the James Cook University Hospital, again the proposals can be supported although the upper gastro intestinal cancer services arrangements will clearly need to be carefully considered.

Transport and car parking

272. It was acknowledged that much more interest was now being taken in relation to transport facilities to assist access to health facilities. Whilst the statistics showed that 75% of patients currently travel to the four hospitals by car, car ownership in County Durham and in the Easington area, in particular, is below the national average and, therefore, there would be a higher proportion of patients travelling by public transport from County Durham.

273. It was noted that in the document produced by the Tees Health and Transport Partnership in response to the Tees Review, there were different arrangements across the four hospitals in respect of disabled parking. At North Tees and Hartlepool, disabled parking was free only for the first two hours. At James Cook and the Friarage, there was no charge for those who are disabled. In terms of equity, the Health Scrutiny members at Durham thought that there should be a common approach, which should be free use for all disabled parking.

274. It was also noted in the transport paper that discounts were available for a weekly pass at North Tees and Hartlepool but it was not clear the level of discount at James Cook. If patients were to be moved between hospitals there was a feeling that the discounts should be broadly similar. Also the view was that patients and visitors who had attended North Tees, Hartlepool and James Cook Hospitals should be provided with more information at the time an appointment is made indicating car parking location and charges.

275. Similarly, it was noted that patients who cannot meet the cost of travel because of low income might be able to claim reimbursement for the cost of travel under the Hospital Travel Cost Scheme which has recently been up-dated. There was a lack of knowledge of this scheme and it was considered that more effective publicity should be considered, again as part of the appointment process.

276. Public transport links in many parts of Easington to the Teesside area are not convenient. It was explained that the transport and health partnership group had recently engaged a consultant to assist them with transport improvement initiatives. There were some initiatives, which had been introduced to improve access to the University Hospital of Hartlepool – the East Durham Hospital link. This service which was tailored particularly to hospital journeys had been introduced using Rural Bus Challenge funding. (The cost of a return journey was £2 per person). This service seemed to be a very significant improvement for local people although the impact was still being assessed.

Summary of issues from County Durham

277. Overall, the proposals provide some benefits for residents of County Durham.

278. Because of the distance of travel for County Durham residents, there is a strong view on behalf of residents to provide more appropriate services locally to avoid patients having to travel to distant hospitals.

279. In terms of public transport, whilst some progress has been made through the Local Health and Transport Partnership to provide more effective solutions to public transport access to Hartlepool, North Tees and the James Cook Hospitals, if the proposals were to go ahead there needs to be close liaison with the Transport Partnership before any changes to take place so that the best public transport arrangements can be put into place. The opportunity should be taken to use this review to seek innovative ways to meet the special requirements of hospital transport for patients and visitors including the disabled similar to the East Durham Hospital Link.

280. In respect of car parking any additional patient flows need to be taken into account in respect of car parking at each hospital. It is suggested that information about car parking location and charges including discounts should be provided at the appointment stage.

281. For people with disabilities, to provide equity, it is suggested that unlimited free parking should be provided at Hartlepool and North Tees Hospitals to bring this into line with arrangements at the James Cook Hospital.

282. More publicity should be given to the Hospital Travel Cost Scheme to assist those who cannot meet the cost of travel because of low income. It may be that the most effective publicity would again be at the appointment stage.

Conclusions

283. The Joint Scrutiny Committee has arrived at a series of conclusions in relation to the Acute Services Proposals. They are recorded below on a thematic basis.

Proposal

The Establishment of a Centre of Excellence in Women's & Children's services at UHH (includes Consultant Led Maternity, Paediatric Services, Gynaecology and Breast Surgery)

284. The Joint Scrutiny Committee feels that in terms of maternity services, this recommendation is not consistent with the ethos of Keeping the NHS Local. The Joint Committee recognises the importance of a consultant led maternity services at UHH serving the communities of Hartlepool and East Durham, although this should not be at the expense of the services currently on offer at UHNT or the wider Tees Valley community. On the weight of evidence received, the Joint Scrutiny Committee has concerns over the impact on JCUH's services and existing body of patients, of the migration of patients from the North Tees area, choosing to access JCUH. Accordingly, the proposal in relation to maternity services is not supported.

285. With reference to the paediatric proposals, the Joint Scrutiny Committee is minded to take on board the advice of the Royal College of Surgeons in document "Children's surgery: a First class service", which is quoted in the body of the report and bibliography. The Joint Scrutiny Committee notes how the document states that trauma and paediatrics should be housed together, for patient safety reasons and as a result, recommends that proposals for paediatric provision should be at the level outlined in the above report, whilst recognising local need. Accordingly, the Joint Scrutiny Committee does not support the proposal for paediatric services, as it stands.

286. In terms of Breast Surgery, the Joint Scrutiny Committee is in support of the proposal. The Joint Scrutiny Committee is pleased to note that all preoperative and postoperative checks and assessments will take place at the woman's local hospital. Attendance at UHH will only be necessary for surgery.

287. In terms of gynaecological services, the Joint Scrutiny Committee understands and accepts the rationale for the proposal and accordingly is in support of this element of the proposal.

Proposal

- **The concentration of elective orthopaedics in UHH**
- **The establishment of a major trauma and emergency surgery facility at UHNT**
- **The increased use of the Friarage for orthopaedics**

288. The Joint Scrutiny Committee understands the rationale for the above proposals and supports their implementation. The Joint Scrutiny Committee understands the intention of, to a large extent, divorcing elective orthopaedics from emergency surgery. This is because, the Joint Committee fully accepts and understands that the former can often be disrupted, depending upon the emergency workload. Given that national targets for such elective work will soon be in force, the Joint Scrutiny Committee agrees that the proposal is a sensible approach to providing the best possible service to two distinct patient groups.

289. In relation to the increased use of the Friarage, the Joint Scrutiny Committee is in full support of this element of the proposal. In the view of the Joint Scrutiny Committee it provides greater choice to patients, contributes to making the Friarage (and its associated support services) more sustainable and potentially frees up some capacity at JCUH.

Proposal
The Establishment of a Tees wide Upper Gastro Intestinal service at UHNT
The establishment of a Tees wide endo-luminal vascular service and the establishment of a vascular network with JCUH

290. The Joint Scrutiny Committee was informed at a meeting on 19 December 2005, that the recommendations in relation to vascular services have been dropped in response to a national confidential enquiry into deaths associated with vascular services, which asserted that the existing service configuration across Teesside was the optimum.

291. The Joint Scrutiny Committee welcomes the agreement reached by the two acute trusts, and would wish to see similar co-operation between the respective agencies replicated. The Joint Scrutiny Committee would, however, like to state that should these proposals had remained, on the strength of evidence received the Joint Scrutiny Committee would not have supported the proposal.

292. In relation to the proposal pertaining to Upper GI services – The Joint Scrutiny Committee, on the weight of the evidence received, strongly opposes the proposal on the following grounds.

293. The Joint Scrutiny Committee has received evidence, which states that the proposed move of such services would have detrimental impacts upon the safety of patients accessing the service and would, therefore represent a retrograde step. The Joint Scrutiny Committee does not feel that there has been sufficient evidence-led rebuttal of this perspective to assuage the Joint Scrutiny Committee's concerns.

294. The Joint Scrutiny Committee has also heard that if the proposal were to be implemented, there would be unnecessary duplication of services between UHNT and JCUH. The finances for which could be better spent.

295. The Joint Scrutiny Committee has received a substantial amount of evidence to indicate that presently at JCUH, the upper GI service has access to a wide variety of support services on the same site. These are services such as Renal, cardiothoracic, radiotherapy and chemotherapy, which the upper GI service often has reason to call upon. The Joint Scrutiny Committee has learned that a significant proportion of those support services will not be provided at UHNT and patients would face a hypothetical wait for expertise to arrive or a journey to JCUH. Given the lack of support services at UHNT, the Joint Scrutiny Committee cannot possibly envisage how patients will benefit from such a proposal.

296. The Joint Scrutiny Committee has also noted that the upper GI unit at JCUH is held in very high esteem nationally and viewed as an example of best practice. The Joint Scrutiny Committee cannot see any logical, patient centred rationale as to why this should be moved to UHNT, which presently, is only able to express the ambition of replicating the current service on offer at JCUH.

297. The Joint Scrutiny Committee has also noted that the current service configuration in relation to upper GI services is supported by two detailed reports by independent authorities (please see para 128). The Joint Scrutiny Committee has received no evidence to indicate that thinking on the topic has changed to such a degree, as to render the conclusions of both reports out of date or 'defunct'. Accordingly, the Joint Scrutiny Committee questions the lack of clear, available medical rationale as to the proposed move of the service.

298. The Joint Scrutiny Committee has also received evidence to indicate that the loss of three upper GI surgeons will also have a significant impact on general surgical capacity at both JCUH and the Friarage. Given the accepted dearth of suitably qualified surgeons nationally, this is a consequence of the proposal that the Joint Scrutiny Committee finds unacceptable.

299. It is for reasons above, which the Joint Scrutiny Committee strongly opposes the proposed move of upper GI services.

Workforce

300. On the weight of the evidence received, the Joint Scrutiny Committee believes that Professor Darzi did not involve staff sufficiently in his work before arriving at his recommendations.

301. Nonetheless, the Joint Scrutiny Committee is pleased to see the Trusts now engaging with staff in considering the proposals and how they would be staffed, should they be accepted. The Joint Scrutiny Committee has received no evidence to indicate that any staffing issues brought about by the proposals are insurmountable. The Joint Scrutiny Committee, therefore, does not wish to raise any objections with reference to the proposals and their staffing.

Financial Planning

302. The Joint Scrutiny Committee is deeply concerned that it has not received any evidence, despite numerous requests within meetings, regarding the financial implications of the proposals published. The Joint Scrutiny Committee notes that at a meeting of the Stockton Health Scrutiny Committee, a figure of £15m was quoted for capital costs to fund the reconfiguration. Yet, this information was not forthcoming to the Joint Scrutiny Committee.

303. The Joint Scrutiny Committee feels that the absence of this information has severely impeded it in taking a view regarding the sustainability, feasibility and value for money of the proposals.

Consultation

304. The Joint Scrutiny Committee feels that as a whole, the consultation process was largely well attempted, whilst it may have been more effective in the urban regions than in rural areas, especially in relation to the distribution of consultation literature.

305. In terms of consultation with the Joint Scrutiny Committee, it is felt that it has been good and the Joint Scrutiny Committee would like to place on record its thanks for the level of assistance offered and its commitment in engaging with Overview & Scrutiny. The Joint Scrutiny Committee has gained the impression, however, that during the latter period of the consultation period, there has been a reluctance to fully inform the Joint Scrutiny Committee on financial information and public feedback.

Transport

306. The Joint Scrutiny Committee is of the view that, on the weight of evidence received, there is not sufficient integration between the planning of health services and the planning of public transport schedules.

307. The Joint Scrutiny Committee, whilst understanding it is not the primary role of the NHS to provide public transport, it would wish to see

improved joint planning between agencies at the earliest possible opportunity.

308. On the strength of the evidence received, the Joint Scrutiny Committee wishes to express its concern over evidence it received from both Ambulance Trusts. This stated that due to the proposed changes, particular cohorts of patients would take longer to transport, which therefore means that ambulance vehicles and crews will be out of circulation for longer.

309. From evidence gathered by Durham County Council, the Joint Scrutiny Committee would also like to raise the issue of disparity between the amount of disabled car parking at the different hospital sites concerned, as well as the disparity of free disabled car parking.

310. Further to that, the Joint Scrutiny Committee wishes to raise that the hospital travel cost scheme for those who may have difficulty funding travel to hospital does not seem to be particularly well publicised. The Joint Scrutiny Committee feels the scheme would benefit from better publicity.

311. In addition, the Joint Scrutiny Committee feels it would be beneficial to patients and their carers if a consistency of car parking charges across the different hospital sites was applied.

Additional Observations of the Joint Scrutiny Committee

312. The Joint Scrutiny Committee would like to bring attention to the fact that it has received a significant amount of evidence from clinicians, which would support the designing, building and opening of a single site for North of the Tees. The Joint Scrutiny Committee is, however, aware of differing public opinions on the topic.

313. Further to that, the Joint Scrutiny Committee would like to bring attention to the fact that the overwhelming majority of paediatricians, who have engaged with the Joint Scrutiny Committee, have advocated the opening of a Tees wide paediatric inpatient unit, for improved outcomes and better concentration of expertise. Whilst the Joint Scrutiny Committee is not in a position to make a clinical judgement on the validity of this concept, it does feel it appropriate to ask the questions as to how desirable and/or achievable this is.

314. As change needs to happen, although the form of change is the subject of much debate, the Joint Scrutiny Committee commends the local NHS to work together in order to pursue possible alternatives to provide sustainable hospital services in the future.

315. The Joint Scrutiny Committee wishes to place on record its view that the overall timeframe for completion of a service review, which was launched in July 2003, has been too long and unhelpful. It seems to have created uncertainty, had a negative impact on public confidence and morale of staff.

Recommendations

316. The Joint Scrutiny Committee recommends to the NHS Joint Committee that it agrees to implement the proposals as consulted upon, pertaining to:

a) Gynaecology
b) Breast surgery
c) The concentration of elective orthopaedics at UHH
d) The establishment of a major trauma and emergency surgery facility at UHNT
e) The increased use of the Friarage for orthopaedics

317. The Joint Scrutiny Committee recommends to the NHS Joint Committee that it does not implement the proposals as consulted upon, pertaining to:

a) The establishment of a Tees wide upper gastro intestinal service at UHNT
b) The establishment of a Tees wide endo-luminal vascular service and the establishment of a vascular network with JCUH
c) Maternity services
d) Paediatric services

318. The Joint Scrutiny Committee does not believe the proposals listed at 317 to be in the interests of local health services and the people the Joint Scrutiny Committee represents.

319. As a result of this, if the NHS Joint Committee accepts any of the proposals above from 317 (a) to 317(d), the Joint Scrutiny Committee will refer the disputed matter to the Secretary of State for Health for determination, under powers granted to it.[21]

[21] Please see p.30 of Overview & Scrutiny of Health – Guidance.

Acknowledgements

320. The Joint Scrutiny Committee has received a substantial amount of assistance in its exploration of the proposals from local NHS Managers and clinicians, who have spent a lot of time at meetings for which The Joint Scrutiny Committee is very grateful. The Joint Scrutiny Committee is particularly grateful for the frankness with which they have spoken to The Joint Scrutiny Committee, which has enhanced the quality of the debate and enriched the evidence considered by The Joint Scrutiny Committee.

321. The local NHS' commitment to the people it serves was evident throughout the Scrutiny exercise, and is something for which the local NHS should take a lot of credit for.

322. The Joint Scrutiny Committee has also had the benefit of significant input from non-NHS witnesses who have attended meetings as well as submitting views on the proposals in writing. The Joint Scrutiny Committee wishes to thank those people for engaging with the scrutiny process and their valuable contribution to the evidence considered.

324. In addition, The Joint Scrutiny Committee has also received a quantity of correspondence from private citizens wishing to add their views about the proposals. The Joint Scrutiny Committee is grateful to those people for taking the time to write and express their views. Every piece of correspondence was fully considered when the Final Report was prepared.

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2. Health & Social Care Act 2001. Can be accessed at http://www.opsi.gov.uk/legislation/about_legislation.htm

3. Health & Social Care Act 2001:Directions to Local Authorities (Overview & Scrutiny Committees, Health Scrutiny Functions). Dated 17 July 2003. Can be accessed at www.dh.gov.uk

4. Statutory Instrument 2002 No. 3048 – The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002. Can be accessed at www.opsi.gov.uk

5. Consultation Document *The right treatment, in the right place, at the right time - Have your say about local hospital services.* Please note - Full length document and abridged leaflet were considered. Can be accessed on www.countydurhamandteesvalley.nhs.uk

6. Report of Professor Sir Ara Darzi : *Acute Services Review – Hartlepool & Teesside*, July 2005. Can be accessed at www.countydurhamandteesvalley.nhs.uk

7. Centre for Public Scrutiny Guidance: *joint health scrutiny committees, a practical guide*. November 2004, Can be accessed at www.cfps.org.uk

8. Report of Professor Sir Ara Darzi: Acute Services Review – County Durham & Darlington, February 2002. Can be accessed at www.cddah.nhs.uk

9. BBC Radio Cleveland Feature on the Matthew Davis show, 23rd November 2005 (Held on CD)

10. 'Patient Flows & Activity Modelling' – Produced by North Tees & Hartlepool NHS Trust and South Tees Hospitals NHS Trust, September 2005.

11. 'Transport to Health' – Produced by the Tees Health & Transport Partnership, August 2005.

12. 'Acute Services Review: Hartlepool & Teesside, Question & Answer Material' – Produced September 2005.

13. 'Acute Services Review – Hartlepool & Teesside – Patient & Public Involvement (PPI) Audit Tool' – Produced August 2005.

14. Transcripts of public consultation meetings held by the NHS at the following locations on the following times:

a) Sedgefield 10 October 2005
b) Northallerton 12 October 2005
c) Stockton 18 October 2005
d) Murton 17 October 2005
e) Hartlepool 19 October 2005
f) Trimdon 20 October 2005
g) Billingham 31 October 2005
h) Guisborough 7 November 2005
i) Darlington 15 November 2005
j) Middlesbrough 18 November 2005
k) Shotton 21 November 2005
l) Barnard Castle 22 November 2005
m) Hartlepool 16 November 2005
n) Eston 24 November 2005
o) Hartlepool Historic Quay 12 December 2005
p) Saltburn 14 December 2005
q) Ingleby Barwick 16 December 2005

15. Letter from Dr Michael Tremlett, Paediatric Anaesthetist, 6 December 2005.

16. Letter and enclosure from Dr Geoffrey Wyatt, Consultant Paediatrician, 18 November 2005.

17. Letter and enclosure from Dr Geoffrey Wyatt and signed by colleagues from Department of Paediatrics at JCUH, 22 December 2005.

18. Correspondence from Professor Sir Alan Craft, President of Royal College of Paediatrics and Child Health, 3 January 2006.

19. Letter and enclosure from Dr. Fiona Hampton, Consultant Paediatrician & Clinical Director, 4 November 2005.

20. Letter from Mr David Clarke, recently retired consultant surgeon, 9 November 2005

21. Paper in relation to specialist surgery at University Hospital of North Tees, by Drs P. Gill & I.L. Rosenberg (from North Tees & Hartlepool NHS Trust)

22. Letter from Chris Willis in relation to consultation, 21 October 2005.

23. Position Paper from South Tees Hospitals NHS Trust in relation to the Acute Services Proposals (previously circulated with The Joint Scrutiny Committee papers for its meeting on 8 November 2005).

24. Letter from Mrs. E. Drabble, 11 November 2005

25. Letter & Newspaper cutting from Mrs. E. Drabble, 17 December 2005.

26. Letter from Mr. K. Caswell, 15 November 2005.

27. Letter from Mr. K Caswell, 12 December 2005.

28. Position of Hartlepool PCT Patient & Public Involvement Forum. Not dated.

29. Position of South Tees Hospitals NHS Trust Patient & Public Involvement Forum. Not dated.

30. Email from Dr J. Canning, Secretary of Cleveland Local Medical Committee, 21 December 2005.

31. Briefing note from Cleveland Local Medical Committee, 18 November 2005. Please note this was circulated with The Joint Scrutiny Committee meeting papers of 12 December 2005.

32. Views of Dr. S. Walton, Consultant in Obstetrics & Gynaecology, Not dated.

33. Views of a collection of clinical staff, in a multiperson signed letter to North Tees & Hartlepool Trust Chief Executive, 6 October 2005.

34. Views of John Macaulay, Not dated.

35. Views of North Tees & Hartlepool Hospitals Patient & Public Involvement Forum, dated 13 December 2005.

36. South Tees Hospitals NHS Trust Board Response to Consultation, dated 20 December 2005.

37. Views of Middlesbrough Council Executive, dated 20 December 2005.

38. Full unabridged final report from Stockton Borough Council Health Scrutiny Committee, following an evidence gathering process which has fed into the Joint Scrutiny Committee.

39. Views of Redcar & Cleveland Borough Council, dated 5 January 2006

40. Views of Richmondshire District Council, dated 10 January 2006

41. Views of Hartlepool Borough Council, 13 January 2006

42. Views of North Yorkshire County Council, dated 7 December 2005

43. Email outlining views of Durham Local Medical Committee, dated 17 January 2006

44. National Framework for Children, Young People and Maternity Services, Department for Education & Skills and Department of Health, October 2004. Can be found at www.dh.gov.uk

45. Children's Surgery – a first class service, Royal College of Surgeons 2000, reviewed in 2005. Can be found at www.rcseng.ac.uk

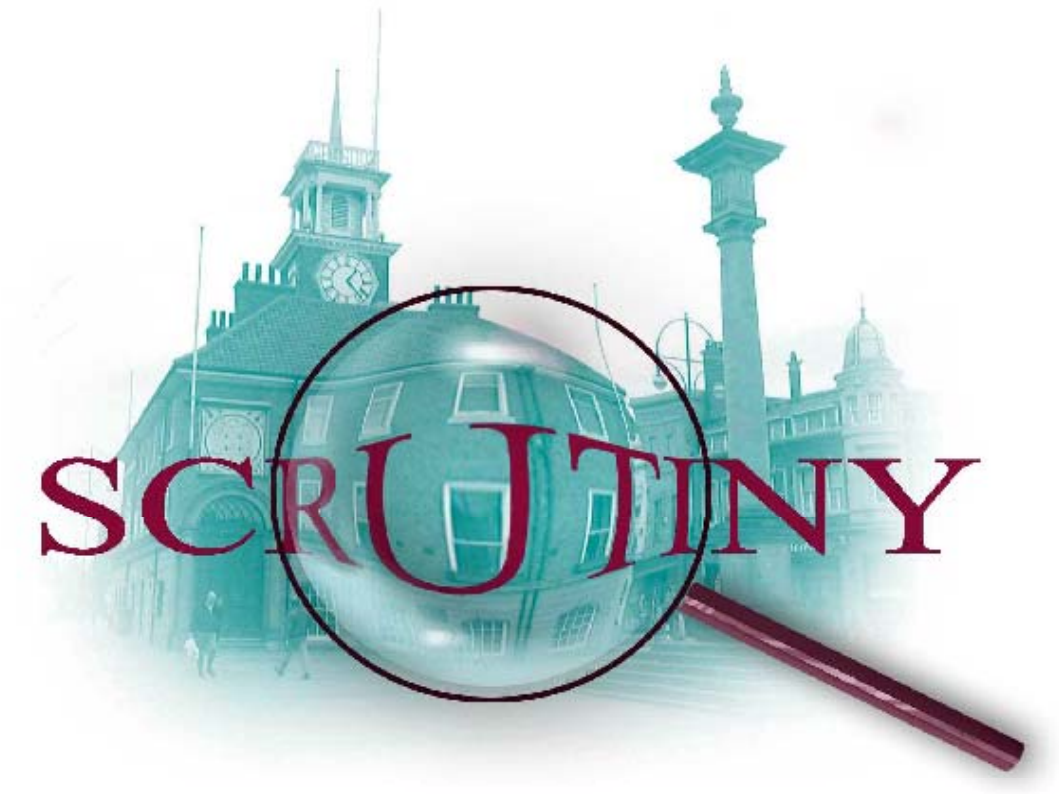
46. The acutely or critically sick or injured child in the District General Hospital, See www.dh.gov.uk Gateway reference 4758.

Glossary of abbreviations used in the Report

JCUH	James Cook University Hospital, Middlesbrough
UHNT	University Hospital of North Tees, Stockton
UHH	University Hospital of Hartlepool, Hartlepool
FHN	Friarage Hospital, Northallerton
PPIF	Patient & Public Involvement Forum
GI	Gastro Intestinal
CLMC	Cleveland Local Medical Committee
NYLMC	North Yorkshire Local Medical Committee
PPI	Public & Patient Involvement
DLMC	Durham Local Medical Committee
SHSC	Stockton Health Scrutiny Committee
DGH	District General Hospital

Health and Social Care
Select Committee

Acute Services Review



2005-2006

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HEALTH AND SOCIAL CARE SELECT COMMITTEE – MEMBERSHIP

Councillor Mrs O'Donnell (Chair)*
Councillor Mrs Womphrey (Vice-Chair)*

Councillor Mrs Apedaile
Councillor Coombs*
Councillor Frankland
Councillor Harrington
Councillor Lupton
Councillor Mrs Nesbitt
Councillor Mrs Robinson
Councillor Mrs Roberts
Councillor Sherris
Councillor Teasdale
Councillor Mrs Trainer

*****Also represent Stockton-on-Tees Borough Council at Joint Section 7 Consultation Committee (Acute Services Review) 2005)

ACUTE SERVICES REVIEW

Introduction

In August 2004 Professor Sir Ara Darzi was asked by the County Durham and Tees Valley SHA to consider how the fullest possible range of services could be maintained at Hartlepool Hospital, taking into account review work already undertaken locally and the proposed provision of health services north and south of the Tees. In December 2004 his brief was extended to cover work under way in relation to the Friarage Hospital, Northallerton as well as the impact of centralisation of specialist services at the James Cook University Hospital, Middlesbrough (JCUH).

The main challenge faced by Darzi was the configuration of acute services between the University Hospital of North Tees (UHNT), at Stockton, and the University Hospital of Hartlepool (UHH) which resulted in the solutions put forward which included the rationalisation of some services between the two hospitals and the centralisation of others at the JCUH.

It is the issue of maternity provision at UHNT that provided the catalyst for objections to Darzi's recommendations although questions have been raised about all aspects of his recommendations not only at UHNT but at the UHH, JCUH and the Friarage Hospital, Northallerton. A Joint Section 7 Consultation Committee (Acute Services Review 2005 (referred to as Joint Scrutiny Committee in this report) involving councillors from Stockton-on-Tees, Middlesbrough, Redcar and Cleveland, Hartlepool, Durham County, and North Yorkshire County Councils has undertaken this work. The Joint Scrutiny Committee is operating during the consultation period (23rd September 2005 and 23rd December 2005) which is the 12-week minimum statutory period as provided for in the Health and Social Care Act 2001.

Stockton Council's Health and Social Care Select Committee is operating as a 'task and finish' group providing additional information to the Joint Scrutiny Committee as there is insufficient time for the Joint Scrutiny Committee to explore all of the issues. Stockton Councillors are particularly keen to investigate the impact of Darzi's recommendations as they affect Stockton residents hence the specific interest in maternity services.

Executive Summary

Stockton-on-Tees Borough Council's Health and Social Care Select Committee undertook to research aspects of Professor Sir Ara Darzi's recommendations. The Committee believes that:

- The terms of reference that was set for the Acute Service Review was fundamentally flawed as the emphasis was for the retention of services at UHH rather than the best provision of services across North Tees.
- Darzi's recommendations do not adequately deal with the staffing issues caused by operating two hospital sites which is particularly concerning as no paediatric emergency and trauma team will be available at UHNT overnight which will also be against clinical governance principles.
- The impact that the proposals on JCUH has not been given sufficient importance especially as the evidence shows that women and children from Ingleby Barwick, Yarm, Thornaby and Eaglescliffe needing health services will choose JCUH in greater numbers than at present.
- A Centre of Excellence already exists at UHNT and that provision of suitable accommodation at UHH will not guarantee its success as excellence will only come from the team that is located there.
- A midwife-led unit will be affected by a shortage of midwives nationally and by the continuation of women to choose a hospital that provides all services.
- The population profile shows that the need for full women and child health provision now and in the future is higher in Stockton Borough than in neighbouring areas and services should be positioned accordingly as this will limit the effect on JCUH.
- It is unacceptable that women in Stockton Borough from lower socio-economic groups will not be given the full range of choice for maternity provision that will available to other women.
- Residents from the lower socio-economic groups in the borough are particularly affected by the move of services away from UHNT and no solution to the public transport arrangements to hospitals further away has been provided therefore further disenfranchising these groups.
- The lack of available financial information for the suggested change to services is a hindrance to the democratic engagement needed for this consultation process and that the investment at UHNT Maternity Unit should be a major factor when considering the cost implications of Darzi's recommendations.
- Throughout this investigation there has been a lack of assurance that the consultation process will reflect the concerns raised and the doubts and objections to Darzi's recommendations.
- The evidence the Committee has compiled, it believes, provides a compelling argument to reassess the limited proposals put forward for consultation and expects that due consideration is given by the Joint Health Scrutiny Committee and the Joint NHS Committee.

Evidence

MATERNITY AND PAEDIATRIC SERVICES

1. Darzi's recommendations will result in the following for two of the hospitals of the North Tees and Hartlepool NHS Trust based on the first Term of Reference set for the review of acute services which was "To consider how the fullest possible range of services can be maintained at Hartlepool Hospital":

2. **The University Hospital of North Tees** should become the main centre north of Tees for emergency surgery, including trauma, with expanded intensive care facilities. It should continue to provide a full accident and emergency service and acute medicine. It should develop as a centre for major complex surgery, including hosting a new North Tees Complex Surgical Centre, providing upper gastrointestinal cancer services for the whole of the Teesside area. Vascular surgery should be developed at the University Hospital of North Tees as part of a clinical network with the James Cook University Hospital. An endo-luminal vascular service should also be developed at the University Hospital of North Tees serving the whole Teesside area. A 24-hour midwife-led maternity unit should be developed. Consultant-led maternity, high-risk obstetrics and paediatric services should be centralised in the University Hospital of Hartlepool.

3. **The University Hospital of Hartlepool** should continue to provide a doctor-led accident and emergency service and acute medicine. It should host a new Centre of Excellence in Women's and Children's Services, including consultant-led maternity, paediatric services, gynaecology and breast surgery. It should increase its inpatient elective surgery portfolio, in particular orthopaedics. Major trauma and emergency surgery out of hours should move to the University Hospital of North Tees.

(NHS Consultation Document, pg 14-15)

4. Darzi's second Term of Reference was to take into account work already undertaken in the course of the Tees Services Review. The Committee does not understand how as a result he arrived at his conclusions which are contrary for maternity provision at UHNT and UHH than that put forward by the original Tees Review. Professor Sir Ara Darzi has not provided any further justification to his proposals than those contained in his 8 July 2005 report. The Committee therefore has based its opinion on available evidence in the course of its investigation as part of the consultation process open until 23 December 2005.

5. A report of the Paediatric Forum of The Royal College of Surgeons of England, *Children's Surgery – A First Class Service*, (May 2000) states that "…Children likely to require high-dependency care or short-term ventilation must only be cared for in units where there is 24-hour, resident, experienced paediatric cover. Those likely to need full intensive care (continued ventilation or level 3) must be treated in a department which has the comprehensive facilities of a Paediatric Intensive Care unit (PICU)." (Royal College of Surgeons of England, 2000:25). The Committee recommend that the proposals for paediatric provision should be at the level as outlined, for such

provision to be provided at UHNT, and that failure to reach such standards should be resisted.

6. Throughout this review Councillors have been concerned that health professional staff opinions have not been fully reflected in the process of reformulating health care delivery either before Darzi made his recommendations or subsequently. The Health and Social Care Select Committee working with the Joint Health Scrutiny Committee were keen to hear from consultants who were prepared to give alternative solutions to the issues surrounding split site working as affects UHNT and UHH.

7. Evidence given by consultants, speaking as concerned individuals following guidance from health authority management, highlighted the concerns proposed by Darzi regarding paediatric care as they are contrary to all clinical governance principles. The Committee is grateful to the consultants that made their opinions known and offered alternative solutions to Darzi's recommendations.

8. Members were warned that it is not safe to have paediatric emergency and trauma at UHNT when it is planned not to have a paediatric team overnight as it will operate a nurse-led facility. Emergency care may as a result have to be provided by a critical care service between 9.00 p.m. and 9.00 a.m. without the specialist provision Darzi states he wants to achieve. This lack of information the Committee feel is inadequate within the consultation process.

9. The Committee was informed that Darzi's proposals for elective paediatric surgery and A&E at UHH and paediatric A&E plus trauma at UHNT will not address the need to have two surgical teams. There is also a severe shortage of specialist and consultant paediatric anaesthetists and that running two surgical teams with its resulting commitments is unlikely to be affordable or be attractive for recruiting staff. **The Committee recommend that this issue be re-examined as failure to adequately plan to overcome staffing issues is a key component to the success of hospital provision in the future.**

10. As well as the issues affecting UHNT and UHH the Committee accepts information provided by consultants about the effect Darzi's proposals will have on JCUH for paediatric care especially emergency care. Consultants already find patients presenting themselves from Ingleby Barwick, Thornaby, Yarm and Eaglescliffe as travelling to JCUH is easier. If the alternative to JCUH is to become UHH rather than UHNT then it is predictable that most families of sick children in these areas will respond by choosing JCUH.

11. Consultants have estimated that JCUH acute paediatric workload will increase by approximately 33 per cent on an assumption that half of the Stockton PCT patients find JCUH easier to access that UHH.

12. The Committee is aware that if Stockton patients fill beds at JCUH this can result in Middlesbrough and Langbaurgh area patients will need to be transferred to UHH, Darlington Memorial Hospital or the Friarage Hospital, Northallerton depending on the availability of beds. **As a result the Committee believe that Darzi's recommendations will only exacerbate a service that is already struggling to cope with demand and suggest that this issue has a higher precedent when considering the location of hospital services.**

13. The Committee has constantly been told by consultants whether in writing or at meetings that a Centre of Excellence is not established by the provision of a building but is developed over time by the specialist team that is formed. **The Committee supports that view and believes that Darzi's recommendations will disrupt the Centre of Excellence for women and children that exists at UHNT and which has already received the funding to equip such a centre. The solution should instead be to develop the existing arrangements at UHNT as being suggested by consultants who have provided their response to the consultation.**

Midwife-led Unit

14. The Committee discussed issues about the introduction of a midwife led unit (MLU) at UHNT with the Heads of Midwifery at UHNT/UHH and Darlington and Bishop Auckland Trusts. Bishop Auckland Hospital became a MLU in 2004 following a report by Professor Sir Ara Darzi. He recommended similar outcomes as being proposed for UHNT so that the smaller population of Bishop Auckland received the MLU and had the choice of a consultant-led unit at either Darlington Memorial Hospital or University Hospital North Durham. **The Committee question why Darzi has reversed his arrangements in order to site an MLU at UHNT based on his previous decision at Bishop Auckland.**

15. Concerns have been raised at a national level with midwifery managers across the UK struggling to recruit midwives and now facing a fight to stop their experienced staff leaving, according to results as part of the Royal College of Midwives (RCM), Annual Staffing Survey 2004. The survey is the 21st consecutive annual questionnaire produced by the RCM and shows that, despite improvement, too few midwives are joining the service. Although the survey figures suggest that the situation across the UK was very slightly better than 2003, the RCM believes that some midwifery services still face staffing challenges (See appendix 1).

16. The RCM state that an extra 10,000 midwives are required to repair the shortages, tackle long-term vacancy rates and relieve the heavy workloads and stress on those currently in post. Information from the Head of Midwifery, UHNT and UHH was that the trust had 10 full time equivalent midwife vacancies as at 17 November 2005.

17. The factors which could limit this inflow to an MLU lie with GPs and Community Midwives promoting Hartlepool and the MLU. Evidence from other sites suggests that for the lower socio economic groups there may well be a willingness to accept direction as to place of delivery (although relative travelling time to Hartlepool compared to JCUH must be a consideration for this group).

18. The Tees Valley Joint Strategy Unit *Analysis of Deprivation in the Tees Valley Using 2001 Census Data* shows that Stockton has several deprived wards in the borough. This would seem to suggest that the amount of patient choice that will be available will be limited in deprived wards to ensure the success of Darzi's proposals whilst those living in the more affluent wards will ensure they are treated at the place of their choice. **The Committee strongly believes that all women should have choice as to where they wish to give birth and that this facility should be irrespective of social classification.**

19. There is a sizeable affluent population in the North Tees catchment area who are, however, likely to be much more independent in their choice of unit. The anecdotal reaction to the estimated risk is that the population of Yarm and Ingleby Barwick, the most affluent ward in the Tees Valley, will definitely move to JCUH. Over time the impact on JCUH will be determined by:
    - the acceptability of a midwifery led unit;
    - the degree to which Hartlepool is perceived as a centre of excellence;
    - the extent of further development in Ingleby Barwick.

20. Information given by the Head of Midwifery at Darlington and Bishop Auckland told of research carried out before changes to birthing arrangements at both hospitals showed that complications are usually found at least 2 hours before birth. Subsequently there have been no complaints submitted in the 18 months that the MLU has operated which has provided for 400 deliveries. Members were informed that 450 women had no contact with a doctor during their pregnancy at UHNT which would have made them suitable for using a birthing centre operated only by midwifes.

21. In the first days of the MLU at Bishop Auckland General hospital health managers had feared expectant mothers might have boycotted the new unit after an incident in which a woman lost her baby and that without the full backing of the community the unit could not survive. Instead of being booked to have her baby at the midwife run unit in Bishop Auckland, the expectant mother should have been booked in at Darlington as she was wrongly classified as being a low-risk expectant mother. The unborn baby was showing signs of distress, a mix-up meant that instead of being taken to Darlington by ambulance, she was told it would be quicker to go by car. A few hours after she arrived in Darlington the baby was dead on delivery.
    (http://www.thisisthenortheast.co.uk/healthspectrum/news/0504/boycott.html)

22. The story was covered nationally whilst severely denting local public confidence in the midwife-led service leading health managers to fear that the unit would not survive without the support of the community. It is this type of event that Members fear could occur at UHNT and what they want to ensure never happens.

23. Members learned that UHNT will be configured differently to other hospitals for provision of an MLU, obstetrics, paediatrics and gynaecology. Members were informed that the only other hospitals operating paediatrics without trauma cover in England was at Southport and Ormskirk Hospitals.

24. Investigating this information it was found that the Southport and Formby PCT agreed to a temporary closure of the MLU from Monday, 5 September 2005 and that those women booked to use the MLU would be transferred to the Consultant led unit in Ormskirk. The MLU, caring for women who met the criteria for low-risk midwifery care, comprises three delivery rooms one of which being an active birth room allowing facilities for a pool. However, the unit had 64 births in 2003/4 and fewer than 100 babies are born annually in the maternity unit.

25. Locally, Guisborough Hospital has been affected by the low use of its MLU and the Committee believe that an MLU at UHNT could be closed under the same circumstances. **The Committee recommend that more research be undertaken before the introduction of an MLU at UHNT.**

Population Profile

26. The Committee examined the population profile for women in the affected areas of this review. The Department of Health's Health & Social Care Information Centre has produced updated population figures at Strategic Health Authority (SHA) and Primary Care Organisation (PCO) level for England and Wales. The data was collected in April 2004 for GP relevant populations as at April 2003. The data has been constrained to the Office for National Statistics 2003 mid-year population estimates - based on the 2001 Census.

PCO name	Females 15_19	Females 20_24	Females 25_29	Females 30_34	Females 35_39	Females 40_44	Total
Easington	**3066**	**2769**	**2488**	**3338**	**3713**	**3668**	**19042**
Hartlepool	**3176**	**2578**	**2391**	**3156**	**3568**	**3495**	**18364**
Langbaurgh	**3199**	**2593**	**2406**	**3160**	**3808**	**3657**	**18823**
Middlesbrough	**7128**	**6363**	**4956**	**6141**	**6807**	**6870**	**38265**
North Tees	**6457**	**5477**	**5393**	**6747**	**7465**	**7486**	**39025**
Sedgefield	**2767**	**2366**	**2426**	**3100**	**3660**	**3464**	**17783**

27. From the figures provided in the above table there are 47.05% more women in the North Tees PCT area of child bearing age than in the Hartlepool PCT area. The argument that women in the south Easington PCT area use UHH for childbirth is, the Committee believes, negated by the fact that women in south Sedgefield PCT area use UHNT. Whilst specific numbers can not be provided for this sub-area the almost equal numbers of women of child bearing age in both Easington and Sedgefield PCT areas has meant that this population has been discounted for this calculation.

28. In figures provided by the National Statistics recording the number of live births showed that within Stockton-on-Tees Unitary Authority area, the area of usual residence of the mother there were 2,115 live births as opposed to 1,065 live births for women from Hartlepool.
(http://www.statistics.gov.uk/downloads/theme_population/FM1_32/Table7.1.xls)

29. The live birth rate for County Durham and Darlington is gently declining, in line with regional and national rates. The most remarkable fall occurs in Easington, where the birth rate has dropped by 4 per 1,000 population between 1991 and 1999.
(County Durham and Darlington Public Health Statistics 2001)

30. The following tables show the projected population changes Stockton Borough and Hartlepool provided by the Tees Valley Joint Strategy Unit in June 2005.

Population changes for Stockton 1991-2021

Mid-Year	Population	Births
1991	175,200	
1991-1996		11,700
1996	177,700	
1996-2001		10,300
2001	183,800	
2001-2006		10,100
2006	187,100	
2006-2011		9,600
2011	189,200	
2011-2016		9,300
2016	189,200	
2016-2021		8,800
2021	187,900	
2001-2021		37,800

Population changes for Hartlepool 1991-2021

Mid-Year	Population	Births
1991	91,100	
1991-1996		6,200
1996	90,400	
1996-2001		5,500
2001	90,200	
2001-2006		5,200
2006	89,600	
2006-2011		5,100
2011	88,000	
2011-2016		5,000
2016	87,600	
2016-2021		4,900
2021	87,100	
2001-2021		20,100

31. All current and future birth rates show the greater demand for services to be centred at UHNT. **As the major concern for attracting specialist consultants is the number of deliveries at a hospital site the Committee**

believe the logical conclusion is that any consultant led service should be at UHNT which will capitalise on the already higher number of births north of the Tees.

Patient Flow

32. In order to understand some of the issues a patient flow and activity modelling exercise was undertaken and completed by the North Tees and Hartlepool Trust and South Tees Acute Trust in August 2005 which has provided the Select Committee with likely outcomes of hospital usage in all aspects of Darzi's recommendations.

33. Patients who originate from Stockton Borough are considered to be the most likely to opt for alternative hospital provision, other than UHH and to be the biggest risk to the organisation in terms of lost activity and income. Therefore, it is anticipated that, of the potential 1,304 gynaecological patients from North Tees PCT who will flow to UHH, a proportion could divert to other hospital sites geographically nearer to home and within easy reach of good road or transport infrastructure. This will become even more apparent when Patient Choice at the point of referral is launched. Potential risks to activity shifts can be estimated. However, a reliable estimate of potential patient flows to other hospitals, informed from a geographical analysis, will require further investigation and even public survey.

34. Based upon the evidence within the 2004-2005 profile of activity, in obstetric care, approximately 70% of deliveries were midwifery led. Given the current 2,001 deliveries at UHNT approximately 30% (n = 601) will transfer to UHH for obstetrician led care. Of the 1,402 patients who will require midwifery led care from the North Tees catchment area it is estimated that 50% could flow to UHH. This would indicate a potential flow of 702 ladies to UHH. Given this estimated shift of deliveries to UHH, this hospital could expect to accommodate 3,001 births. UHNT could expect to accommodate approximately 702 midwifery led deliveries. The Committee were informed that this figure is highly speculative as successful MLU's tend to have a maximum of 5-600 births

35. Based upon activity evidence of other midwifery led maternity units, with obstetric led services as part of the organisational profile, provided at another hospital site, such as Bishop Auckland, it is estimated that the unit could be at risk of providing services for as little as 250 births in the first year, rising in the second year and subsequently beyond, as client confidence in the midwifery led unit sways prospective client behaviour. As a result of this and the inability to accurately determine client behaviour in terms of alternative flows to Darlington and James Cook University Hospitals alternative patient flows must be modelled to mitigate against the potential risks.

36. The Committee believe that Darzi has failed to reflect Department of Health initiatives which are said to increase patient choice and would mean that health funding would 'follow' the patient. This lack of economic consideration in Choose and Book and Payment by results is likely to have a detrimental effect in Stockton and Hartlepool especially if the Teesside Health Trusts are competing for the funding that comes with patients. **The Committee recommend that the economic impact of health initiatives are fully costed before Darzi's proposals are implemented.**

Transport

37. The main flows of Teesside patients to hospital are as follows –

PCT	Patient flow
Easington	Primarily to the UHH, with some patients from the north of the patch going to City Hospitals Sunderland
Hartlepool	Overwhelmingly to the UHH
Langbaurgh	Overwhelmingly to the JCUH
Middlesbrough	Overwhelmingly to the JCUH
North Tees	Primarily to the UHNT, with some patients from the south of the patch going to the JCUH and some elective patients going to the UHH
Sedgefield	Divided between the UHNT, Darlington Memorial Hospital, Bishop Auckland General Hospital, and University Hospital of North Durham

38. The recommendations in the Darzi report outline what local people have said about the need for as many services as possible to be delivered close to where they live. This, he recognizes, means that additional travel will be necessary in future.

39. Darzi points out that the local ambulance service will need additional resources to ensure that trauma patients from north of the Tees arrive rapidly at the UHNT; to cover any transfers of patients from A&E at the UHH who need out of hours emergency surgery, which will be centralised at the UHNT; and to ensure good access for the local population, in cases of urgency, to their preferred maternity service.

40. Transfer of a woman in labour to a consultant led maternity unit from North Tees would be a journey of 12.6 miles to Darlington Memorial Hospital, 14.4 miles to The James Cook University Hospital and 14.5 miles to University Hospital, Hartlepool. **The Committee questions the rationale that would result in women being transferred to the hospital furthest from UHNT, especially in times of emergency.**

41. Recognition is given to the local authorities involved in the Tees Services Review which has already led a great deal of work to identify ways of strengthening public transport links between the UHNT and the UHH. This Darzi states will now need to be taken forward to deliver the excellent transport links which are essential if elective surgery at the UHH, including women's and children's services, is to be a preferred choice for the population north of the Tees.

42. The census in 2001 indicated that across the County Durham & Tees Valley Strategic Health Authority area only 67% of local households has access to a car (or van), which is below the national average. However even where households do have access it cannot be assumed this will always be immediately available in an emergency. For non-urgent travel, encouraging access by modes other than the private car will be key in managing on-site parking issues and other adverse effects from traffic growth in relation to access to health sites. Furthermore, levels of car ownership are lowest in those areas with greatest need, and amongst the elderly, who are most likely to need to access health care, emphasising the importance of ambulance and public transport.

43. In order to address the issue of low car ownership and elderly peoples' needs improved hospital bus services were introduced in April 2004 following a successful Urban Bus Challenge bid by Stockton and Hartlepool Councils, North Tees and Hartlepool NHS Trust and Stagecoach north East. The bid, worth £730,336 over three years provides a free Hospital Shuttle service to transport outpatients, visitors and staff between UHNT and UHH while other routes serving the two hospitals were to be upgraded.

44. The free service operates between 8.00 a.m. and 9.00 p.m. on weekdays and 2.00 p.m. and 8.00 p.m. at weekends and Bank holidays, including Christmas and New Year. The other hospital bus improvements are:

- Upgrading of Stagecoach Service 37 from UHNT and Park End, Middlesbrough, to run every half hour and extended to JCUH to provide a direct link between North Tees and Middlesbrough hospital sites;
- Low floor accessible vehicles; and
- Passenger waiting facilities at UHNT and UHH and stops along the 37 routes to be upgraded.

45. At the same time as winning the Urban Bus Challenge bid North Tees and Hartlepool Trust announced a contribution of £600,000 over the three-year lifetime of the Urban Bus Challenge bid. **The Committee is aware that no monies have been contributed by the Trust and is concerned about future support arrangements for local transport initiatives.**

46. The Committee did learn of, and supports, the introduction of the new *Community Lynx* 'demand responsive' bus service. This Rural Bus Challenge-funded scheme will serve the Borough's rural communities by providing access to health care and other facilities where traditional bus services aren't available.

Finance

47. Health Service funds are allocated using the following formula elements:

- **Weighted capitation targets** which calculates a PCT's fair share of available resources subject to the age distribution of the population, the amount of additional need, and unavoidable variations in the cost of providing services.
- **Recurrent baselines** which represent the actual current allocation that a PCT receives.
- **Distance from target** which is the difference between (A) and (B) above. If (A) is greater than (B), a PCT is said to be under target. If (A) is smaller than (B), a PCT is said to be over target.
- **Pace of change** is the speed at which PCT's are moved closer to their weighted capitation targets.

48. Using the above formula means that Stockton has been 3.5% below their target and as a result is benefiting from increased growth.

49. The Darzi recommendations indicate that investment will be needed to support thriving, reconfigured services on Teesside. They include the expansion of critical care facilities at the UHNT, additional diagnostic equipment and technology to support integrated working across the UHNT and the UHH. There will also be capital expenditure associated with the move of some services between the UHNT and the UHH, and the setting up of the *Centre of Excellence in Women's and Children's Services* at the UHH and the *North Tees Complex Surgical Centre* at the UHNT.

50. Such investments, Darzi recognizes, need to be fully scoped and considered by the North Tees and Hartlepool NHS Trust and the South Tees Trust, working with the local PCTs and the SHA.

51. Darzi does not take into account the level of investment at UHNT which the Committee believe is a failing within his recommendations. In May 2001 the

Prime Minister, Rt Hon Tony Blair MP, officially opened the new maternity unit at UHNT, part of a £7 million redevelopment. Located on two floors of the hospital's tower block the unit contains:

- A maternity suite, including ten delivery rooms and Teesside's only birthing pool;
- A dedicated theatre and a recovery area for women who required surgery;
- A specially designed bereavement suite;
- A neonatal unit with 16 beds, four of which are for intensive care of poorly new born babies and premature babies and five beds for mothers who either need additional support for themselves or for their babies before going home;
- An antenatal/postnatal suite;
- Parents sitting room including a small play area for children.

52. This investment was by way of Private Finance Initiative (PFI). Under a PFI scheme, a capital project has to be designed, built, financed and managed by a private sector consortium, under a contract that typically lasts for 30 years. As a result UHNT will continue to pay for the development whilst no longer benefiting from the service that will be provided at UHH which requires redevelopment before it is able to match UHNT.

53. UHH is undergoing a £309,000 refurbishment of its maternity unit that will provide a birthing pool, private side rooms, a new day room and family kitchen, extra beds and increased security. It was the consultants considered opinion that £10m is the amount required to replicate UHNT midwifery, gynaecology and obstetric provision at UHH. **The Committee recommend that before any further PFI contracts are developed the maternity provision at UHNT is fully re-examined to limit the cost implications of Darzi's proposals.**

54. The Committee had hoped to gather information regarding the cost implications of the Darzi recommendations but were informed by the Director of Finance, North Tees and Hartlepool PCT that this information was not yet available as the financial exercise was not yet complete. **The Committee recommends that the financial element of the Acute Service Review is in place so that it could be considered before the consultation process ends.**

55. Whilst many of the financial implications of the Darzi report were awaited the Committee was advised that a business case had been considered by the County Durham and Tees Valley SHA which identified an estimated cost of £15 million to improve services at UHH and maintaining services at UHNT. **The Committee questions the way in which monies can be found for capital projects rather than being made available to support services which are instead threatened with reorganisation which results in the extra capital expenditure.**

56. The information available to the Committee informed Members that Stockton would receive most growth in funding as a result of Government funding schemes and that North Tees PCT had enjoyed more growth than other PCT's in recent years (£20 million/annum).

Conclusion

57. Throughout its investigation of this issue the Committee has never received the assurance that the consultation process undertaken by the NHS Joint Committee will deliver any changes to the Darzi recommendations. Subsequently the Committee questions whether the consultation will truly reflect the concerns of residents or health professionals who have raised concerns, doubts and objections to the recommendations.

58. The lack of key information (e.g. finance, ambulance service provision, public transport arrangements) is of grave concern to the Committee. It believes that all information is required in order to justify consulting on any proposed changes to service provision. Without this information being available during the consultation period means that it can not be considered by anyone not on the NHS Joint Committee. The Committee feel this is inadequate for such an important decision.

59. The Committee believe the terms of reference were formulated incorrectly and that to have as the first stated aim that of ensuring a fullest possible range of services be maintained at UHH has a disproportionately negative outcome for the other hospitals on Teesside.

60. The evidence the Committee has compiled, it believes, provides a compelling argument to reassess the limited proposals put forward for consultation and expects that due consideration is given by the Joint Health Scrutiny Committee and the Joint NHS Committee.

APPENDIX 1

THE ROYAL COLLEGE OF MIDWIVES STAFFING SURVEY 2004

This survey is the 21st produced by the Royal College of Midwives (RCM) and provides evidence on matters relating specifically to midwives practising in the UK of whom over 95% are represented by the RCM and 99% of whom are employed in the NHS.

RESULTS OF THE SURVEY

The main findings from our annual survey of staffing levels – as at 1 July 2004 – are summarised below. (See Table 1)

The size of the sample – 340 midwifery units – was bigger than previous years as a result of further improvements in the database.
Of the 130 maternity units that provided details of vacancies, 76% (99 units) were experiencing some level of staffing shortage. This rose to 81% (81 units) in England. Last years figures showed 77% reporting vacancies overall and 83% in England.
Across the UK, vacancies represented 5.2% of funded establishment (5.4% in July 2003). The vacancy rate for England stands at 5.8% (6.6% last year).
Long Term Vacancies (Those lasting for 3 months or longer) have increased from 53% of vacancies last year to 68% of vacancies this year
London has vacancy rates of almost 15%, and the South East almost 10%. The West Midlands is also a cause for concern as their rates are around 6%.

JOINERS AND LEAVERS

Recruitment is down from 12.1% to 11%, similarly the numbers of leavers is down from 9.3 to 7.4%
There has been an increase of almost 300 student midwives reported to have joined the service this year. However, an RCM survey of midwifery students shows that 1 in 5 student midwives leaves the course because of financial difficulties.
The number of newly qualified midwives is up from 572.8 to 868.25
The number returning to practice has risen from 82 to 99.
'Others' has risen from 50.83 to 57.32. The number recruited from overseas has almost doubled from 26 last year to 49 this year.

STAFFING ESTABLISHMENTS

The number of HOMS who believe that establishment is not adequate has gone down from 71 % (101 units) in 2002 and 77.3% (92 units) in 2003 to 66.6% (86 Units this year).
The factors that are considered to contribute to this problem are set out in Table 6.

Recruitment and Retention Prospects
When asked what had happened to JOB APPLICATIONS in the last year,
37 % of HOMs reported no change in the number of applications for midwifery posts (51 % last year),
37 % reported an increase in applications (29 % last year)
23 % reported a decrease in applications (31 % last year).
When asked about RECRUITING AND RETAINING MIDWIVES:
46.9 % of HOMs reported no change in the last year (42.2% last year)
28.9% reported that it had become harder to recruit and retain midwives (42.2.% last year)
24.2 % reported that it had become easier to recruit and retain midwives (15.5% last year).
Where the recruitment and retention of midwives was becoming harder, the main causes – as they have been in previous surveys - appear to be heavy workloads and stress. This is consistent with the reasons that midwives themselves give when they leave the profession. (See Mavis Kirkham "Why Midwives Leave")

The RCM is committed to playing a positive role in promoting the profession of midwifery and have recently

Together with Daycare Trust, produced a good practice guide on the provision of childcare and flexible working
Produced "Working Better Together – *a good employment guide for midwives"* that outlines good employment practice currently performed in midwifery units throughout the UK
Worked in Partnership with the Department of Health, Workforce Development Confederations and HOMs to increase the number of returners to midwifery
Worked in Partnership with the Department of Health and other stakeholders to deliver AfC
Cooperated with the government in developing a 6 point plan to promote the profession

Other notable figures can be found in Table 9

CONCLUSION

Although vacancy rates in some regions are still excessively high we consider we are beginning to see the first signs of some recovery. We believe it is critical that increased support for midwifery is sustained if these first shoots of recovery are to continue to grow.

TABLE 1. VACANCY RATES AS AT JULY 1 2004

Region/ Country	WTE Establishment	WTE Actual	Vacancies	As % WTE Establishment		As % WTE Actual	
				03	04	03	04
ENGLAND							
Eastern	1266.7	1207.5	59.2	7.2	4.7	7.7	4.9
London	1500.7	1420.6	209.8	15.4	14.0	18.3	14.8
North West	1987.7	1910.5	77.2	2.6	3.9	2.7	4.0
North & Yorks	1122.4	1242.1	41.1	4.6	3.7	4.9	3.3
South East	1421.1	1290.3	130.8	8.1	9.2	8.8	10.1
South West	1348.5	1308.9	39.6	2.8	2.9	2.9	3.0
Trent	701.1	685.2	16.0	5.4	2.3	5.7	2.3
West Midlands	1242.7	1172.2	71.7	7.6	5.8	8.2	6.1
SCOTLAND	1607.2	1758.3	21.5	0.9	1.3	0.9	1.2
WALES	931.0	896.2	34.8	1.2	3.7	1.2	3.9
N. IRELAND	513.2	498.6	14.6	2.2	2.9	2.3	2.9
GRAND TOTAL	13642.2	13390.6	716.2		5.2		5.4

TABLE 6. FACTORS ATTRIBUTED TO INADEQUATE MIDWIFERY ESTABLISHMENT

Factor	Responses 2002	Responses 2003	Responses 2004
Levels of sickness/maternity leave	60	65	63
Changes in delivery rates	23	36	56
Impact of woman-centred care	73	56	48
Reduction in junior doctors hours	58	52	45
Social/demographic change	37	33	20
Midwifery budget cuts	15	16	17
Other factors	51	57	54
Number of responses	101	119	130

'Other factors' are cited as the third most important factor and these include:
Increased levels of care and interventions due to more high risk and complex cases
Increasing workload associated with midwifery posts
Changes to Service provision/Reorganisation – often as a consequence of the closure of surrounding units
Increases in part time working and training
An increase in specialist services
Difficulties in recruiting to high cost areas

TABLE 9. FACTORS ATTRIBUTED TO RECRUITMENT AND RETENTION PROBLEMS

Factor	No. of HOMs 2002	No. of HOMs 2003	No. of HOMs 2004
Stress	28	38	31
Heavy workloads	23	38	34
Lack of family-friendly policies	10	5	11
Inadequate pay	17	22	10
Financial cutbacks	3	12	8
Inappropriate grading	4	11	5
Return to practice problems	2	3	5
Other factors	26	38	45

Stress and Heavy Workloads are again the first and second most important reasons given

Lack of family friendly policies has more than doubled since the last survey.

Inadequate pay as a factor has more than halved

Other factors

- Reluctance to work standard hours in line with the exigencies of the service
- Lack of affordable housing
- Lack of qualified midwives in the area
- Geographical location as an impediment to recruitment and retention.

Plea to Health Secretary over maternity services

Jul 6 2006

Mike Blackburn, Evening Gazette

Health Secretary Patricia Hewitt was today urged to keep a Teesside maternity unit precisely where it is - at the University Hospital of North Tees.

Stockton Council's Health Select Committee this week made a formal submission to the Secretary of State in response to controversial plans put forward last year by Professor Sir Ara Darzi.

The proposals would see consultant-led maternity and children's services removed from North Tees hospital, leaving only a midwife-led maternity unit in its place. Mothers and children needing specialist services would have to go to Hartlepool.

The all-party submission by Stockton urges the Health Secretary to reverse the proposal.

This would mean retaining the Women and Children's Centre of Excellence at North Tees and continuing all paediatric and emergency gynaecology there. At the same time, a midwife-led unit, supported by facilities for surgery such as caesareans, would be developed in Hartlepool.

Councillor Mary Womphrey, chair of Stockton's Health Select Committee, said: "The Committee strongly believes the Darzi proposal is wrong for this area and wrong for our residents. We strongly urge the Minister to reverse it.

"From the very start, it set out with flawed aims. These were based around finding ways to keep maternity services in Hartlepool, with no mention made about the needs of Stockton residents.

"The University Hospital of North Tees is highly regarded as a Centre of Excellence, yet there is no guarantee such quality could simply be moved to Hartlepool."

Six councils were represented on a Joint Scrutiny Committee that has considered the Darzi plan. Four believe that full maternity facilities should be offered at both Stockton and Hartlepool. But Stockton does not consider such provision to be viable or sustainable.

Councillor Ann Cains, Stockton's cabinet member for adult services and health, said: "The very real danger is that if North Tees is left with only a midwife-led unit, it is unlikely to achieve 700 births per annum. If this figure is not achieved, it would close after three years."

Evening Gazette Our Say

To whom it may concern;

Re: Acute Services Review

In response to the Acute Services Review Committee's invitation to local Authorities to submit a position statement on the Darzi proposals, I would like to confirm that Hartlepool Borough Council has *unanimously* declared its support for the Darzi proposals:-

First, in response to considerable local interest and concern Professor Darzi was invited to a meeting of Hartlepool Borough Council during March 2005 to discuss the future of Hartlepool's hospital services. This resulted in the Council unanimously agreeing to support the following motion:

> "Hartlepool Borough Council wishes to express its thanks to Professor Darzi for attending this meeting of the Council. It regrets that the terms of reference given to him by the Strategic Health Authority do not fully and accurately reflect the commitments given by the Secretary of State for Health and the Prime Minister that hospital services in Hartlepool would not be downgraded as a result of his review. It therefore calls on the Health Authority and Department of Health to revise those terms of reference in line with the statements and commitments of the Prime Minister and the Secretary of State so that hospital services in the town can be both maintained and improved, on the current site, within the shortest possible time."

Following the publication of the Darzi Report in July 2005 the Council, once again unanimously agreed to support the proposals and recommended that:

> "That the Member of Parliament for Hartlepool be requested to facilitate an early meeting with the Health Minister and a delegation of Hartlepool Councillors to ensure that the recommendations detailed in the Professor Darzi report are implemented."

Members of the Joint Committee are aware that evidence from medical professionals throughout the review has established one unifying fact - that the status quo cannot be maintained. Therefore it seems logical that the Committee should adopt a whole systems approach that pays regard to both the impact of implementing Darzi and equally the impact of *not* implementing Darzi across Tees Valley.

Hartlepool is clear that we are unable to look at acute hospital services in isolation from what is happening in the primary, community and social care domains. Whilst noting the concerns expressed by other Local Authorities in relation to the Darzi proposals, it is our view that the proposals present a vision for both Hartlepool and Teesside of how clinical services may be organized to ensure that:-

- they have a sustainable and vibrant future
- they make the greatest possible contribution to improving access to treatment, increasing the choices open to patients and delivering high quality care – in line with the objectives set out in the NHS Plan

Hartlepool welcomes the Darzi proposals as for Hartlepool it ensures that a population already dealing with multiple depravation and under-developed primary care facilities is able to maintain and build upon its much needed local hospital services. There is an acute shortage of General Practitioners in the area which has led to an over-reliance on University Hospital Hartlepool. It is worthy of note that Hartlepool residents use hospital services 10-12% more than the England average, and urgent care in particular, to a greater degree than elsewhere.[1] The Darzi proposals recognize both the difficulties faced by Hartlepool residents in accessing primary care and the importance of securing the viability of Hartlepool hospital for the region.

In summary, Hartlepool Borough Council fully supports the proposals made by Sir Ara Darzi as being robust, sustainable and meeting the needs of Hartlepool residents and Teesside.

Yours sincerely,

Harry Clouth,
Chairman of Adult & Community Services and Health Scrutiny Forum

Stuart Drummond,
Mayor of Harltepool

[1] As quoted in the Darzi Acute Services Review Report July 2005

ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM REPORT

25 July 2006

Report of: Adult and Community Services and Health Scrutiny Forum

Subject: PCT Reconfiguration

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1. PURPOSE OF REPORT

1.1 To present the views of the Adult and Community Services and Health Scrutiny Forum in relation to the reconfiguration of Primary Care Trusts.

2. BACKGROUND INFORMATION

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:-

(a) 1 option for a SHA coterminous with the boundaries of the Government Office of the North East Region.

(b) 2 options for PCTs:-

(i). Option 1 – two PCTs: a County Durham and Darlington PCT and a Teesside PCT.

(ii). Option 2 – six PCTs, retaining the five Tees Valley unitary authority PCTs and a single County Durham PCT. (However, the consultation document included a proposal for a single management team which does not appear to be consistent with the Secretary of State's decision).

The consultation period commenced 14 December 2005 with a completion date of 22 March 2006. During the consultation process strong support was expressed from the main public sector bodies in Hartlepool to retain a Hartlepool PCT. This includes Hartlepool Partnership's response: 'Locality Plus' – Retaining a Co-terminus PCT in Hartlepool **(Appendix 1)** and also Hartlepool Borough Council. The Adult and Community Services and Health Scrutiny Forum response to the consultation process is attached at **Appendix 2.**

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 As part of the announcement on the future configuration of PCTs, the Acting Permanent Secretary wrote on the 16 May 2006 **(Appendix 3)** to the Strategic Health Authority and other Partners to outline some conditions that the new PCT would be subject to once the 15% management cost saving had been achieved. The primary two conditions were outlined as follows:-

(a) All PCTs must retain and build on current partnership arrangements, including Local Area Agreements already established in partnership with local authorities. They should also consider the use of joint appointments with local authorities where appropriate.

(b) A strong locality focus must be retained, and where necessary, locality structures should be put in place. Funding plans to reduce health inequalities and address poverty in socially and economically deprived areas such as Easington and Chester le Street must be maintained and PCTs should ensure patient and public involvement and Practice Based Commissioning arrangements are maintained and improved.

The remaining four conditions 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).

2.6 Following the announcement, the Strategic Health Authority wrote to all NHS PCT Executives and Chairs on 23 May 2006 to consider the conditions set out in the Acting Permanent Secretary's letter and 'to work with Chief Executives

within their cluster to begin to identify the shared management arrangements that will deliver Primary Care Trusts that are fit for purpose for the future.' **(Appendix 4).**

2.7 Hereafter, the Strategic Health Authority wrote on the 30th May 2006 **(Appendix 5)** 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.

2.7 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 however, the Chairman of Hartlepool PCT informed the Health Scrutiny Forum that these proposals have not been shared with the PCT Staff, PCT Board or the corresponding Local Authority.

3. PCT RECONFIGURATION PROPOSALS

3.1 As no formal proposals have been shared with Hartlepool Borough Council, the Adult and Community Services and Health Scrutiny Forum considered a range of options 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** – This would be to retain Hartlepool PCT as it currently stands with its own management team, Board and Professional Executive Committee (PEC). The Forum learned that this option is not deemed to be viable by the PCT Chief Executive as the PCT ability to meet 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 **Shared Management Arrangement – Tees Valley -** 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. The Forum acknowledged that 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 The Forum also learned that 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:

(a) use of one financial ledger system
(b) One payroll system
(c) Single IT services across Tees
(d) 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 The Forum accepted that 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 **Greater Local Integration -** 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:

(a) 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.

(b) 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.

(c) 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 The Forum recognised that 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 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. FINDINGS

4.1 It was evident that Option One, 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 In contrast while Option Two does ensure the 15% savings would be met, it would result in 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.

4.3 The Forum noted with concern the potential difficulties that Hartlepool Borough Council may face in forming a close working relationship with a more distant team. In addition, concern was expressed around the potential impact on the implementation of the LAA which would be affected as the management team would have to consider the wider needs of the Tees Valley and not just those of Hartlepool. The Council's 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. Thus the Forum accepted that this is not an option that would appear to be in the best interests of Hartlepool.

4.4 The Forum found that Option Three 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.

4.5 The Forum noted that the option for full integration is something that the Local Authority 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.

4.6 The Forum recognised the need to take great care to minimise the impact upon services provided by the Local Authority in terms of capacity and in ensuring that the Social Care star rating did not suffer as a result of spreading the management teams' capacity across two organisations.

4.7 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. If efficiencies are to be made these must be achieved by considering innovative ways of working. Four different strands will need to be determined in greater detail. These are:

(i). Governance/Management
(ii). Commissioning of acute and "community based" health and social care services.
(iii). Service provision
(iv). Back office functions.

The Forum noted that if a joint arrangement was considered preferable there may in the first instance be additional costs to Council which would need to be considered further once an option was determined.

4.8 A further risk that was noted was the 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.

4.9 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. CONCLUSIONS

5.1 The Adult and Community Services and Health Scrutiny Forum concluded:-

(a) That healthcare in Hartlepool has benefited from the existence of a co-terminus PCT.

(b) That the SHA proposals to reconfigure Hartlepool PCT did not take into account directions from the Secretary of State to 'retain and build on current partnership arrangements.'

(c) That the current proposals to reconfigure do not retain a strong locality focus nor do they establish effective locality structures.

(d) That local accountability and local decision making is essential to tackle health inequalities and poverty in a socially and economically deprived area such as Hartlepool.

6. RECOMMENDATIONS

6.1 The Adult and Community Services and Health Scrutiny Forum recommends that:-

(a) The Local Authority work closely with all partners including Hartlepool PCT and the SHA to develop the most appropriate PCT configuration.

(b) That the option selected builds on current partnership arrangements established with the Local Authority.

(c) That a strong locality focus is retained, and improved where appropriate.

COUNCILLOR GERLAD WISTOW – CHAIRMAN OF THE ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM

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Background Papers

The following papers were used in the preparation of this report

1. Report of Hartlepool Partnership entitled 'Locality Plus – Retaining a Coterminus PCT in Hartlepool'

2. "Locality Plus" - Hartlepool Borough Council's Health Scrutiny 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 Acting Permanent Secretary Hugh Taylor to David Flory – Dated 16 May 2006.

3. Letter from SHA to PCT Chairs and Chief Executives – Dated 23 May 2006.

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

5. Report of the Director of Adult and Community Services entitled 'PCT Reconfiguration – Tees Valley' to the Adult and Community Services and Health Scrutiny Forum held on 23 June 2006.

'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:

- 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

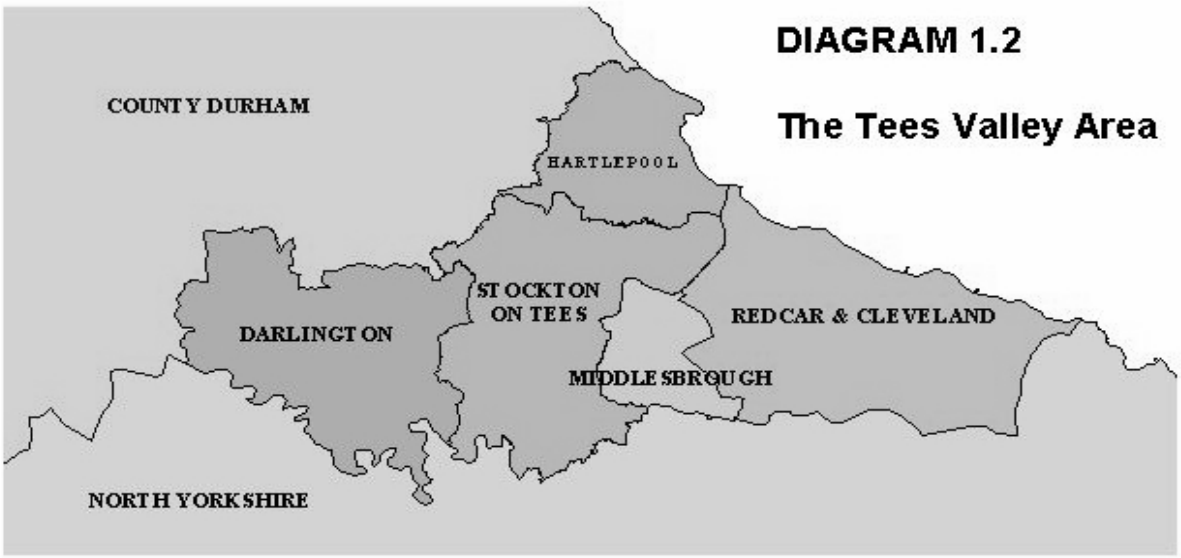
It is important to emphasise the *distinctiveness* of Hartlepool. The town is not a recent creation - the first recorded settlement was at the Saxon Monastery in 640AD, and the first charter for the town was issued in 1145. The town as it is today has grown around the natural haven that became its commercial 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.

DIAGRAM 1.2

The Tees Valley Area



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.

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, 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

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:

- 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. 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.*' 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.

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 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.*

[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.

LOCALITY PLUS

Hartlepool Borough Council's Health Scrutiny Committee's response to the County Durham and Tees Valley Strategic Health Authority's consultation on new Primary Care Trust arrangements in County Durham and the Tees Valley:

Ensuring a patient-led NHS.

Locality Plus

Hartlepool Borough Councils Health Scrutiny Committee's response to SHA consultation on PCT Reconfiguration

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Locality Plus

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.

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.)

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.

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.

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:

- One option for a SHA for the Government Office of the North East Region.
- Two 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.

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".*

The SHA produced a formal document, Consultation on new Primary Care Trust arrangements in County Durham and Tees Valley, which the Chief Executive of the SHA presented to the Adult and Community Services and Health Scrutiny Forum on 14 February 2006.

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

This is the formal response of Hartlepool Borough Council's Health Scrutiny Committee.

SUMMARY

Hartlepool Borough Council's Health Scrutiny Committee thanks the SHA for providing the opportunity to comment upon the possible reconfiguration of local PCTs. Unfortunately however, we believe the consultation process is flawed for the following reasons:

- The Secretary of State required the SHA to consult on two options, the second of which was to retain the five Tees Valley unitary authority PCTs. This is not the second option presented for consultation by the SHA. Your Option 2 is the retention of the four 'unitary' PCT Boards and Professional Executive Committees (PECs), with centralised management and administration for the (now defunct) Teesside area. It is also proposed that management and administration for Darlington PCT, part of the Tees Valley City Region, be centralised within the proposed County Durham PCT.

- Your consultation document states: *"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."* This effectively dismisses your Option 2 as being a viable option.

- The above comments from your consultation document refer to management working practices which would be the same under both options. Consequently, if Option 2 is not viable neither is Option 1, thus we have no viable options to consider.

We consider there is an over-emphasis on financial savings within the consultation document at the expense of the other criteria, particularly given Sir Nigel Crisp's statement that *"we will be looking to reconfigured PCTs to have a clear relationship with local authority social services boundaries".*

The SHA should request that the Secretary of State makes the North East a special case in so far as the level of financial savings are concerned, so that the 'true coterminosity' option she proposed for consideration can be considered on a level playing field with other regions of the country. In other areas of the country 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 it might not be possible to achieve the required savings from the remaining areas.

The consultation document implies that Option 1 is favoured over Option 2 in that it does not require reductions in employee costs to achieve the £6 Million savings proposed. However, no alternative options to achieve that level of saving have been considered. e.g.

- A Strategic Health Authority is no longer necessary. The Government has centralised regional administration for planning, transportation, housing, etc. within regional government offices, with some democratic input from their regional assemblies. Strategic health can be administered in the same manner, with the North East acting as a pilot. What level of saving would this approach achieve?

- How much will be saved if the Secretary of State's proposed option of true coterminosity is implemented? Economies will be obtained by merging local authority and PCT commissioning teams, with management being provided by the local authority and/or joint appointments.

- 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 have not been included in the consultation paper.

The assessment of the options against the required criteria presented in your consultation document does not include an assessment of Option 2 against the improve commissioning and effective use of resources criterion.

Under our assessment of the Secretary of State's proposed option of true coterminosity, it is shown to be a relatively stronger option than either of those assessed by the SHA.

The following statement made in your Submission to the Secretary of State, October 2005, is even more relevant today given the proposals within the White Paper Our Health, Our Care, Our Say for greater integration of PCT and local authority commissioning services:

"This option (Option 1) *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."*

Given the reasons set out above, Hartlepool Borough Council's Health Scrutiny Committee recommends and strongly urges the SHA to recommend to the Secretary of State that she authorises the implementation of the true coterminosity option for Hartlepool and the Tees Valley. For the avoidance of doubt this requires five PCTs based upon the five unitary authority boundaries, each consisting of a Board, a PEC, management and commissioning teams integrated with those of their local authority, and where they can be shown to be the most efficient and effective providers, back office functions and direct service provision.

BACKGROUND

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" (now 4 star) Comprehensive Performance Assessment (CPA) rating for each of the last 4 years. The 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). 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".*

The full Hartlepool Borough 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 Hartlepool Partnership in order to minimise management costs and increase local control over decisions about health services.

- 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".*

It is clear, therefore, that there is strong support from the main public sector bodies in Hartlepool for the retention of a true 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.

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 1145AD. 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 ´city region`, formed by the five boroughs of Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland, Stockton-on-Tees, and their hinterlands.

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.

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. It is worth noting that both options upon which the SHA is consulting would recreate these old Cleveland County Council (previously Teesside) boundaries. As well as acquiring unitary status, Hartlepool Borough Council has also developed one of the few elected mayor systems in the country, a highly successful development which 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 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 Hartlepool Partnership and, for example, through 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, and is the reason why we have titled this paper **Locality Plus**. Health is one of the most important partners. Serving 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.

ACHIEVEMENTS

Our Local Strategic Partnership (LSP) is known as the Hartlepool Partnership. This key Boroughwide 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 our elected Mayor as vice chair. Hartlepool PCT is a core and vital member of the Partnership.

Our Community Strategy provides the Partnership's vision for Hartlepool. 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 Strategy consists of seven themes, each with a Priority Aim:

Jobs and the Economy
Develop a more enterprising, vigorous and diverse local economy that will attract investment, 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 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 Chief Executive of the PCT, which 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 (for people with disabilities)
- supporting people
- mental health LIT
- older persons NSF LIT
- health inequalities
- learning disabilities partnership board
- children and families planning group

This is a broad approach to health and wellbeing, and one which 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 loss of the locally-focused PCT as a key partner would be of serious concern to the other partners and more importantly, make health improvement for the people of Hartlepool more difficult to achieve.

Our track record of achievement within Hartlepool has resulted in our being awarded a Local Area Agreement (LAA) with '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 Council and the PCT are seeking ways to use the LAA to further refine joint working and reinforce the community and public health agenda. Delivering the NHS Improvement Plan [2005] refers to the relationship with local authorities as being 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. The Council, PCT and other partners consider that the 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 5 October 2005 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 the SHA and Government to encourage us in this mission.

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:

- 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 Directors for Children's Services and Adult and Community Services and the Assistant Director for Adult Care. 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 Council's Adult and Community Services Department Management 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 Council firmly believes that the loss of the current, coterminous 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 under either option as the both involve the creation of a Teesside PCT.

These networks have already had an impact with a commitment to exploring the scope for joint appointments. The two statutory agencies already have a jointly appointed, managed and funded Director of Public Health, as well as a joint Head of Mental Health and two joint commissioning posts for learning disability and mental health services. We are currently considering a joint appointment at assistant director level, for adult health and social care, and intend to explore further opportunities for joint appointments and collaborative working, in relation to support arrangements as well as commissioning requirements.

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. 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 reached by the Department of Health. 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 announcement by the Secretary of State late last year 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 it is still possible for the PCT and Council 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 Council's Neighbourhood Forum areas.

The 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 we intend 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 White Paper Our Health, Our Care, Our Say, 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 coterminosity of 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 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".

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 one another. 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 Government's Together We Can strategy 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 Council and PCT are fully committed and one we believe would be at risk should the PCT functions be subsumed within a larger Tees PCT.

We believe the strengths of the stand alone Hartlepool PCT will be difficult to replace by a locality arrangement made by a distant Teesside PCT, as proposed under both options in your consultation document.

We have already demonstrated that Hartlepool PCT is an embedded partner at strategic level through 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. Commissioning a Patient Led NHS (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".*

Your consultation document acknowledges the coterminosity principle, but in practice has disregarded it in favour of what you believe is a stronger commissioning function. Not all SHAs take such a line. The Cumbria and Lancashire SHA submission to the Secretary of State, 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 your proposals for Hartlepool and Teesside would leave us with a large PCT having no coterminosity with any local authority. This is not in the best interests of the health and wellbeing of the residents of Hartlepool.

The White Paper Our Health, Our Care, Our Say 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 through such initiatives as our highly acclaimed Connected Care model, that 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 which we wish to see increased. We are now working together in 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.

The PCT is supportive of the shift to Practice Based Commissioning (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. The PCT has a sound relationship with local clinicians and it is important that this is not put in jeopardy by unsuitable structural change.

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 authority and the PBC governance forum. This role would consist of:

- acting as the purchasing agent: negotiating and monitoring contracts;
- 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.

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 PCT's relationship with its coterminous partners is crucial, for PBR will not, on its own, encourage the provision of care in a more appropriate setting, this will only 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 (LDP) of the PCT for 2005/6 – 2007/8. 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. The 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".*

OPTION ASSESSMENT

Option 2 in your consultation document is based on the premise that a PCT merely consists of a PCT Board and its Professional Executive Committee (PEC), but clearly this cannot be correct as any definition of a PCT must include its employees. Whilst your incredibly narrow definition enables you to claim you are consulting upon two options, in practice there is only one option dressed up as two. As a consequence we consider the consultation process to be flawed.

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."* This 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 2 is unworkable, so is Option 1, thus we have no workable option to consider. The consultation process is flawed.

The four Teesside PCT Boards proposed under Option 2 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 incurring a financial deficit, will it be picked up by the other partners? If so, how will Hartlepool's Board be held to account?

Sir Nigel Crisp requires £250 million of savings in overhead costs across the country. The SHA state this equates to £6 million for County Durham and the Tees Valley. Your consultation document implies that Option 1 is favoured over Option 2 in that it does not require reductions in employee costs to achieve the £6 Million savings proposed. However, no alternative options to achieve that level of saving have been considered, e.g.

- A Strategic Health Authority is no longer necessary. The Government has "centralised" regional administration for planning, transportation, housing, etc. within regional government offices, with some democratic input from their regional assemblies. Strategic health can be administered in the same manner, with the North East acting as a pilot. What level of saving would this approach achieve?

- How much will be saved if the Secretary of State's proposed option of true coterminosity (five complete PCTs on coterminous boundaries with the five unitary authorities of the Tees Valley) is implemented? Economies will be obtained by merging local authority and PCT commissioning teams, with management being provided by the local authority and/or joint appointments.

- 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 have not been included in the consultation paper.

The £6 Million saving requirement could be fulfilled through a combination of savings from the true coterminosity option, integration of the SHA within the Government Office for the North East, and back office savings as yet not costed.

Alternatively, the SHA could request that the Secretary of State makes the North East a special case in so far as the level of financial savings are concerned, in order that the true coterminosity option she proposed can be considered on a level playing field with other regions of the country. In other areas of the country 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.

Your October 2005 submission to the Secretary of State and your consultation document include assessments of Option 1 and Option 2 (although there is no assessment of Option 2 against the improve commissioning and effective use of resources criterion), but contains no assessment of the true coterminosity option requested by the Secretary of State. Consequently, we set out below our assessment of true coterminosity against your assessments.

1. Secure high quality, safe services

There is no evidence to suggest that PCTs are unable to commission safely. Much of the quality and safety issue relies on the way providers deliver services, and that is their own responsibility. The NHS has many audit and quality frameworks for which SHAs are accountable, rather than PCTs. 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. Further integration with Council commissioning services should produce more efficient and effective commissioning.

2. 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. Your consultation options have the potential to damage past achievement and hinder future progress.

3. 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. The fact you recognise that the larger PCTs you propose would have to set up local arrangements to attempt to preserve relationships, suggests local arrangements such as ours, are the ideal.

4. 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.

5. 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 their own commissioning teams led by 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.

6. 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, there 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. Whilst true coterminosity is unlikely to improve upon the current risk of financial imbalance, equally, there is no evidence of larger PCTs so doing.

7. 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.

SUMMARY

Criteria	1	2	True
1	✓	x	✓
2	✓	x	✓
3	x	x	✓
4	x	✓	✓
5	✓	x	✓
6	✓	✓	x
7	x	x	✓

(NB the crosses and ticks are relative measures.)

* Assessment taken from SHA submission to Government, October 2005

\+ Assessment taken from current SHA Consultation document, December 2005

CONCLUSIONS

Option 1
We agree with your comment (SHA Submission to Government, October 2005) that:

"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."

We consider this option not to be viable.

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, consequently we consider this option to be less viable than Option 1.

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

David Flory
Chief Executive
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Tel: 020 7210 3000
Direct Line: 020 7210

16 May 2006

Gateway reference: 6550

Dear David,

***Commissioning a Patient-Led NHS*: Primary Care Trusts**

Thank you for your hard work over the last few months and your report on the outcome of the local consultations.

I know that this has been a testing and difficult time for you and your staff and I wanted to put on record my thanks for the strong leadership you have shown in seeing this through.

The Secretary of State has carefully considered the proposals made by the SHA, along with advice from the External Panel. She has listened carefully and noted the views of a range of local stakeholders and, on balance, has decided that the future configuration of PCTs within your area should be as set out below:

- County Durham PCT,
- Darlington PCT,
- Stockton-on-Tees PCT,
- Hartlepool PCT,
- Middlesbrough PCT, and
- Redcar and Cleveland PCT.

The Secretary of State's decision to establish the new PCTs is made on the basis that they and the new SHAs will be subject to the following conditions:

- All PCTs must retain and build on current partnership arrangements, including Local Area Agreements already established in partnership with local authorities. They should also consider the use of joint appointments with local authorities where appropriate.

- A strong locality focus must be retained, and where necessary, locality structures should be put in place. Funding plans to reduce health inequalities and address poverty in socially and economically deprived areas such as Easington and Chester-le-Street must be maintained and PCTs should ensure patient and public involvement and Practice Based Commissioning arrangements are maintained and improved.

- All PCTs must also deliver their share of the 15% management cost savings, strengthen commissioning and ensure robust management of financial balance and risk.

- The SHA should consider whether shared management teams would benefit PCTs in meeting these criteria. The Department would be very supportive of plans for joint management teams where you believe that to be the best solution.

- Where joint management teams are proposed, the SHA should also consider shared PEC arrangements and how clinical time spent on corporate business could be minimised, allowing them to focus instead on service redesign, bringing benefit to patients in their locality.

- Where recommendations were made in the consultation reports setting out conditions that should be applied to the new configuration, the new PCTs and SHAs should consider those conditions and determine how they should be taken forward and monitored.

I attach maps and tables which show the current and future PCT configuration in each SHA and nationally. Our aim, as you know, is for the new PCTs to be established on 1 October 2006.

Ambulance Trust Configuration

We have now considered the feedback received on the consultation on ambulance trust configuration. I am pleased to be able to tell you that the Secretary of State has agreed that from 1 July 2006 there will be 12 ambulance trusts in England, with a move to reduce to 11 trusts later. Feedback from most areas did not indicate any significant reasons to change our original proposals. However, in a few areas we have responded to concerns by modifying the detail of the configuration. Full details of the final configuration is set out in the enclosed map and table.

Some concern was raised in the consultation that local responsiveness and flexibility could be lost through having larger trusts. The Secretary of State has therefore decided that ambulance trusts will be required to ensure that their services are meeting the needs of all localities and populations within their boundaries. A direction to this effect will be issued to the new trusts at the time of establishment.

An announcement will be made this week on the designate Chairs and designate Chief Executives of the new ambulance trusts.

You will wish to be aware that Lord Warner has today written to MPs of all English constituencies to set out the future PCT and ambulance trust configurations and enclosing a copy of this letter.

Department of Health

I have also written to the Government Offices for the Regions to inform them of the new configurations. I would be grateful if you could communicate these decisions to your other local stakeholders, with immediate effect, in particular to those local authorities that have social services responsibilities.

Yours ever,

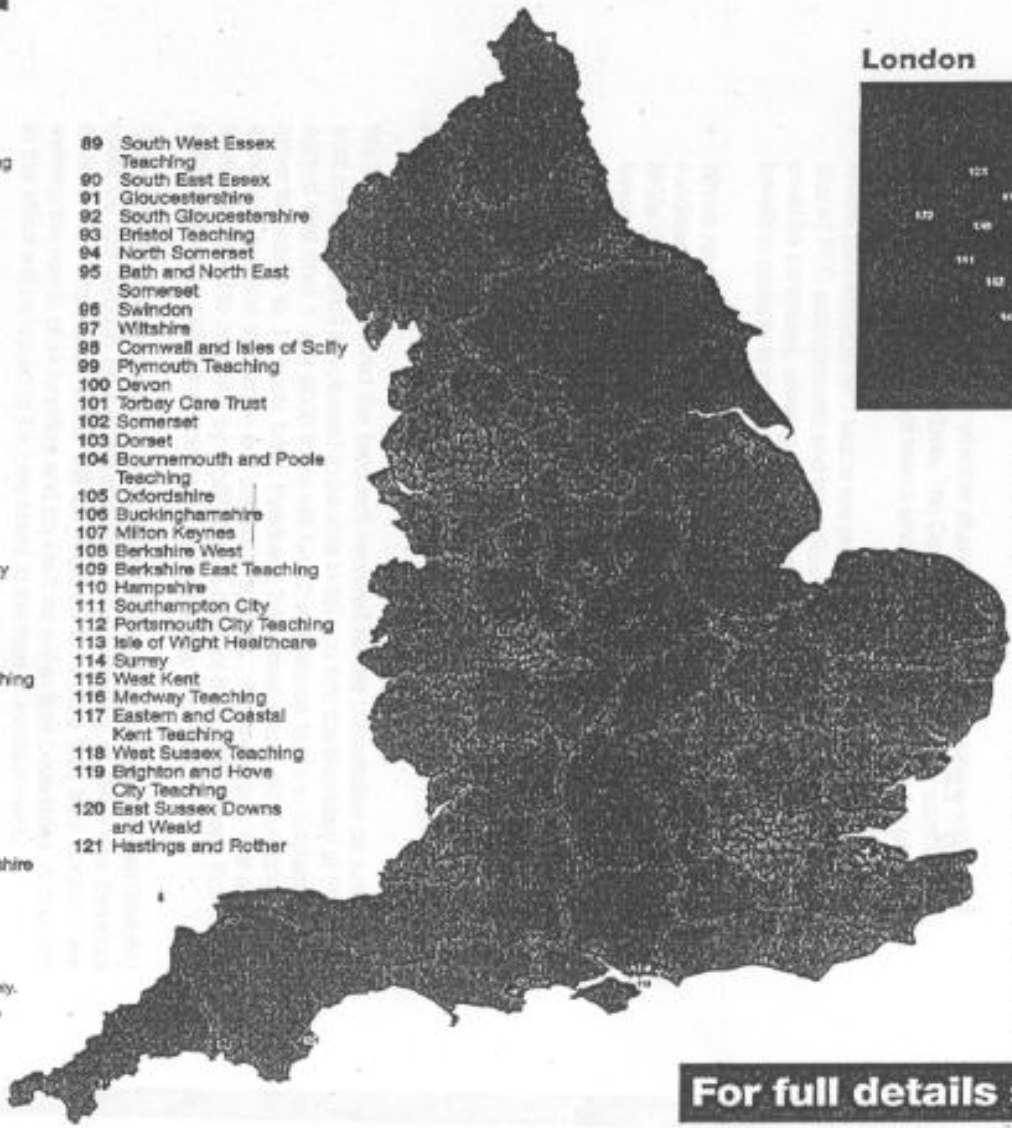
HUGH TAYLOR
ACTING PERMANENT SECRETARY

cc. Chair, County Durham and Tees Valley SHA,
Chief Executive Designate, North East SHA
Chair Designate, North East SHA
Chief Executives, Local PCTs
Chairs, Local PCTs
Local MPs

x 3

Primary Care Trust Configurations

England



KEY

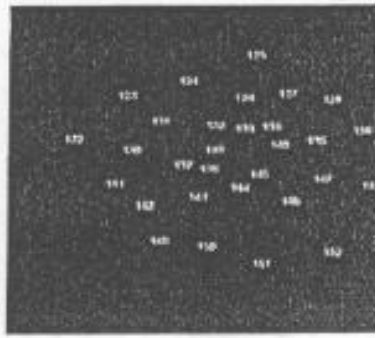
1 Northumberland Care Trust
2 Newcastle
3 North Tyneside
4 Gateshead
5 South Tyneside
6 Sunderland Teaching
7 County Durham
8 Hartlepool
9 Darlington
10 Stockton-on-Tees Teaching
11 Middlesbrough
12 Redcar and Cleveland
13 Cumbria
14 North Lancashire
15 Blackpool
16 East Lancashire
17 Sefton
18 Central Lancashire
19 Blackburn with Darwen Teaching
20 Wirral
21 Liverpool
22 Knowsley
23 Halton and St. Helens
24 Ashton, Leigh and Wigan
25 Bolton
26 Bury
27 Rochdale, Haywood and Middleton
28 Warrington
29 Salford Teaching
30 Trafford
31 Manchester
32 Oldham
33 Tameside and Glossop
34 Stockport
35 West Cheshire
36 East Cheshire
37 North Yorkshire and York
38 Bradford and Airedale Teaching
39 Leeds
40 Calderdale
41 Kirklees
42 Wakefield
43 Barnsley
44 Sheffield
45 Rotherham
46 Doncaster
47 East Riding of Yorkshire
48 Hull Teaching
49 North Lincolnshire
50 North East Lincolnshire
51 North Staffordshire
52 Stoke on Trent Teaching
53 Shropshire County
54 Telford and Wrekin
55 South Staffordshire
56 Wolverhampton City
57 Walsall Teaching
58 Dudley
59 Sandwell
60 Heart of Birmingham Teaching
61 Birmingham East and North
62 South Birmingham
63 Solihull
64 Coventry Teaching
65 Herefordshire
66 Worcestershire
67 Warwickshire
68 Derbyshire County
69 Derby City
70 Bassetlaw
71 Nottingham City
72 Nottinghamshire County Teaching
73 Lincolnshire Teaching
74 Leicester City Teaching
75 Leicestershire County and Rutland
76 Northamptonshire Teaching
77 Peterborough
78 Norfolk
79 Cambridgeshire
80 Suffolk
81 Great Yarmouth and Waveney Teaching
82 Bedfordshire
83 Luton Teaching
84 West Hertfordshire
85 East and North Hertfordshire
86 West Essex
87 Mid Essex
88 North East Essex
89 South West Essex Teaching
90 South East Essex
91 Gloucestershire
92 South Gloucestershire
93 Bristol Teaching
94 North Somerset
95 Bath and North East Somerset
96 Swindon
97 Wiltshire
98 Cornwall and Isles of Scilly
99 Plymouth Teaching
100 Devon
101 Torbay Care Trust
102 Somerset
103 Dorset
104 Bournemouth and Poole Teaching
105 Oxfordshire
106 Buckinghamshire
107 Milton Keynes
108 Berkshire West
109 Berkshire East Teaching
110 Hampshire
111 Southampton City
112 Portsmouth City Teaching
113 Isle of Wight Healthcare
114 Surrey
115 West Kent
116 Medway Teaching
117 Eastern and Coastal Kent Teaching
118 West Sussex Teaching
119 Brighton and Hove City Teaching
120 East Sussex Downs and Weald
121 Hastings and Rother

Map is for illustrative purposes only.

Map shows proposed boundaries of PCTs. Actual boundaries to be prescribed by statutory orders. Names of PCTs subject to final approval.

Teaching status to be confirmed.

London



LONDON

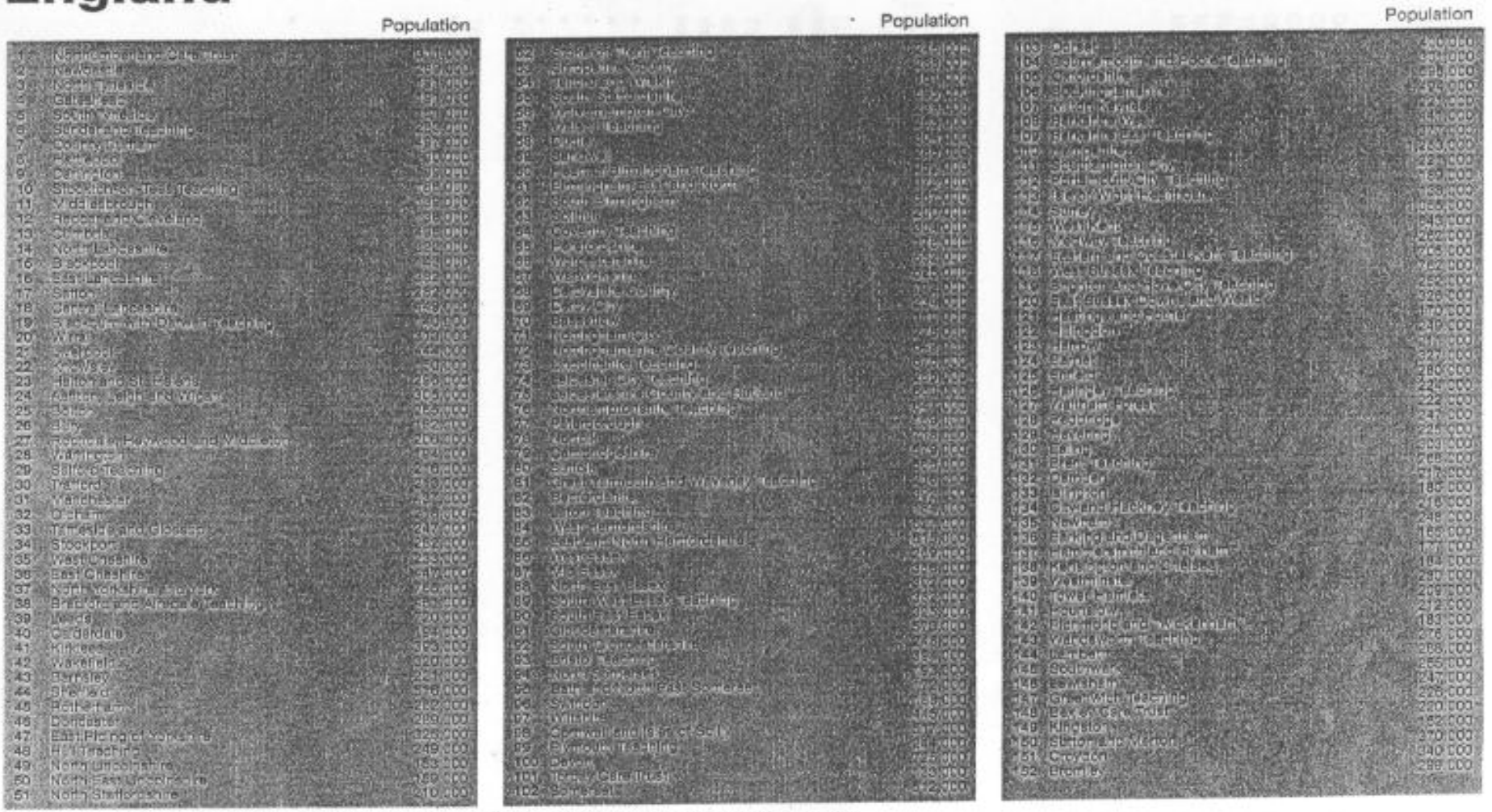
122 Hillingdon
123 Harrow
124 Barnet
125 Enfield
126 Haringey Teaching
127 Waltham Forest
128 Redbridge
129 Havering
130 Ealing
131 Brent Teaching
132 Camden
133 Islington
134 City and Hackney
135 Newham
136 Barking and Dage
137 Hammersmith and
138 Kensington and C
139 Westminster
140 Tower Hamlets
141 Hounslow
142 Richmond and Twi
143 Wandsworth Teach
144 Lambeth
145 Southwark
146 Lewisham
147 Greenwich Teachir
148 Bexley Care Trust
149 Kingston
150 Sutton and Merton
151 Croydon
152 Bromley

For full details see overle

Primary Care Trust Configurations

NHS

England



Population sizes are approximate. Source – Population – Mid-2004 Resident Population Estimate (2001 Census Based), Office for National Statistics.

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DF/LB/LTR951

23 May 2006

To: All Local NHS PCT Chief Executives

Cc: All Local NHS Trust Chief Executives
All Local NHS Trust Chairs
All Local NHS PCT Chairs

Dear Colleague

Commissioning a Patient-Led NHS: Primary Care Trusts

Following Hugh Taylor's letter of 16 May 2006 and the meeting with Chairs and Chief Executives on 18 May 2006, we are writing to set out the next steps to develop effective management arrangements for Primary Care Trusts in North East England.

We would ask each Primary Care Trust Chief Executive to now consider the conditions set out in Hugh Taylor's letter and to work with Chief Executives within their cluster to begin to identify the shared management arrangements that will deliver Primary Care Trusts that are fit for purpose for the future. Given the 15% management savings that are required of each individual PCT, we are keen to receive the new principles you would propose for your cluster in relation to:

- streamlined governance arrangements;
- the integration of corporate and managerial functions across Primary Care Trusts;
- strengthened commissioning functions, including practice based commissioning;
- maintaining a locality focus and continuing to develop the health improvement agenda;

In relation to all of these areas you will need to ensure that your initial cluster discussions address the need to:

- deliver the 15% management cost saving in each PCT and in each cluster;
- minimise duplication as far as possible;
- demonstrate maximum efficiency;

- make effective use of scarce skills and the management capacity available within the given resources;
- support effective partnership working with many stakeholders;
- establish strong primary care organisations which will be fit for purpose for the future.

We look forward to receiving your initial submission by Monday 5th June 2006. In some clusters, you may wish to provide a range of options with an identified preferred option.

It is the responsibility of the Strategic Health Authority to ensure that effective managerial arrangements are in place for the Primary Care Trusts in North East England. We will consider your initial submissions along with work currently being undertaken at the SHA so that optimum managerial arrangements can be put in place across the North East as soon as is practical. We will, of course, continue to discuss these arrangements with you as they develop.

Yours sincerely

David Flory.

David Flory
Chief Executive

Karen Straughair
Chief Operating Officer

County Durham and Tees Valley NHS
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30 May 2006

Mr Paul Walker
Chief Executive
Hartlepool Borough Council
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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

ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM

25 July 2006

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Support Officer

Subject: Scrutiny Investigation into Social Prescribing

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1. PURPOSE OF REPORT

1.1 To make proposals to Members of the Adult and Community Services and Health Scrutiny Forum for their forthcoming investigation into Hartlepool's 'Social Prescribing'.

2. BACKGROUND INFORMATION

2.1 At the meeting of the Adult and Community Services and Health Scrutiny Forum on 13 June 2006 this Forum established its annual work programme which consisted of two topics for in-depth review namely, 'Social Prescribing' and the 'Development of PCT Services.' This work programme was subsequently endorsed by Scrutiny Co-ordinating Committee on 30 June 2006 and as a result Members are asked to review the proposed scoping of social prescribing that is outlined below.

2.2 The aim of the investigation is essentially to explore the ways in which social prescribing can be further developed in Hartlepool. While Social Prescribing has been widely used for people with mild to moderate mental health problems with a range of positive outcomes, increasingly social prescribing is being used as a route to reduce social exclusion for disadvantaged, isolated and vulnerable populations.

2.3 This investigation would aim to explore a number of factors (outlined below) with a view to understanding the link between primary care, the Local Authority, Voluntary and Community Sector (VCS) Funding, and VCS Services to identify how non-medical interventions can assist people with longer term or complex health and social care needs in maintaining their own independence and to live as fulfilling a life as possible.

3. OVERALL AIM OF THE SCRUTINY INVESTIGATION

3.1 To explore the ways in which social prescribing is being developed in Hartlepool.

4. PROPOSED TERMS OF REFERENCE FOR THE SCRUTINY INVESTIGATION

4.1 The following Terms of Reference for the review are proposed:-

(a) To gain an understanding of national policy and practice in relation to 'Social Prescribing';

(b) To seek evidence for the effectiveness of Social Prescribing;

(c) To identify current provision of social prescribing in Hartlepool;

(d) To identify challenges in integrating social prescribing within primary care practice and other areas;

(e) To identify the funding streams that currently support and in future will support Social Prescribing and, to examine the long-term sustainability of these;

(f) To compare what good practice exists in other Local Authorities in relation to social prescribing;

(g) To seek the views of the service users in relation to social prescribing initiatives; and

(h) To seek the views of GPs and service providers in the statutory and non-statutory sectors.

5. POTENTIAL AREAS OF INQUIRY / SOURCES OF EVIDENCE

5.1 Members of the Forum can request a range of evidential and comparative information throughout the Scrutiny review.

5.2 The Forum can invite a variety of people to attend to assist in the development of a balanced and focused range of recommendations. Members may wish to include the following in their investigation:-

(a) Representatives from Hartlepool Borough Council;

(b) Representative from the Voluntary and Community Sector, for instance, HVDA;

(c) Representatives from Hartlepool MIND;

(d) Portfolio Holder for Adult Services and Public Health;

(e) Local service users;

(f) Local GPs; and

(g) Hartlepool PCT.

6. COMMUNITY ENGAGEMENT

6.1 Community engagement plays a crucial role in the Scrutiny process and paragraph 5.2, details who the Forum could involve. However, thought will need to be given to the way in which the Forum wishes to encourage those views.

7. PROPOSED TIMETABLE OF THE SCRUTINY INVESTIGATION

7.1 Detailed below is the proposed timetable for the review to be undertaken, which may be changed at any stage:-

25 July 2006 – 'Scoping of the Scrutiny of the Topic' – The purpose of this meeting is to establish an overall aim for the investigation and the terms of reference for the review.

6 September 2006- 'Setting the Scene' – Formal meeting of the Forum to set the scene and outline national policy and practice in relation to Social Prescribing.

10 October 2006- 'Establishing Current Service Provision in Hartlepool'- At this stage of the investigation it is proposed that Members establish a picture of current provision of Social Prescribing in Hartlepool and, the effectiveness of the initiatives thereof. Funding streams could also be usefully considered at this stage.

14 November 2006 –'Identifying the challenge of Integration' – To identify challenges (if any) in integrating social prescribing within primary care practice and other areas.

Date to be Determined – 'Best Practice' – Best Practice Authorities in relation to Social Prescribing would be invited to provide the committee with evidence.

19 December 2006 – 'Community Engagement' – This meeting would allow the Forum to hear from service users and providers in the statutory and non-statutory sector.

30 January 2007 – 'Draft Final Report' – Members would be invited to consider a draft final report.

Once the draft final report has been agreed by the Forum the report will be progressed to Scrutiny Co-ordinating Committee at the earliest opportunity for endorsement. Thereafter, the report will be presented to Cabinet and other stakeholders as considered appropriate. Feedback and review is scheduled within six months of completion or within 28 where the recommendations relate to NHS bodies.

8. RECOMMENDATION

8.1 Members are recommended to agree the Adult and Community Services and Health Scrutiny Forum's remit for the Scrutiny investigation as outlined in this report.

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BACKGROUND PAPERS

The following background papers were used in the preparation of this report:-

(a) Developing Social Prescribing in Hartlepool, Commissioned by Hartlepool Partnership and Hartlepool Voluntary Development Agency – February 2006.

(b) Solutions not medication – Hartlepool NDC 2004

(c) Social Prescribing for Mental Health, Northern Centre for Mental Health – February 2004.