CABINET AGENDA

HARTLEPOOL
BOROUGH COUNCIL

Monday 13th March 2006

at 10:00 a.m.

in Committee Room B

MEMBERS: CABINET:

The Mayor, Stuart Drummond

Councillors Fortune, Hill, Jackson, Payne and R Waller

1. APOLOGIES FOR ABSENCE

2. TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS

3. MINUTES

3.1 To receive the Record of Decision in respect of the meeting held on 27th February, 2006 (*previously circulated*)

4. BUDGET AND POLICY FRAMEWORK

None

5. KEY DECISIONS

5.1 Final Second Local Transport Plan *(Director of Neighbourhood Services)*
5.2 Coronation Drive – Contaminated Land Update and Application to Defra Covering Remediation Costs *(Director of Neighbourhood Services)*

6. OTHER ITEMS REQUIRING DECISION

6.1 Safer Hartlepool Partnership – Annual Adult Drug Treatment Plan 2006/07 – (*Head of Community Safety and Prevention*)

6.2 Hartlepool Borough Council's response to the Strategic Health Authority's Consultation on PCT Re-configuration – (*Chief Executive)*

7. ITEMS FOR DISCUSSION

None

8. ITEMS FOR INFORMATION

None

9. REPORTS FROM OVERVIEW OF SCRUTINY FORUMS

None

EXEMPT ITEMS

Under Section 100(A)(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following items of business on the grounds that it involves the likely disclosure of exempt information as defined in the paragraphs referred to below of Part 1 of Schedule 12A of the Local Government Act 1972 as amended by the Local Government (Access to Information) Act 1985

10. EXEMPT KEY DECISIONS

None

11. OTHER EXEMPT ITEMS REQUIRING DECISION

None

CABINET REPORT

13th March 2006

HARTLEPOOL
BOROUGH COUNCIL

Report of: Director of Neighbourhood Services

Subject: FINAL SECOND LOCAL TRANSPORT PLAN

SUMMARY

1. PURPOSE OF REPORT

To consider and approve the draft final second Hartlepool Local Transport Plan.

2. SUMMARY OF CONTENTS

Background information and Executive Summary of draft final second Hartlepool Local Transport Plan.

3. RELEVANCE TO THE CABINET

Transport is the responsibility of the Portfolio Holders for Regeneration & Liveability and Culture, Housing & Transportation, but has relevance for the other Portfolio Holders also.

4. TYPE OF DECISION

This is a key decision (test ii applies).

5. DECISION MAKING ROUTE

Cabinet, 13 March 2006.

6. DECISION(S) REQUIRED

That the Cabinet approve the draft final second Hartlepool Local Transport Plan and authorise the Director of Neighbourhood Services to approve the final text version of the Plan for submission to the Government by 31st March 2006.

Report of: Director of Neighbourhood Services

Subject: FINAL SECOND LOCAL TRANSPORT PLAN

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1. PURPOSE OF REPORT

1.1 To consider and approve the draft final second Hartlepool Local Transport Plan.

2. BACKGROUND

2.1 The Local Transport Plan (LTP) is a strategic document that the Government requires the Council to produce every five years. It describes our long-term transport strategy and sets out our policies to deliver transport improvements to address local transport problems. These improvements represent a step-change in the delivery of a local transport strategy that will contribute towards achieving the long-term vision for Hartlepool set out in the Community Strategy.

2.2 The Transport Act 2000 made it a statutory requirement for local transport authorities to produce and implement a LTP that takes account of Government guidance. The current Hartlepool LTP covers the five year period from 2001 to 2006. The final second LTP for the period 2006 to 2011 must be submitted to the Government by 31st March 2006.

2.3 Hartlepool's provisional second LTP for the period 2006-2011 was submitted to the Government in July 2005 and included draft strategies, transport schemes, implementation programme and targets. Since this date, the provisional Plan has been further developed to take account of the confirmed allocation of capital funding and consultation on proposed transport improvements

2.4 Work is still on-going in finalising the detail of the final second LTP (Draft Executive Summary attached as **Appendix 1**) in accordance with the Government's Full Guidance on Local Transport Plans Second Edition (December 2004).

2.4 The following themes have focused the development of Hartlepool's provisional second LTP:

- **Setting transport in the wider context** – demonstrating the central role of transport in contributing towards the long-term vision for Hartlepool as well as regional strategies and national-level policies.
- **Shared priorities for Local Government** – delivering the shared priority of 'meeting transport needs more effectively' including Delivering Accessibility, Tackling Congestion, Safer Roads and Better Air Quality. Delivery of the shared priorities for transport will also contribute towards improving Quality of Life.

- **Analysis of local transport problems and opportunities** – informing existing evidence through involvement of local people, the business community, those delivering public services, adjacent local authorities and other key stakeholders affected by the LTP.
- **Delivering value for money** - ensuring that the Plan will deliver the best possible results, given the availability of funding and the existing state of infrastructure and services.
- **Consultation and involvement** – providing a timely and effective opportunity for all interested parties to contribute towards and influence the development of the Plan.
- **Monitoring and appraisal** – assessing progress towards delivering objectives through targets and indicators.

2.5 Following submission in March 2006, the Government will assess the final second LTP for quality of planning, impact of LTP targets and deliverability. The outputs of these assessments will be added to produce a final score and ranking for the LTP assessment as a whole in 2006. The Department for Transport anticipates that 50% of the final score will depend on plan quality, 30% of the score will depend on impact of LTP targets and 20% of the score will depend on deliverability.

3. CONSULTATION

3.1 The Council has paid particular attention to effective consultation and involvement of stakeholders in local transport in the development of the provisional second LTP. A comprehensive consultation and involvement programme commenced in November 2004. This programme has been focused on partnership working and public participation and consultation and included a Council Members' Seminar, one-to-one meetings with local stakeholders and public meetings, forums and exhibitions.

4. FINANCIAL IMPLICATIONS

4.1 There are no financial implications.

5. RECOMMENDATIONS

5.1 That the Cabinet approve the draft final second Hartlepool Local Transport Plan and authorise the Director of Neighbourhood Services to approve the final text version of the Plan for submission to the Government by 31st March 2006.

Appendix 1

EXECUTIVE SUMMARY

Introduction

This is Hartlepool's final second Local Transport Plan (LTP) which Hartlepool Borough Council is submitting to the Government in March 2006. This Plan describes how the Council and it's partners intend to build a high quality, integrated and safe transport system that supports Hartlepool's continued economic growth and regeneration.

Over the next five years we will work in partnership with other organisations and agencies to deliver a wide range of local transport schemes and policy measures to address the identified problems. These improvements represent a step-change in the delivery of a long-term transport strategy that will contribute towards delivering the shared central-local government priorities and achieving the long-term vision for Hartlepool.

In delivering our first LTP, a wide range of schemes and initiatives have been delivered to achieve targets, contribute towards the aims and objectives and address the identified problems. These successes have built a strong foundation on which the Borough's new long-term transport strategy and second LTP have been built.

The key priorities for the second LTP are to improve access the key services and facilities for those most in need, to improve safety and security, to manage forecast increases in traffic growth and congestion and to minimise the adverse impacts of traffic on air quality and climate change. The Plan also supports the wider quality of life objectives as part of Hartlepool Community Strategy.

Improving accessibility is considered to be the most important priority for Hartlepool. The barriers preventing people accessing employment, education and training and health care will be reduced by widening travel choice and horizons, increasing physical accessibility and reducing the cost of travel. In the longer term, we will reduce the need to travel by influencing the physical location of services and improve the way that services are delivered.

The roads will be made safer by reducing the incidence and severity of personal injury road crashes and creating a safer environment in which to travel. A new approach to road safety will focus on influencing driver behaviour through education, encouragement and enforcement initiatives. Engineering measures will reduce the incidence and severity of injury at road crash 'hot-spots' and support the safer routes to school programme.

The forecast increase in traffic growth and congestion will be minimised by encouraging a modal shift to more sustainable modes of travel, managing and maintaining the road network in the most efficient and effective way and improving the reliability of journeys for all modes of transport. The continued development and promotion of smarter choices will play an increasingly significant role.

The environmental impact of transport on local air quality will be reduced promoting the use of lower emission vehicles and cleaner fuels as well as encouraging more sustainable modes of travel by increasing awareness of the link between car use, air quality and climate change. Improved monitoring of air quality will enable early identification of developing air quality problems.

This Plan sets out a realistic, prioritised and deliverable programme of transport improvements that will deliver the best improvement in transport related objectives for the funding expected to be available. This includes making the best use of the existing transport network, maintaining assets in a cost-effective way, delivering benefits through managing demand for travel and influencing travel behaviour. The development of transport services and infrastructure

identified in this Plan will represent best value for money for the users, operators and the Council.

The Future Challenge

Hartlepool faces a number of challenges over the next 15 years. The key challenge is helping to ensure that we can support and maintain the Borough's continued economic growth without compromising our other priorities. It is clear from future traffic growth and congestion forecasts that travel and environmental conditions in the Borough could become unsustainable and threaten Hartlepool's economic prosperity and quality of life in the longer term. Transport has a key role to play in supporting the continued regeneration of the Borough by providing for the increased demand for travel and reducing inequalities and social inclusion.

Context for Developing the New LTP

The second LTP has been developed to support the wider policy and planning context. This includes the need to take account of those national and regional policies and agendas towards which transport can play a significant role. The key improvements that these agendas are trying to achieve include:

- Improved health and reduced obesity
- Increased educational attainment at all ages
- Reduced unemployment
- Creating safer and stronger communities
- Reducing social exclusion

At the local level, the LTP supports the objectives set out in a number of policy documents. These include the Hartlepool Community Strategy, Neighbourhood Renewal Strategy, Local Plan, Sustainable Energy Strategy and Climate Change Strategy. Transport has a significant role to play in the delivery of these wider objectives, providing opportunities for accessing education and employment opportunities, increasing the use of sustainable and more healthy modes, and by integrated planning to reduce the need to travel and promoting sustainable communities.

Building on our Success

In delivering our first LTP over the past five years, more than £13 million of capital funding has been invested to deliver a wide range of transport improvements across the Borough. This has helped to improve our transport systems and provide a better quality of life for our residents, employees and visitors and contributed towards achieving Hartlepool's wider vision and objectives.

Achievements to date include:

- Bus priority and pedestrian improvements on York Road 'super core' bus route corridor
- Design and commissioning of Tees Valley Real Time Passenger Information System
- Installation of CCTV on over 50% of Stagecoach Hartlepool's bus fleet
- Completing detailed design and securing all approvals required for the Hartlepool Transport Interchange project
- Introduction of decriminalised car parking enforcement
- Local safety schemes at Marina Way, Park Road and Seaton Carew
- Major highway junction improvements at Hart Lane/Raby Road and A689 Stockton Street/Hucklehoven Way
- Extension of the cycle route network including Burn Valley Gardens, Seaton Common and Brenda Road
- Travel plans adopted at 47% of all primary schools

- Easier access for the mobility impaired with raised kerbs provided at 31% of all bus stops, and over 300 dropped pedestrian crossings
- More people using rail services at Hartlepool and Seaton Carew railway stations
- Maintained good condition of our principal and unclassified road network

Consultation and Involvement

Particular attention has been given to enabling local people and organisations to contribute towards, and influence, the development and content of the second LTP. An extensive consultation and involvement programme specifically linked to the Plan commenced in November 2004. This includes co-operative working with relevant departments and divisions within the Council, discussions with neighbouring local authorities, involvement of a wide range of interested stakeholders and agencies as well as public exhibitions and surveys. A framework has been developed to take the Plan forward in partnership with key organisations over the next five years.

Transport Strategy

The new transport vision and strategy for the Borough has been based on the shared central-local government priority of 'meeting transport needs more effectively'. This includes:

- Delivering Accessibility
- Safer Roads
- Tackling Congestion
- Better Air Quality

Recognising the wider quality of life benefits that transport can bring, the strategy also reflects the broader vision for the Borough set out in the Community Strategy. This vision is being delivered through seven priority aims that relate to the shared central-local government priorities and represent key areas for Hartlepool's forward planning and prioritisation. These priority aims include:

- Jobs and the Economy
- Lifelong Learning and Skills
- Health and Care
- Community Safety
- Environment and Housing
- Culture and Leisure
- Strengthening Communities

Vision for Transport

Reflecting the central role of transport in contributing towards the long-term vision and priorities for Hartlepool's community, a new vision for transport has been developed:

'Hartlepool will have a high quality, integrated and safe transport system that supports continued economic growth and regeneration. It will provide access to key services and facilities for all members of society, promote sustainable patterns of development and movement and minimise the adverse effect of traffic on local communities and the environment. The development of transport services and infrastructure will represent best value for money for the users, operators and the Council.'

In achieving the key priority aims for accessibility, road safety, congestion and air quality, an improved 'quality of life' for all will be achieved. This includes promoting healthy living through more active lifestyles and wider access to health and social care and maintaining continued economic prosperity and regeneration by supporting the needs of the local economy in a sustainable manner.

Key Aims

This transport vision for Hartlepool will be achieved by the following key aims:

- To promote social inclusion by ensuring that everyone can **access** the key services and facilities that they need
- To improve the overall **safety** and security of the transport system for everyone
- To ensure that traffic **congestion** does not hinder economic development or cause severance to local communities
- To minimise the adverse impacts of transport on **air quality** and climate change

Transport Strategy Objectives

A number of objectives have been established to set out how to achieve the aims of the transport strategy. These objectives are shown under the transport priority they seek to support most, although they all support each of the priorities to some extent.

Delivering Accessibility

- To reduce the barriers to accessing employment, education and training and health care
- To support well located and designed development that reduces the need to travel

Safer Roads

- To reduce the incidence and severity of personal injury road crashes
- To create a safer environment in which to travel

Tackling Congestion

- To encourage more sustainable modes of travel, especially in urban areas
- To improve the reliability of journeys for all modes of transport
- To maintain, improve and make more efficient use of the existing highway network

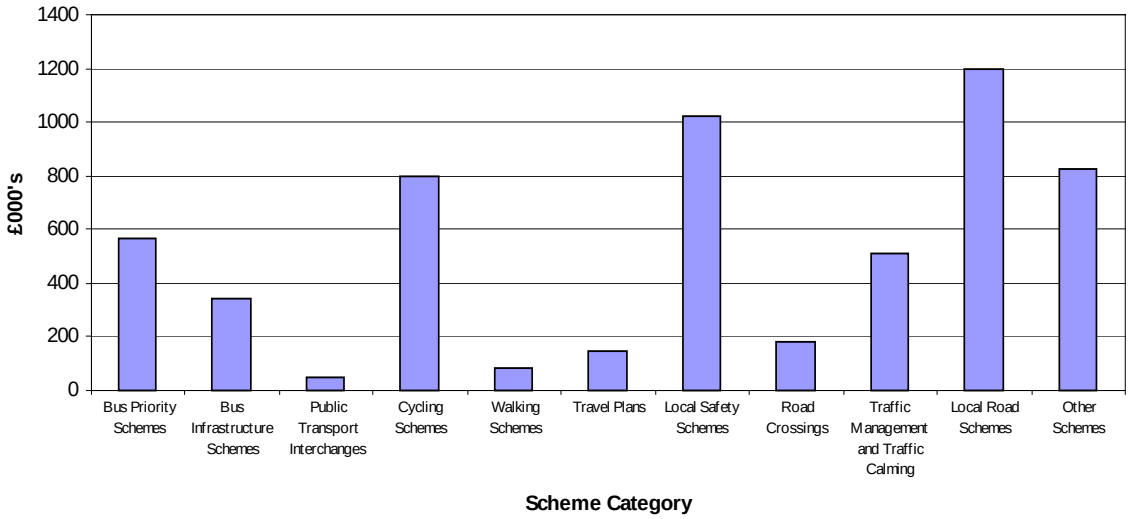
Better Air Quality

- To promote and encourage low emission vehicles and alternative fuels
- To increase awareness of the link between car use, air quality and climate change
- To improve the monitoring of local air quality

Delivering the Second LTP

The confirmed level of capital funding for the five-year period of the second LTP (2006/07 to 2010/11) is £10.476 million. This includes £5.726 million for Integrated Transport (Block) and £4.750 million for structural maintenance. This allocation is similar to the first LTP period.

Allocation of Integrated Transport Block Funding 2006/07 to 2010/11



The allocation of capital funding to different areas of the transport programme and their contribution to the shared priorities for transport are provided below.

Contribution to the Shared Priorities for Transport

Categories	LTP Funding	Contribution to Shared Priorities A	SR	C	AQ	QL
Integrated Transport						
Bus Priority Schemes (BL)	567	✓✓	✓	✓✓✓		✓
Bus Infrastructure Schemes (BI)	340	✓✓✓	✓	✓✓		✓
Public Transport Interchanges (IN)	50	✓✓		✓✓		✓
Cycling Schemes (CY)	800	✓✓✓	✓✓	✓	✓✓	✓✓
Walking Schemes (WA)	87	✓✓✓	✓✓	✓	✓✓	✓✓
Travel Plans (TP)	150	✓✓		✓✓	✓✓	
Local Safety Schemes (LS)	1,020	✓	✓✓✓			✓✓
Road Crossings (RC)	180	✓✓	✓✓✓			✓✓
Traffic Management and Traffic Calming (TM)	508	✓	✓✓	✓✓		✓
Local Road Schemes (RD)	1,197	✓	✓✓	✓✓✓	✓✓	✓
Other Schemes (OS)	827	✓✓	✓✓	✓	✓	✓✓
Sub-total	*5,726*					
Maintenance						
Highway Maintenance (MM)	4,400	✓✓	✓✓	✓✓✓		
Bridge Maintenance (MM)	350	✓	✓✓	✓✓		
Sub-total	*4,750*					
Total	**10,476**					

✓✓✓ - High contribution ✓✓ - Medium contribution ✓ - Low contribution

Delivering Accessibility

Reducing social exclusion, particularly for people from disadvantaged groups and areas, is identified as a key problem to be addressed in Hartlepool. The need to improve access to jobs, education and training, health care and commercial centres is a significant and recurring theme in both the Community Strategy and Neighbourhood Renewal Strategy. Improving accessibility is therefore considered to be the most important of the shared priorities for Hartlepool.

Although the majority of Hartlepool's residents can reach main destinations in Hartlepool within the specified journey times by public transport, it is the general accessibility issues that have the greatest impact on the travelling public. Difficulties with these issues have been strongly voiced through consultation with local people, organisations and communities throughout the development of the second LTP.

The Council recognises that it has a crucial role to play in improving accessibility through the planning, delivery and management of local transport as well as improving the provision of other services and developments. Working together with a wide range of local stakeholders, the Council has developed an Accessibility Strategy that forms a core part of the second LTP. It includes targeted accessibility assessments and action plans for areas, groups and issues.

Key Issues

The analysis of accessibility problems facing Hartlepool has identified the following key issues:

- Regional and National Connectivity
- Access to Health Care
- Access to Employment and Training
- Movement within the Town Centre
- Access for Demographic Groups
- Availability of Local Bus Services
- Coverage and Quality of Travel Information
- Cost of travel
- Personal safety and security
- Physical accessibility for people with mobility constraints

Key Priority

The key priority over the next five years is to improve accessibility to key services and facilities for disadvantaged areas and socially excluded groups of people in greatest need.

Strategy

The strategy for Delivering Accessibility is to work in partnership with other organisations to reduce the barriers to accessing employment, education and training and health care and to support well located and designed development that reduces the need to travel. The interventions planned to improve the level of accessibility over the five-year period of the second LTP include:

- Widening travel choice for people who do not have access to a car
- Widening travel horizons to help people know and understand available travel options
- Improving the reliability of travel for bus passengers and freight movements
- Increasing personal safety and security whilst travelling
- Increasing physical accessibility for people who are mobility impaired
- Reducing the cost of travel for young people, elderly people and people who do not have access to a car
- Reducing the need to travel by influencing the physical location of services and improving the way that services are delivered

Safer Roads

A wide range of road safety related schemes and initiatives have been delivered over the period of the first LTP to address many of the identified accident problems. This has resulted in reductions in the number of slight casualties as well as reducing the number of car occupants, pedestrians and cyclists injured on Hartlepool's roads. However, despite significant efforts, the Council's excellent performance in reducing the number of deaths and serious injuries in the 1990's has not been maintained. The location of road traffic accident has become increasingly dispersed as accident clusters have been treated.

It is evident that significant accident prevention work still needs to be done. The forecast increase in traffic growth will require a reduction in accident rates to avoid an increase in the number of collisions. Action needs to be taken to ensure that road danger does not impact on peoples' lives including community severance affecting the vibrancy of neighbourhoods, high traffic speeds generating more emissions, personal safety and security concerns contributing to poor accessibility and social exclusion and increased cost to the economy resulting from accident related congestion and injuries.

The Council recognises that it has a central role in reducing the impact of road accident casualties on the community and is committed to policies and actions that contribute towards improved road safety and achieving local and national casualty reduction targets in partnership with other organisations. A Road Safety Plan has been developed that forms a core component of the Borough's new transport strategy.

Key Issues

The analysis of road safety problems facing Hartlepool has identified the following key issues:

- Increasing traffic growth and congestion
- Deaths and serious injuries on the primary road network
- Increasingly dispersed location of road traffic accidents
- Poor safety of vulnerable road users
- Perceptions of personal safety and security

Key Priority

The key priority over the next five years is to improve the overall safety and security of the transport system for everyone.

Strategy

The strategy for Safer Roads is to work in partnership with other organisations and agencies to reduce the incidence and severity of personal injury road crashes and create a safer environment in which to travel. The schemes and initiatives planned to improve road safety over the five-year period of the second LTP include:

- Reducing the number of accidents and severity of injuries by targeting engineering measures at known accident 'hot-spots'
- Influencing driver behaviour and improving the skills of all road users
- Encouraging individuals to accept responsibility for their own and others safety
- Enforcing speed limits and traffic regulation orders
- Integrating road safety improvements with programmes for regeneration and neighbourhood renewal

Tackling Congestion

Traffic congestion has not been a key issue for Hartlepool through the first LTP period. However, traffic flows have increased steadily over recent years, particularly on the principal road network and in urban areas. Congestion is now starting to be experienced in the town centre during peak hours where the network is operating near to capacity. This congestion is starting to affect the punctuality of bus services, the reliability of freight movement, the safety of pedestrians and cyclists and air quality.

Computer traffic modelling work has indicated significant future traffic growth in line with increased demand and distance for travel following continued regeneration. This would result in congestion affecting a much larger part of the Borough's road network in the future. Left unchecked, this congestion could threaten Hartlepool's continued economic growth and prosperity, increase road danger and affect the environment and the quality of life.

Reducing congestion is at the heart of the Government's transport strategy. The Traffic Management Act 2004 imposes a duty on local traffic authorities to manage their networks to secure the expeditious movement of traffic (i.e. all road users) on their network, and to facilitate the same on the networks on others. The Council recognises that it has a crucial role to play in managing or mitigating the impact of congestion at the local level to implement the network management duty.

Key Issues

The analysis of congestion problems facing Hartlepool has identified the following key issues:

- Increasing levels of car ownership in line with economic growth and prosperity
- Increasing car use and dependency
- Increasing volumes of traffic on the primary and local road network
- Highway network operating at or above capacity
- Unreliability of journeys, particularly affecting bus passengers and movement of goods
- Changing patterns of employment in line with continued regeneration of the region
- Growing population as the regeneration of Hartlepool continues

Key Priority

The key priority over the next five years is to make sure that traffic congestion does not hinder continued economic development or impact on local communities.

Strategy

The strategy for Tackling Congestion is to work in partnership with other organisations and agencies to encourage a modal shift to more sustainable modes of travel, especially in urban areas, manage and maintain the road network in the most efficient and effective way and improve the reliability of journeys for all modes of transport. The schemes and initiatives planned to tackle congestion over the five-year period of the second LTP include:

- Providing facilities for sustainable modes of travel, including public transport, walking and cycling
- Promoting smarter choices
- Controlling the provision and availability of car parking
- Maintaining the highway network
- Increasing the capacity at junctions of the primary road network

Better Air Quality

There are currently no significant air quality problems in Hartlepool that are a direct consequence of transport. All objectives set out in the National Air Quality Strategy continue to be met and there is no need to declare an Air Quality Management Area at the present time. It is expected that this position will be maintained throughout the second LTP period.

However, road transport has been found to be the main source of ground level air pollution in Hartlepool. The condition of local air quality is gradually deteriorating as a direct consequence of increasing traffic levels. We need to ensure that increasing levels of road traffic and congestion will not make the situation worse for human health and the environment.

The Council recognises that it must play a leading role in encouraging the use of more sustainable modes of travel, managing traffic growth and minimising congestion to control and maintain local air quality and contribute towards tackling climate change. The interventions to be delivered through the strategy for Better Air Quality are aimed at reducing the environmental impact of transport at the source.

Key Issues

The detailed review and assessment air quality in Hartlepool has identified the following key issues:

- Road transport is the main source of ground level air pollution
- Increasing traffic growth and congestion on the primary and local road network
- The deteriorating condition of local air quality in the urban area
- The increasing impact of poor air quality on human health
- The growing threat of climate change resulting from carbon dioxide emissions, of which road transport is a major source

Key Priority

The key priority over the next five years is to minimise the impact that transport has on the environment to control and maintain local air quality and contribute towards reducing global warming and tackling climate change.

Strategy

The strategy for Better Air Quality is to work in partnership with other organisations to reduce the environmental impact of transport at the source. This includes promoting the use of lower emission vehicles and cleaner fuels as well as encouraging more sustainable modes of travel by increasing awareness of the link between car use, air quality and climate change. Improved monitoring of air quality will enable early identification of developing air quality problems.

The schemes and initiatives planned to control ad maintain local air quality over the five-year period of the second LTP include:

- Promoting the use of lower emission vehicles and cleaner fuels
- Increasing awareness of the link between car use, air quality and climate change to encourage more sustainable modes
- Improving the monitoring of local air quality to enable early identification of developing air quality problems

Targets and Monitoring

Monitoring of our progress towards achieving targets and objectives is an integral part of the delivering the Plan. The indicators and targets for the five-year period of the second LTP are as follows:

Performance Indicator	Target
Road condition (principal)	No overall deterioration in condition
Road condition (non-principal)	No overall deterioration in condition
Road condition (unclassified)	No overall deterioration in condition
Footway condition	No overall deterioration in condition
Number of deaths and serious injuries (all ages)	20% reduction from 2004 to 2010
Number of children killed and seriously injured	25% reduction from 2004 to 2010
Number of slight injuries	No increase over recent levels
Number of bus passenger journeys	3% annual decline to 2010
Bus passenger satisfaction	Maintain bus passenger satisfaction levels to 2009/10
Access to local health centres	To be confirmed
Number of cycling trips	No reduction in cycling levels
Mode share of journeys to school	No reduction in the ration between the total number of pupils and the total number of car journeys to school between baseline and 2010/11
Punctuality of local bus services	90% punctuality by 2014/15
Core bus route patronage	3% annual growth for 3 years on improved core bus route corridors
School travel plans	All schools to have an effective travel plan by 2010
Improvements to bus stops on core routes	All bus stop infrastructure on core bus routes to be improved by 2010
Rail passenger journeys	3% annual growth
Number of door-to-door passenger journeys	To be confirmed

CABINET REPORT

13th March 2006

Report of: Director of Neighbourhood Services

Subject: CORONATION DRIVE – CONTAMINATED LAND UPDATE AND APPLICATION TO DEFRA COVERING REMEDIATION COSTS

SUMMARY

1. PURPOSE OF REPORT

1.1 The purpose of this report is to update Cabinet in respect of progress made since the previous report of 6th September 2005 and to gain approval for the Director of Neighbourhood Services to apply to DEFRA for support covering the remediation costs, if required.

2. SUMMARY OF CONTENTS

2.1 The report includes:

(a) a progress statement;

(b) details of correspondence with DEFRA in connection with a potential application for funding for the remediation work.

3. RELEVANCE TO CABINET

3.1 This is a highly sensitive issue which is having a severe impact on the residents of a large residential estate.

4. TYPE OF DECISION

4.1 Key decision (test ii applies).

5. DECISION MAKING ROUTE

5.1 Cabinet, 13 March 2006.

6. DECISION(S) REQUIRED

6.1 That the Cabinet note the progress made.

6.2 That the Cabinet authorise the Director of Neighbourhood Services to apply to DEFRA for Grant to the value of up to £4.5m should this be required and to further research the concept of the Council having the power to carry out the remediation work in default.

6.3 That the Cabinet note that should the application for Grant be approved by DEFRA, a further report will be submitted requesting approval to carry out the remediation by tendering the works, utilising a select list procedure.

Report of: Director of Neighbourhood Services

Subject: CORONATION DRIVE – CONTAMINATED LAND UPDATE AND APPLICATION TO DEFRA COVERING REMEDIATION COSTS

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1. PURPOSE OF REPORT

1.1 The purpose of this report is to update Cabinet in respect of progress made since the previous report of 6th September 2005 and to gain approval for the Director of Neighbourhood Services to apply to DEFRA for support covering the remediation costs, if required.

2. PROGRESS

2.1 The statutory minimum three month consultation period in relation to the contaminated land determinations elapsed on 3rd November 2005.

2.2 The Council received a response on 3rd November 2005 from Vizards Tweedie Solicitors acting on behalf of one of the parties potentially responsible. This response contained a 19-page report prepared by W.S. Atkins, an Engineering Consultant, reviewing the document written by the Council's Consultant White Young Green Environmental (WYGE). This response contained Atkins' concerns regarding the methodology and sampling adopted by White Young Green.

2.3 Upon the request of the residents' committee the Engineering Manager (Alan Coulson), the Principal Engineer (Dave Thompson) and the Senior Engineer (Dennis Hancock), along with the Council's external legal advisor, Andrew Wiseman from Trowers and Hamlins Solicitors, all attended a resident's meeting held at the Staincliffe Hotel on 17 November 2005. This meeting was well attended by residents.

2.4 A response prepared by White Young Green to the W.S. Atkins report has been sent to Vizards Tweedie and a round the table technical meeting was held on 16th February 2006. White Young Green maintain that they have undertaken the assessment from a sound technical and scientific basis in accordance with the Part IIA Legislation and that their findings are consistent with the determination of the majority of the site as 'contaminated land'. Vizards Tweedie have advised that they wish to make further representations following the technical meeting and have been advised that these are required by Monday 6th March 2006. A meeting is to be held on this date between Council officers and the Council's technical and legal advisors to consider the way forward.

3. DEFRA CLARIFICATION REGARDING REMEDIATION GUIDELINES

3.1 Officers have been seeking clarification from DEFRA regarding their '3 Year Rule' under which DEFRA may provide Supported Capital Expenditure Revenue [SCE(R)] to the Council to undertake remediation works should the Council demonstrate that they have the power under the legislation to carry out the work.

3.2 The DEFRA rules for funding state that:

"capital support will not be available where a local authority expects to recover costs within three years. In cases where a local authority intends to recover its costs, or part of its costs, in the longer term, capital support may be available in relation to any costs which are not being recovered, for example where costs have been waived or reduced".

The Officers and the Council's legal advisor's interpretation of this was that funding would therefore be extremely limited because the Council would seek to recover the majority of costs from a Class A person.

3.3 DEFRA had written to the MP, Iain Wright, on 27th June 2005 and stated:

"In certain situations, authorities have the power under section 78N of the Act to undertake remediation, and can then seek to recover costs from appropriate persons subsequently. Our capital programme can help in such cases because it recognises that costs recovery may take several years and support may help cover a gap. We can consider bids where an authority does not expect to be able to recover its costs within three years, and can show why this is the case."

This statement, although very positive, seemed to contradict the funding rules (as discussed in paragraph 3.2 above). Officers therefore wrote to DEFRA on 31st October 2005 (letter attached as **Appendix 1**) pointing out the apparent ambiguity and asking them to explain.

3.4 DEFRA responded on 14th November 2005 (letter attached as **Appendix 2**) recognising in point 5 of their letter that our particular situation:

"was not explicitly addressed by the current guidance"

DEFRA stated that they would consider support to cover a gap where an appeal against a remediation notice looks certain thus making the way to cost recovery difficult. However they qualify this statement by saying "Of course, the point about whether the local authority has powers to remediate still applies, but if this can be dealt with then a bid for support can be considered".

3.5 The Council, in our particular situation under Part IIA legislation, only have the power to remediate following non-compliance with a remediation notice by an appropriate person. However an appeal against a remediation notice would mean that the notice is suspended and remediation could only be undertaken if there is imminent risk, which is not applicable in this case. There may, however, be other avenues available to the Council and this is discussed further in paragraph 3.8 below.

3.6 DEFRA however within their letter cite appeals against a remediation notice as a circumstance where the cost recovery looks uncertain and therefore further clarification was sought by Officers as to whether in this particular situation DEFRA would be willing to consider a bid for support by the Council.

3.7 DEFRA replied by e-mail and stated that:

"This is slightly difficult in the sense that DEFRA can't really comment on whether an LA has or doesn't have powers to do something under the law in a specific live case. This is a matter for you and your legal advisers. We outlined one possible scenario in paragraph 6 of my letter of 15 November, but we cannot tell if this or any other scenario applies in this case and it would not be our proper role here to attempt to. However, if you do conclude that you have the powers to remediate, then we are not going to try and second-guess this, and this is where the capital programme may be able to help as indicated in paragraph 5".

3.8 The Council's external legal advisor, Andrew Wiseman, has advised that an appeal suspends the Remediation Notice served upon the Appropriate Person. This means that the Appropriate Person does not need to take any action under the notice until the appeal is determined by the Courts. If there were believed to be an imminent risk then the Council would have the power to carry out remediation whilst the notice were suspended. If the Appropriate Person were successful in their appeal then the Council could not recover the money spent from them. It is arguable that as there is no imminent risk and if the notice were suspended pending the appeal, then the Council does not have the power to carry out remediation under the contaminated land regime. Having said that, if the Council considered it appropriate to carry out the remediation and DEFRA were willing to fund it (as they indicate they may be), it may not be an issue as specific consent may be able to be obtained from DEFRA or the Council may be able to use some other power (other than that under Part IIA) to carry out the remediation. However, this concept would need to be explored in more detail before this route could be recommended.

3.9 Should the Council proceed with remediation either by specific consent from DEFRA or using another power, it is considered that this should not prejudice the outcome of any cost recovery against the Appropriate Person being sought by the Council under the Part IIA legislation.

4. THE WAY FORWARD

4.1 As detailed in paragraph 2.4 above, a meeting will be held on 6th March 2006 to discuss the options available to the Council to progress considering the representations from the potential Class A person.

4.2 It may be that in order to secure remediation the Council must serve a remediation notice on the Appropriate Person. At this point the Appropriate Person must either comply with this notice or appeal against the notice within 21 days.

4.3 In advance of any potential appeal by the Appropriate Person, approval is sought from Cabinet for the Director of Neighbourhood Services to apply to DEFRA for financial support to undertake the remediation currently estimated at a maximum cost of £4.5m. Advice is currently being sought from specialist remediation contractors in respect of the options available for remediation. It is imperative that any submission to DEFRA is technically sound, environmentally sustainable and financially viable. Approval to apply immediately for financial support is being sought at this point in time in order to avoid any unnecessary delays further down the legislative process.

4.4 If the appeal by the Class A person were unsuccessful, then that would mean that the Class A person would have to carry out the remediation or, if the Council had already carried out the remediation, pay the Council's reasonable costs.

4.5 There are various grounds of appeal open to the Appropriate Person, examples of which are that they may consider that they are not the correct Class A person through to considering that the type of remediation being required is unreasonable. What happens after a successful appeal would depend on the Court's findings. If, for example, the Court found that they were not the correct Class A person, then the Council would have to go against whoever was the correct Class A person. If the court decided that the remediation being requested was unreasonable then the Class A person would have to carry out remediation that was viewed to be reasonable.

5. FINANCIAL IMPLICATIONS

5.1 DEFRA have provided CLAN (Contaminated Land Advisory Note) 1/06 which sets out, for Local Authorities, a guide to the DEFRA Contaminated Land Capital Projects Programme for 2006/07. This guide now appears to reflect much of the correspondence quoted in Section 3 above.

5.2 The way in which DEFRA fund contaminated land schemes has changed significantly. Support will now be delivered by direct grants made to the Council under section 31 of the Local Government Act 2003, instead of support via additions (called SCE(R) loan sanctioning) to the Council's Revenue Support Grant.

This is a significant benefit to the Council, as the Council does not need to budget for repayment of the loan from existing revenue funding.

5.3 The disadvantage of this change is that there is an expectation that more Councils' may apply for funding for contaminated land projects. Applications will therefore be prioritised by DEFRA against the available resources which will be increasingly committed as the financial year proceeds. An early application is therefore imperative.

6. DECISION(S) REQUIRED

6.1 That the Cabinet note the progress made.

6.2 That the Cabinet authorise the Director of Neighbourhood Services to apply to DEFRA for Grant to the value of up to £4.5m, should this be required, and to further research the concept of the Council having the power to carry out the remediation work in default.

6.3 That the Cabinet note that should the application for Grant be approved by DEFRA, a further report will be submitted requesting approval to carry out the remediation by tendering the works, utilising a select list procedure.

Appendix 1

OFFICERS LETTER

Letter to:
Steven Griffiths
Contaminated Land Branch (LEQ)
DEFRA
Zone 4/D11
Ashdown House
123 Victoria Street
London
SW1E 6DE

31 October 2005

Dear Mr Griffiths

Part IIA and Coronation Drive

Thank you for you letter dated 26th October 2005.

I note that you are willing to assist with specific questions about the funding rules or policy, and, therefore I would be most obliged if you could provide clarification of the following issues, prior to the next residents meeting on Thursday 17th November 2005: -

- In correspondence dated 27 June 2005 ref 218054 from Ben Bradshaw, Minister for Local Environment, Marine and Animal Welfare to Hartlepool's MP, Iain Wright the penultimate paragraph states "In certain situations, authorities have the power under section 78N of the Act to undertake remediation, and can seek to recover costs from appropriate persons subsequently. Our capital programme can help in such cases because it recognises that cost recovery may take several years and support may help cover a gap. We can consider bids where an authority does not expect to be able to recover its costs within three years, and can show why this is the case".

- Yet, the guide for Local Authorities to the Contaminated Land Capital Programme 2005/06 Section 5 covers cost recovery by Local Authorities. Sub-section 5.3 states that "capital support will not be available where a local authority expects to recover costs within three years. In cases, where a local authority intends to recover its costs, or part of its costs, in the longer term, capital support may be available in relation to any costs which are **not** being recovered, for example where costs have been waived or reduced".

I would be most obliged if you could explain the apparent ambiguity between the above two paragraphs.

- Iain Wright MP has written the Council's Chief Executive following receipt of the correspondence from DEFRA, requesting that the Council consider the option of undertaking remediation work promptly, funded through DEFRA's Contaminated Land Capital Projects Programme, whilst simultaneously seeking to recover costs from any Class A polluter. The MP has also written to the residents in the same vain.

I would be most obliged if you could advise whether the MP's request to the Council can be accommodated within the funding regime rules.

Yours sincerely,

Ian Parker
Director of Neighbourhood Services

Appendix 2

DEFRA LETTER

zone 4/D11
Ashdown House
123 Victoria Street
London SW1E 6DE

Telephone 020 7082 8565
Website www.defra.gov.uk

74295

defra
Department for Environment
Food and Rural Affairs

Ian Parker
Director of Neighbourhood Services
Hartlepool Borough Council
Bryan Hanson House
Hanson Square
Hartlepool
TS24 7BT

AC

Your ref IP/DH/SD/EN100
Date 14 November 2005

Dear Mr Parker

Part IIA and CORONATION DRIVE

1. Thank you for your further letter of 31 October in respect of the above mentioned site. You asked if we can explain the "apparent ambiguity" between references made in Ben Bradshaw's letter of 27 June to Iain Wright MP and paragraph 5.3 of our capital programme guidance note CLAN 1/05, "A Guide for English Local Authorities".

2. I think the best way I can help to clarify matters is to set out more fully how we see the rules working, which I hope will remove any confusion or ambiguity.

3. First, as Ben Bradshaw's letter to Iain Wright MP indicated, before we can consider any application under our programme, the authority will have to satisfy itself that it has the powers to carry out the remediation, in accordance with the 1990 Act. This point is made in the first sentence of para 5.1 to our CLAN guide. Defra could not readily give capital support to a project where it appeared that the local authority did not have powers to carry it out. Whether an authority has the powers to carry out works is a matter for the authority of course, and the law in Part IIA is complicated in this area. We do not know if or how far your authority has explored its powers to remediate, given the fact that it is (we understand) pursuing a potential appropriate person under the Act, but presumably it will be doing so if it is considering undertaking remedial action. In relation to the bid submitted recently, we have as you know asked about powers.

4. Second, if we assume that the council has powers to remediate, then paragraph 5.3 of our CLAN sets out the general eligibility criteria. It says that support will not be available where a local authority expects to recover costs within three years. It goes on to note that in cases where LAs intend to recover costs, or part, in the longer term, we can support costs which are not being recovered, for example where costs have been waived or reduced. The sort of situation covered here is where, at the time of the bid for support, the liabilities are established, the way ahead to recovery looks clear, and the costs which can't or won't be recovered are capable of being gauged. One example of this is where charging notices on property are being used. In other words, our support can help meet the gap between what can be recovered, and what cant, for example because recovery is limited by the hardship rules.

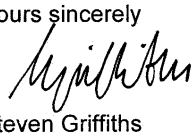
5. Thirdly, there is a situation which is not explicitly addressed by the current guidance, and which may be relevant here. This is where costs recovery looks difficult or uncertain, as well as long-term, for some reason. For example where an appeal against any remediation notice or other legal disputes look certain, but not much else is clear. In such situations we can consider applications for capital support to cover a gap. Of course, the point about whether the LA has powers to remediate still applies, but if that can be dealt with then a bid for support can be considered, even though the CLAN 1/05 guide doesn't deal with this possibility explicitly.

6. Examples of where powers to remediate might arise even though there is one or more appropriate persons who may be liable are the cases outlined at section 78N(3)(b) and (e) of the Act (see also the description in Annex 2 of DETR Circular 02/2000 at paras 11.1 to 11.11 which is a helpful explanation of the situations where LAs may be undertaking remediation). We do not know whether this case would fit those provisions.

7. I cannot advise whether remediation by the authority is possible in this case. It is for your authority, not Defra, to explore such questions in the light of its powers and duties and the full facts of the case. We are not in a position to know the facts. We also need to ensure that we do not prejudge the outcome of any appeals which may come to the Secretary of State in future, or appear to be taking sides. But the short answer to your question is that if the authority has the powers, then we should be able to consider a bid. As you know we can only support the capital cost, and some directly associated project costs, and not for example legal work.

8. I hope this is helpful. As I think we have indicated before, we do not look for reasons to withhold support and while the legislation and funding rules make for a rather complicated package it is normally possible to assist authorities' projects.

Yours sincerely



Steven Griffiths
Contaminated Land branch (LEQ)

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Email steven.griffiths@defra.gsi.gov.uk

CABINET REPORT

13th March, 2006

Report of: The Head of Community Safety and Prevention

Subject: SAFER HARTLEPOOL PARTNERSHIP – ANNUAL ADULT DRUG TREATMENT PLAN 2006/07

SUMMARY

1. PURPOSE OF REPORT

1.1 To consider the Safer Hartlepool Partnership Drug Treatment Plan for 2006/07 which needs to be submitted to the National Treatment Agency (NTA) by 23rd March 2006.

2. SUMMARY OF CONTENTS

2.1 The Safer Hartlepool Partnership is responsible for the local implementation of the Governments 10year drug strategy and all associated monitoring requirements. An annual Adult Drug Treatment Plan is required by 23rd March and is a key performance-monitoring tool. The Plan contains a summary of the local drug situation, a self-assessment of local services against the national service framework, an illustration of financial investment and comprehensive action plans for service development and improvement.

2.2 A draft of the Adult Treatment Plan 2006/07 has already been submitted to the NTA who organised a meeting of regional stakeholders and Safer Hartlepool Partnership representatives to consider the information and offer suggestions for improvement. A formal response from that meeting is still awaited and any suggestions will need to be incorporated into the Plan prior to the final return by 23rd March. Thereafter the Treatment Plan will have its status of being a Red, Amber or Green Plan confirmed and be signed off as a formal agreement of activity.

2.3 The draft Plan has also been made available to a wide audience for comment including the three Neighbourhood Consultative Forums, stakeholders, the Primary Care Trust, user groups and service providers and the Safer Hartlepool Partnership Executive.

2.4 The Adult Treatment Plan 2006/07 illustrates the success of planned improvements including an extension to the Community Drug Centre and increased number of criminal justice interventions and programmes. There have been 563 problem drug users into treatment against a target of 432, waiting times to access treatment are now averaging 1.7 weeks (well within the national target of 3 weeks) and 71% of those referred are retained in treatment for longer than 12 weeks against the LDP target of 45% of referrals.

2.5 This success on the key performance indicators above will need to be maintained with more challenging targets already agreed for 2006/07: -
Section 1.01 Numbers into treatment - 630
Waiting times across various modalities e.g. 80% of referrals access specialist prescribing within three weeks
Retention - 77% of caseload retained in treatment longer than 12 weeks.

2.6 Additional finance has been secured with a significant increase in the allocation through the Home Office Adult Pooled Budget up over 40% to £1,096,460, and continued funding for the Drug Intervention Programme, Persistent and Prolific Offender programme, Restrictions on Bail and from April 1st Tough Choices.

2.7 The self assessment in part 2 of the plan confirms the need for focussed work on harm reduction activity and the action planning grids in Part 3 of the Plan provide detail on a wide range of specific service developments ranging from preventative educational campaigns and training, support to families, increased treatment modalities and the strengthening of Tier 4 specialist support and mental health links.

3. RELEVANCE TO CABINET

3.1 The submission is a partnership document, which covers a number of areas, including community safety and crime.

4. TYPE OF DECISION

4.1 Non Key.

5. DECISION MAKING ROUTE

5.1 Cabinet Meeting 13th March 2006.

6. DECISION(S) REQUIRED

6.1 To consider and support the Annual Drug Treatment Plan submission for 2006/07.

Report of: The Head of Community Safety and Prevention

Subject: SAFER HARTLEPOOL PARTNERSHIP – ANNUAL

1. PURPOSE OF REPORT

1.1 This report illustrates the reporting requirement for the Safer Hartlepool Partnership on the national drug strategy and local drug issues and seeks support of the annual Adult Drug Treatment Plan for 2006/07 prior to submission to the National Treatment Agency.

2. BACKGROUND

2.1 The Governments 10year National Drug Strategy, as detailed in 'Tackling Drugs Together', then updated in 2002 requires local Community Safety Partnerships or Drug Action Teams to deliver objectives and local targets in 4 key areas:-

Reducing the availability and supply of drugs
Preventing young people becoming involved in drugs
Reducing the negative impact drugs have on communities
Providing more, effective and better treatment.

2.2 Originally Hartlepool Drug Action Team (DAT) was responsible for the implementation of the national drug strategy due for completion by April 2008 however the merger of the DAT with the Crime Reduction and Disorder Partnership and Youth Offending Service provides an overarching Safer Hartlepool Partnership that now addresses the collective agenda of:-

Reducing crime and fear of crime
Tackling drug issues
Managing the Youth Offending Service

2.3 The Safer Hartlepool Partnership(SHP) chaired by the Mayor has been able to consider the above objectives and provide a strategic response to the often integrated problems and links between the prevention of crime, drug use and associated crime funding drug misuse.

2.4 Within the SHP structures there are a number of operational task groups that lead on elements of crime and disorder or the youth agenda, and the drugs strategy has at least five sub groups with ad hoc working parties developed as and when needed to inform the Executive and ensure local drug policy and targets are delivered.

2.5 Following the update of the national drug strategy there has been a focus and introduction of initiatives dealing specifically with the links between crime and

drugs. The Drug Intervention Programme(DIP), Persistent and Prolific Offenders project(PPO), and Restrictions on Bail(ROB) have been successful in engaging offenders into treatment and from April 2006 Tough Choices will also be introduced into Hartlepool.

3. MONITORING OF THE NATIONAL DRUG STRATEGY

3.1. The Home Office Drug Directorate, the National Treatment Agency (NTA) and the Government Office North East Drug Team (GONE) who link closely with Government Office Crime and Disorder Teams monitor the National Drug Strategy in the main.

3.2. Information continues to be provided through annual plans, quarterly progress reports, monthly statistical returns, mid and year end meetings with Regional Panels and NTA/GONE representatives attend a variety of Safer Hartlepool meetings. Hartlepool Primary Care Trust and the Strategic Health Authority have additional separate systems for health information reports.

3.3. There are additional performance management frameworks for some of the criminal justice drug projects however drug issues are to be focussed through the Hartlepool Crime Disorder and Drug Strategy 2005 – 2008 and future Local Area Agreements, whilst still retaining some discrete reporting structures.

3.4. The Performance Management Framework or COMPACT has been removed as has the need for a Young Peoples Substance Misuse Plan however the most comprehensive plan that for Adult Drug Treatment remains.

4. ADULT DRUG TREATMENT PLAN 2005/06

4.1 The Plan (Appendix 1) relates to adult drug treatment services only and consists of three main parts:-

(i) a strategic and financial statement of current and proposed service development, targets and investment from drug specific and mainstream budgets.
(ii) A self assessment of progress against a number of areas or tiers of service some of which form the National Health Service framework or Models of care quality standards
(iii) Specific action planning grids detailing objectives, tasks, lead agencies, timescales and finance.

4.2 The strategic summary confirmed through Police intelligence, service providers and local research confirms that heroin continues to be the adult main illegal drug of choice. There is use of cocaine and crack but unlike other areas there has not been a significant expansion of crack use. Local drug users acknowledge police activity to close crack houses quickly has had an impact.

4.3 There has been improvement to the national process of gathering statistical detail on numbers entering treatment but there are still some anomalies and baseline targets set in previous years are now acknowledged as being too low. Hartlepool had an LDP target of 432 problem drug users into treatment and has exceeded that with 563 in treatment by January 2006.

4.4 The criminal justice initiatives such as Dordrecht, Drug Intervention Programme and Restrictions on Bail have been of particular value with over 250 of those in treatment engaged through these routes.

4.5 Hartlepool benefited in 2005/06 from increased drug funding for the criminal justice programmes this will continue in 2006/07 and the Home Office Substance Misuse Pooled Budget annual allocation has had a 41% uplift that is £1,096,460 making a total of over £3,000000 available.

4.6 The Safer Hartlepool Partnership inherited from Hartlepool DAT a three year drug treatment development strategy, which is now bearing fruit. Capital investment in 2005/06 has doubled the size of the Community Drug Centre, the reconfiguration of services has established a local Substance Misuse Services with increased nursing staff and prescribing options. Additional investment has also been meant more complimentary support through intensive outreach, family support and harm minimisation facilities.

4.7 Part 2 of the Plan illustrates through means of a traffic light assessment progress against the national framework of services. In general progress has been consistent and apart from activity related to harm reduction Hartlepool is deemed to be green/amber in terms of service delivery.

4.8 Priorities for 2006/07 continue to be the development of GP involvement and Shared Care healthcare. Primary care Liaison staff have been appointed to work in GP surgeries and Pharmacists are also expanding their services to support drug users and families.

4.9 Housing and secure accommodation is a prerequisite for any individual to be able to sustain drug treatment and change their circumstances. Partnership work continues to develop opportunities with necessary all the protocols, practice and floating support to strengthen tenancy status of drug users. In addition further liaison with employment, training and education agencies will allow further options for users to improve their lives. Part 3 of the Plan offers more detail of the range of tasks and milestones required to tackle and ensure improved service development.

4.10. A draft of the 2006/06 Adult Treatment Plan 2006/07 was developed through a series of meetings and workshops and agreed through the appropriate Task Groups, Joint Commissioning Group and Safer Hartlepool Partnership Executive being submitted to the NTA in January. A wider audience were invited to comment through presentations at Neighbourhood Consultative Forums, user and provider groups.

4.11 Following the draft submission a meeting between representatives of Safer Hartlepool Partnership and the Regional NTA Panel of stakeholders took place in February when the detail was discussed.

4.12 A formal letter is expected from the NTA Panel, which will identify any amendments and areas that the Plan need to address. Once received these suggestions and any other comment will be considered and a final Plan produced. The final Plan needs to be submitted by 23rd March thereafter the NTA will confirm the status of the Plan (Red/Amber/Green), will sign it off with the Partnership and monitor regularly against the targets and activity contained in the Plan.

5. RECOMMENDATIONS

5.1 Members are requested to confirm their support to the Safer Hartlepool Partnership Adult Drug Treatment Plan 2006/07.

CONTACT OFFICER: Chris Hart, Planning and Commissioning Manager

Background Papers

Drug Strategies

NTA Guidance for Annual Treatment Plan 2006/07
Audit and Performance data – Safer Hartlepool
JCG Minutes and budget – Safer Hartlepool

Appendix to 6.1

Safer Hartlepool

DRAFT 2

Adult drug treatment plan 2006/07

Part 1: Strategic summary, national targets, partnership performance expectations and funding profile

This strategic summary, self-assessment and attached planning grids have been approved by the Partnership and represent our collective action plan.	
Signature	*Signature*
Chair, Partnership name	Chair, Adult joint commissioning group

Section A Strategic summary

A1 Partnership drug treatment strategy

Hartlepool is a compact district with a fairly static drug using community. To maximise resources and sustainability Safer Hartlepool Partnership (SHP) is working towards a fully integrated response to drug issues in order that there is a comprehensive holistic response to an individuals needs. SHP provides the co-ordination of strategic planning and development of initiatives with services promoting them selves under the umbrella of SHP.

The Community Drug Centre in Whitby Street is the nucleus of prescribing, healthcare and wraparound services but links with numerous other agencies and outreach activity provide locality access and referral routes to cater for the widest need. Increased space has ensured
More prescribing and health facilities, non-prescribing responses, involvement of other agencies e.g. SSD, health visitors, midwives and generally assisted in more effective care planning, targeted programmes and packages of support being available.

The reconfiguration of the above practice Substance Misuse Service (SMS) addresses both prescribing across the whole system and also delivers healthcare and harm minimisation initiatives. The clinical lead working through the SMS has responsibility for developing and encouraging shared care and support to GP practices with dedicated primary care liaison staff, and additional investment identified for 2006/07.

Core treatment providers have designed and implemented common processes and systems which include information sharing, joint protocols**,** shared case files, improved care pathways and joint care planning, reviews individualised support packages. These relationships continue to be reviewed and built upon to improve the quality and effectiveness of responses to drug use. User involvement, community and voluntary sector participation has also been encouraged and is much valued in shaping services fit for future operation.

Over 2005/06 the Hartlepool model of service provision is coming to fruition. The criminal justice initiatives are making significant contact and encouraging increasing numbers of drug using offenders into treatment, waiting times are within national targets, investment has been given to wrap around support, aftercare and opportunities to reintegrate individuals back into mainstream services and the community. Local monitoring detail and NDTMS data is assisting analysis of progress and shape of future developments.

SHP aim to continue with such improvements and consolidate the activity, processes and joint work of the treatment services with an emphasis on ensuring an equal partnership with service users in determining care plans and treatment received whilst facilitating family participation too.

A2 Summary of problem drug situation

Safer Hartlepool Partnership seeks to address the needs of at least 882 problem drug users through a range of initiatives that will engage, retain and assist individuals to successfully complete treatment programmes in line with their aspirations.

Due to the fairly static community within Hartlepool the majority of pdu's are known to the system and this knowledge is used within PPO and similar targeting exercises. Over 550 individuals will have accessed Tier 3 treatment in 2005/06 with up to another 150 having made contact with Tier1/2 services for help. SHP are not complacent and in long term planning have considered research by the Edge/consultant and Addvance in 2004/5 suggestion there could be 1, 200 Hartlepool people using a range of drugs though not experiencing any issues nor seeking help

Generally there is a closed drug market with numerous low-level dealers operating to fund their own habits. Of those accessing treatment approximately 68% will be male with similar profiles across the criminal justice initiatives apart from Dordrecht. The greatest use is by 18 – 29 year olds the more prolific age group for males tends to be those aged 25 – 29 years, for women it is those aged 18 – 24 years with a slight reduction in the younger age groups using class A drugs.

The percentage of bme community in Hartlepool is very small which is reflected in numbers attending treatment services. Activist within the bme community suggest to protect confidentiality and culturally some bme drug users move to family support outside of the area to deal with their addictions.

Those presenting to treatment agencies come from all areas of Hartlepool however higher numbers of referrals come from the Town Centre areas of Stranton, Belle Vue and Dyke House where there is a concentration of poor housing. Access to stable accommodation is fundamental to the drug users ability to address their addiction and is a priority for 2006/07.

The majority of Hartlepool pdu's are poly-drug users but an analysis of 2004/05 declared primary drug use shows use of heroin (over 75%) followed by crack (0.8%) and cocaine (0.4%).
There is of course variation between the age groups with over half of the 18's and under using cannabis as their primary drug of choice with those over 40 years using alcohol.

Analysis of data from tests of those arrested for trigger offences indicates that there may be a slight decrease of heroin use alone, with an increase in use of heroin and crack together. This will be considered together with the Crack research completed December 06 by Stuart Honour and Addvance group. The local research involved predominantly long term and crack users and was a follow on from the 2004 exercise to assess the emergence of crack market. This local research is suggesting that there has not been a significant upsurge in crack use and amongst the findings that will need to be considered in greater detail only 12% of sample used crack every day compared to 70% who used heroin daily. Crack is seen by this sample group as a luxury or treat used as and when finance allows. For those using crack regularly daily spend could be of the order of £30,720 per annum (£85 per day) regular heroin users daily spend is on average £14,892 (£40 per day). Heroin spend when compared with 11 other districts where this research has taken place is near he bottom of the league. Bradford £24,192, Newcastle £14,305.

National research suggests the link between acquisitive crimes to drug misuse and analysis of trigger offences (JSU) would seem to support the success of the programmes. In 2004/05 Hartlepool overall crime and trigger offence rates decreased at a greater pace that Tees Valley as a whole, 11% for overall crime and 20% for trigger offences bettered only by Darlington (21%).
DIP and other local criminal justice initiatives have been successful in contacting and engaging Drug using offenders into treatment. Whilst most are known and may have been/are in treatment there are many who continue to revolve through he system without a sustained positive outcome. In 2006/07 investment and changes to operation will look to intensifying proactive support to assist these individuals being retained in treatment and therefore more successful in addressing their drug use and criminality.

Across the drug treatment system there is an acknowledgement that local services have improved, waiting times are down and in many cases lower than the national targets, substitute medication levels are more appropriate and staff attitudes and relationships with service users are better.

A3 Partnership key treatment priorities

- Expand Shared Care through training, protocols and practical support of dedicated staff
- In conjunction with Supporting People and housing providers increase the opportunities to address housing needs of drug mis-users/offenders.
- Develop family support initiatives and encourage family/carers engagement in treatment
- Implement harm reduction strategy including initiatives to reduce drug related deaths
- Develop Safer Hartlepool Alcohol Strategy with associated links to drug, substance misuse, crime and disorder.
- Participate through Community Safety/Crime and Drugs Strategy and similar strategies to have an integrated approach to crime, substance misuse and drugs locally.

Section B National targets

B1 Numbers of drug users in treatment (adults and young people)

B1.1 Estimated number of problem drug users (PDU) in partnership area	882	Source	Home Office
Local estimate of problem drug users in Partnership area	1,200	Source	The Edge/Linda Wright/Addvance 2004/05

Data to be used is always DAT of residence		**Performance 2004/05**	**Target 2005/06**	**Target 2006/07**	**Target 2007/08**
B1.2 Total number in treatment	LDP(T43)	412	432	(477)	(527)
	Partnership target	533	570	630	750
B1.3 Percentage change over previous year	LDP	12.5%	4.9%	(10.4%)	(10.5%)
	Partnership target	45.6%	4.87%	12.7%	17.9%
B1.4 Percentage of PDUs in treatment	LDP	46.7%	49%	(54%)	(60%)
	Partnership target	60%	63%	71%	85%

B2 Retention rates

Data to be used is always DAT of residence		**Performance 2004/05**	**Target 2005/06**	**Target 2006/07**	**Target 2007/08**
B2.2 Percentage retained in treatment for 12 weeks or more	LDP	38%	45%	50%	55%
	Local target		65%	70%	75%
	Partnership target	71%	71%	77%	84%

B3 Waiting times targets

First treatment intervention	**Partnership performance %**	**Planned performance %**		
	31 Dec 2005	**31 March 2006**	**31 March 2007**	**31 March 2008**
Inpatient drug treatment	75%	78%	82%	85%
Residential rehabilitation	68%	70%	77%	85%
Specialist prescribing	78%	80%	83%	85%
GP prescribing	85%	87%	88%	88%
Structured day programmes	40%	62%	74%	85%
Counselling	50%	60%	77%	85%
Other structured treatment	57%	60%	72%	85%

Subsequent treatment intervention	**Partnership performance %**	**Planned performance %**		
	31 Dec 2005	**31 March 2006**	**31 March 2007**	**31March 2008**
Inpatient drug treatment	74%	78%	82%	85%
Residential rehabilitation	80%	83%	85%	85%
Specialist prescribing	80%	83%	85%	85%

GP prescribing	90%	90%	90%	90%
Structured day programmes	65%	70%	75%	85%
Counselling	75%	75%	80%	85%
Other structured treatment	60%	70%	78%	85%

Section C Partnership performance expectations

Drug treatment system – partnership performance plans

C1 Successful completions

Successful completions = discharges who complete treatment or are referred on for other services	**National average 2004/5**	**Partnership performance %**	**Planned performance %**		
		2004/05	**2005/06**	**2006/07**	**2007/08**
Inpatient drug treatment	38%	47%	50%	55%	60%
Residential rehabilitation	40%	65%	70%	75%	75%
Specialist prescribing	30%	30%	54%	65%	75%
GP prescribing	30%	39%	40%	42%	44%
Structured day programmes	31%	32%	36%	40%	42%
Counselling	30%	30%	66%	75%	80%
Other structured treatment	32%	-	45%	54%	60%

C2 Places in treatment

	Actual number of places commissioned		**Proposed number of places to be commissioned**	
	2004/05	**2005/06**	**2006/07**	**2007/08**
Inpatient treatment	42	12	24	24
Residential rehabilitation	40	25	25	25
Specialist prescribing	400	600	720	800
GP prescribing	20	20	90	200
Structured day programmes	70	80	90	100
Counselling	40	45	80	100
Other structured treatment	160	250	300	300

C3 Primary care prescribing services

	Actual %	**Planned performance %**		
	2004/05	**2005/06**	**2006/07**	**2007/08**
C3.1 Percentage of all GPs prescribing	2.6%	5%	7%	9%
C3.2 Percentage of GPs in shared care	2%	4%	11%	16%
C3.3 Percentage of GP practices in shared care	9%	13%	19%	31%

Criminal justice – Drug Interventions Programme (DIP)

C4 Custody suite and court based interventions – non-intensive DIP areas only. Please note performance requirements for intensive DIP areas are agreed via Compact targets

	Expected performance 2005/06	Planned performance 2006/07	Planned performance 2007/08
C4.1 Proportion of adults who are not on the CJIT caseload with whom contact is made, who are assessed by CJIT	N/a	N/a	N/a
C4.2 Proportion of adults assessed by the CJIT as needing a further intervention who are taken onto the caseload	N/a	N/a	N/a
C4.3 Proportion of adults taken onto caseload who engage in treatment	N/a	N/a	N/a

C5 Throughcare/aftercare – non-intensive DIP areas only

	Expected performance 2005/06	Planned performance 2006/07	Planned performance 2007/08
C5.1 Number of CARAT referrals from prisons	N/a	N/a	N/a
C5.2 Proportion of CARAT clients for whom follow up action was taken by CJIT	N/a	N/a	N/a

Criminal justice – community sentences

C6 Community sentence with drug rehabilitation requirement (including DTTOs)

	Performance 2004/05	NPD Target 2005/06	NPD Target 2006/07 (if known)	NPD Target 2007/08 (if known)
C6.1 Commencements	22	23	Not known	Not known
C6.2 Successful completions (number)	4	9	Not known	Not known

Harm reduction initiatives

C7 Vaccinations against Hepatitis B Virus (HBV)

	Performance	Planned performance		
	2004/05	**2005/6**	**2006/07**	**2007/08**
Number of individuals offered HBV vaccinations	30	150	170	200
Number of individuals who take up HBV vaccinations	30	135	153	180

C8 Proportion of current or ever injecting drug users tested for Hepatitis C Virus (HCV)
*** Implications for support following tests immense. Debate required with Health**

	Performance	Planned performance		
	2004/05	**2005/6**	**2006/07**	**2007/08**
Percentage of current or ever injecting drug users tested for HCV	0%	14%	16%	20%

C9 General healthcare assessment

	Performance	Planned performance		
	2004/05	**2005/6**	**2006/07**	**2007/08**
Number of individuals receiving a general healthcare assessment	360	380	504	650

C10 Specialist and pharmacy-base needle exchange programmes

	Performance	Planned performance		
	2004/05	**2005/06**	**2006/07**	**2007/08**
C10.1 Number attending specialist needle exchange	**700**	**720**	**730**	**750**
C10.2 Number in contact with pharmacy exchange schemes	**0**	**0**	**80**	**160**
C10.3 Total number of pharmacies in partnership area		**17**		
C10.4 Percentage of pharmacies in scheme	**0%**	**05**	**295**	**415**

Housing

C11 Supported housing

	Baseline	Expected performance	Planned performance	
	2004/05	**2005/06**	**2006/07**	**2007/08**
Numbers of drug users entering housing support*	**-**	**30**	**45**	**55**

* As measured by the Single Client Record Form, the number of primary and secondary needs drug users entering Supporting People services

Section D Substance misuse pooled treatment budget (SMPTB) allocation and funding profile

	SMPTB allocation	**2004/05**	**2005/06**	**2006/07**	**2007/08**
D1	Total substance misuse pooled treatment budget (SMPTB)	610,000	775,000	1,096,460	1,237,730
D2	SMPTB allocation to Young People's Partnership Grant	50,000	62,345	88,249	99,615

Please detail all funding available to the joint commissioning group to support delivery of the partnership treatment plan.

	Funding profile	**2004/05**	**2005/06**	**2006/07**	**2007/08**
D3	SMPTB available for adult drug treatment (D1 minus D2)	560,000	712,655	1,008,211	1,138,115
D4	SMPTB underspend carried forward from previous year	52,000	0	125,000	N/k
D5	DIP main grant	539,750	547,310	547,310	430,310
D6	Police	110,190	53,500	55,105	56,758
D7	PCT mainstream	421,217	555,183	579,046	603,945
D8	Social services	110,545	110,545	113,800	117,200
D9	Probation – partnerships	74,000	90,000	91,500	93,045
D10	Supporting people	0	0	0	0
D11	Other (please list below)				
	CDRP Local Authority PPO Tough Choices Workforce Building	325,452	25,000 109,000 81,000 53,834	*268,834	268,834
	NRF NDC	31,000	31,400 119,405 14,353 42,064	*207222	207222
	SRB Tackling Drugs	78,000 116,591	Total other to be confirmed 121,254	Total Other assumed yet to be agreed 126,468	131,906
D12	Total funding for adult drug treatment and DIP delivery (D3 – D12 inclusive)	2,418,745	2,666,503	3,122,496	3,047335

Has the partnership created a pooled budget for adult drug treatment, fully available to the joint commissioning group? **YES**

Partnerships in receipt of the SMPTB since 2001 must maintain mainstream investments, including inflation uprating, which is subject to audit checking. Lead PCT directors of finance will be required to verify this through the local delivery plan (LDP) reporting process.

Have **all** mainstream funding commitments been maintained and inflation uplifted?* **YES**

*If the answer is NO, please supply a written explanation as an appendix to this strategic summary.

Draft 2

Adult drug treatment plan 2006/07

Part 2: Self-assessment checklist

COMPLETED BY

Partnership Task Group

Hartlepool

RED	Not in place or not at standard required and significant needs/improvements identified
AMBER	Progress being made but further work/investment required to meet identified need/standard
GREEN	Provision in place and/or good progress being made against assessed need and required standards

Introduction

Please refer to the corresponding guidance notes *Adult drug treatment planning 2006/07: Guidance notes on completion of the plan for strategic partnerships* available on www.nta.nhs.uk when completing this checklist.

Drug system management

The major focus of the NTA's treatment effectiveness strategy (2005-08) is on service providers. Parallel developments need to take place to further improve the management of local treatment systems.

Commissioning a local drug treatment system

This self assessment system recognises that drug treatment systems are complex and require appropriate management and support. The standards included in this self-assessment section are taken from the consultation version of *Models of care update 2005*.

Assessment of services, provision and standards	**R/A/G**	**Planning grid ref**
Commissioning mechanisms have formal strategic partnerships with key stakeholders including health, social care, criminal justice, housing and employment services, drug treatment providers and local drug users and carers	Green	
Annual needs assessments are conducted in line with nationally agreed methodology to profile the diversity of local need for drug treatment which includes rates of morbidity and mortality, the degree of treatment saturation or penetration, and the impact of treatment on individual health, public health and crime	Green	
Partnership has, as a result of the needs assessment, a clear understanding of the extent to which services at all tiers meet the different needs of diverse communities and gaps in service provision, and actions to address any gaps within the roll out of the treatment effectiveness strategy are detailed across all planning grids	Green	
Drug treatment plan is in line with *Models of care update 2005* with focus on reducing harm to individuals and communities and improving clients' journeys through treatment and predicting client flow through local treatment systems and improving the effectiveness of local drug treatment systems	Green	
Partnerships demonstrate best practice in handling public money, contracting with providers and performance monitoring of service level agreements	Green	
Partnerships ensure performance management on key performance indicators is in line with all partnership organisations requirements and plans	Green	
Commissioning functions are "fit for purpose" and have involvement from key stakeholders at an appropriate level of seniority to deliver a strategic response	Green	
Commissioning mechanisms have formal arrangements with local drug user groups to enable consultation and involvement in the planning, commissioning and review of the local drug treatment system	Green	

Commissioning mechanisms have formal arrangements with service providers to enable consultation and involvement in the planning, commissioning and review of the local drug treatment system	Green	
Local protocols are in place between drug treatment system strategic partnership and key health, social care and criminal justice agencies including housing, employment and primary care which support the treatment stabilisation and resettlement agendas	Green	

RED	Not in place or not at standard required and significant needs/improvements identified
AMBER	Progress being made but further work/investment required to meet identified need/standard
GREEN	Provision in place and/or good progress being made against assessed need and required standards

Information systems

At local partnership level an assessment should be made as to the effectiveness of local IT and reporting arrangements which will support national developments. Additional guidance on the self assessment is included in the treatment plan guidance on the NTA website.

Assessment of services, provision and standards	**R/A/G**	**Planning grid ref**
Compliance with NDTMS monthly returns by tier 3 and 4 treatment providers in line with service level agreements	Green	
Compliance with NDTMS core data set requirements in terms of data quality	Green	
Data sharing protocols	Green	
Appropriateness (or adequacy) of IT systems in treatment provider services to provide regular and accurate supply of data to NDTMS and commissioners	Green	
Investment plans for the purchase/development of new/enhanced IT systems to meet clinical needs of providers and NDTMS needs	Green	

Workforce development

The required expansion and improvement of the treatment sector cannot be achieved without significant expansion in the workforce, and a step change in the training and professional development of these employees. Additional guidance on the self assessment is included in the treatment plan guidance on the NTA website

Assessment of services, provision and standards	**R/A/G**	**Planning grid ref**
Partnership workforce strategy (see workforce development guidance for details of workforce strategy requirements)	Amber	
Provider services progress towards creating a supportive learning environment which includes plans for work based assessment of competence and numbers registered for awards	Amber	
Service level agreements specify required workforce activities including induction, individual training plans, appraisal, supervision, CPD (continued professional development), and NVQ3 in Health and Social Care with all provider services job descriptions, person specifications and recruitment processes expressed in line with DANOS and other relevant national occupational standards, together with funding for training and development of staff and managers	Amber	

RED	Not in place or not at standard required and significant needs/improvements identified
AMBER	Progress being made but further work/investment required to meet identified need/standard
GREEN	Provision in place and/or good progress being made against assessed need and required standards

User involvement in drug treatment system

The involvement of users in the design of the local treatment system and their involvement throughout the implementation, monitoring, review and evaluation processes and the development of advocacy services is an essential element of developing effective drug treatment systems. Additional guidance on the self assessment is included in the treatment plan guidance on the NTA website

Assessment of services, provision and standards	**R/A/G**	**Planning grid ref**
Service users who are representative of the diverse communities within the partnership area, are involved in needs assessment, setting partnership plan priorities and are consulted on plan at draft stage and throughout the process with evidence that the involvement has resulted in action at partnership and provider level	Green	
Partnership service user involvement strategy which includes current, ex and potential service users	Green	
Resources and investment including user involvement expenses and remuneration arrangements, child care and transport costs; grant aid/funding to local user groups	Green	
Network of advocacy and support services aimed at drug users which involves, where appropriate, PALS (NHS), local authority and independent sector	Green	
Service level agreements require services to: display a service user charter, include user consultation in service reviews, and promote access to advocacy for users	Green	

Carer involvement in drug treatment system

The involvement of carers in the design of the local treatment system and their involvement throughout the implementation, monitoring, review and evaluation processes is an essential element of developing effective drug treatment systems. Additional guidance on the self assessment is included in the treatment plan guidance on the NTA website

Assessment of services, provision and standards	**R/A/G**	**Planning grid ref**
Carers who are representative of the diverse communities within the partnership area, are involved in needs assessment, setting partnership plan priorities and consulted on plan at draft stage and throughout the process with evidence that the involvement has resulted in action at partnership and provider level	Amber	
Resources and investment for carer involvement covering appropriate remuneration, expenses and organisational costs	Green	
Service level agreements include a requirement for services to include carer consultation in service reviews	Amber	

RED	Not in place or not at standard required and significant needs/improvements identified
AMBER	Progress being made but further work/investment required to meet identified need/standard
GREEN	Provision in place and/or good progress being made against assessed need and required standards

Drug treatment system delivery

Harm reduction strategy

Effective harm reduction requires a strategy that spans partner agencies and is delivered at all tiers of the treatment system. This year additional guidance and a harm reduction self-audit toolkit have been developed to define and facilitate the development of such a strategy where it does not already exist (see www.nta.nhs.uk for details).

Assessment of services, provision and standards	**R/A/G**	**Planning grid ref**
Partnership harm reduction self-audit completed (or equivalent agreed with NTA regional office)	Amber	
Partnership harm reduction strategy agreed and delivered across the drug treatment system which covers policies, programmes, services and actions to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs	Amber	
Blood-borne virus control (BBV)		
Multi-agency strategy for BBV control across all partner agencies including links to local health protection unit	Red	
Universal BBV prevention activities across all services	Red	
Training plan to support delivery of BBV prevention activities across all services	Amber	
BBV testing in place for all at risk drug users	Amber	
Vaccinations routinely provided to drug users for HAV and HBV	Amber	
Treatment care pathway for drug users with hepatitis and HIV	Amber	
Drug-related deaths		
Multi-agency strategy to reduce drug-related deaths, which builds on previous work to meet the DH target to reduce deaths by 20% by 2004	Amber	
Multi-agency DRD review group for confidential enquiries	Green	
Programme of overdose training supported by overdose agreements, for users, carers and emergency service staff	Green	
Interventions to minimise the risk of overdose and diversion of prescribed drugs	Green	
Specific harm reduction interventions		
Open access advice and information service including motivational and brief interventions	Green	

Pharmacy, centre based, and, if appropriate, outreach needle exchange with full range of harm minimisation equipment and information	Amber	
Needle exchange outlets offer general health advice and, where appropriate, assessment and have referral routes to primary, sexual and dental health care services	Green	
Outreach services (detached, peripatetic and domiciliary) targeting high risk and priority groups	Green	
General healthcare assessment is routinely provided to all service users and this is required within service level agreements	Green	

RED	Not in place or not at standard required and significant needs/improvements identified
AMBER	Progress being made but further work/investment required to meet identified need/standard
GREEN	Provision in place and/or good progress being made against assessed need and required standards

Treatment journey

This section focuses on improving the impact of treatment, alongside consolidation of improvements in access and capacity. This requires partnerships to evaluate the service user treatment journey including retention in treatment for long enough to impact on behaviour, have a care plan which identifies their needs and a programme of action to deliver their treatment goals, promote progression through the system for all individuals including support for positive lifestyles including access to stable accommodation, education, training and employment. The outcome of the treatment journey should deliver improvements in individual drug user's health and social functioning, lower public health risks from blood borne viruses and overdose, and improvements in community safety.

Assessment of services, provision and standards	**R/A/G**	**Planning grid ref**
Access to treatment		
Screening, assessment and referral for structured drug treatment from open access services (tier 2 referrals to tier 3 and 4 services)	Green	
Open access drug interventions which attract and motivate drug misusers into local treatment systems including engagement with offenders (tier 2 interventions)	Green	
Service provision is based on local need providing access that is appropriate to service users from all backgrounds and characteristics within the partnership area	Green	
Waiting times within national targets and providing timely access to structured drug treatment interventions	Green	
Management and, where required, reduction of waiting times action plan which includes delivery of NTA improvement programme and includes routine review and exceptions reporting of all waiting times of over 6 weeks	Green	
CJIT assessment of target offender population i.e. those testing positive or those arrested/charged with trigger offences	Green	
Waiting times for DIP clients accessing structured treatment (including CJIT case management) and particularly substitute prescribing where appropriate	Green	
Where restriction on bail is implemented, effective arrangements to communicate test results to courts and undertake assessment	Green	

and follow on treatment		
Engagement in treatment		
Target of retention in treatment of more than 12 weeks achieved or bettered with all client groups including offenders	Green	
Management and, where required, improvement of retention rates action plan	Green	
Treatment delivery		
Each service user is supported to improve their health, social circumstances and well being by the provision of individually tailored care plans which are regularly reviewed	Amber	
Individuals receive information, advice, injecting equipment and brief interventions and treatment to help reduce potential harm due to the transmission of blood borne virus's, drug related infections and overdose, and improves their physical health	Green	

RED	Not in place or not at standard required and significant needs/improvements identified
AMBER	Progress being made but further work/investment required to meet identified need/standard
GREEN	Provision in place and/or good progress being made against assessed need and required standards

Treatment delivery (cont)	**R/A/G**	**Planning grid ref**
Service user "significant others" have access to support and interventions to reduce harm related to drug misuse. This includes intervening to reduce the risk of significant harm to children of service users and ensuring significant others have access to support in their own right	Amber	
Full range of evidence based structured treatment interventions as outlined in *Models of care updated 2005*	Green	
Comprehensive and robust case management arrangements in place within the CJIT	Green	
Effective continuity of care arrangements between prisons, CJITs and specialist treatment providers	Green	
Range of drug treatment interventions for drug misusing offenders in DIP	Green	
Range of drug treatment interventions for drug misusing offenders subject to community based court orders	Green	
Treatment completion/community re-integration		
Partnership has identified current performance in terms of planned and unplanned discharges for treatment with plans in place to improve performance year on year	Green	
Service level agreements with all service providers clearly stipulate planned discharge performance expectations and are reviewed quarterly with agencies	Amber	
A range of aftercare, 'move on' and support services are commissioned within specialist services to facilitate clients' transition from specialist drug services into wider resettlement, aftercare and community integration services	Green	

Partnership (including all relevant stakeholders) has a written joint strategy explicitly linked to the Local Authority Homelessness Strategy and Supporting People Strategy to increase access to housing and housing support by drug users in order to assist stabilisation and resettlement	Green	
Joint strategy is supported by an action plan which ensures all key partners have shared definitions, objectives and outcomes	Amber	
Partnership has undertaken a local assessment of met and unmet need for housing and housing support by drug users	Green	
Specific operational protocols between the partnership, the LA Supporting People Team and housing providers	Amber	
Partnership has a written strategic plan to increase access to education, training and employment by drug users in order to assist stabilisation and resettlement	Amber	

Appendix to 6.1

Safer Hartlepool Partnership

DRAFT 2

Adult drug treatment plan 2006/07

Part 3: Planning grids

Safer Hartlepool Partnership

Planning grid 1: Commissioning a local drug treatment system

This planning grid should include objectives and action plans in relation to:

- Commissioning, financial, performance management and information activities to support delivery of the treatment plan
- Development of strategic local partnerships
- Information systems
- Delivery of support services – and in particular access to stable accommodation, education, employment and training

This grid replaces and updates grid 7 from the 2005/6 plan and should reflect any continuing objectives from 2005/06

Summary of self-assessment

The merged operation of drugs, crime and young people within Safer Hartlepool Partnership improving strategic, financial and operational activity. Performance monitoring Group of SHP and JCG monitor regularly. Review SHP structures in 2006/07 to further streamline and strengthen. Links to other strategic bodies and plans in place e.g. LSP, Health & Care Partnership, Supporting People LAA process.

The appointment of Planning and Commissioning Manager 1/1/06 with Commissioning Officer to be appointed by April 06. Admin, finance and analysis support secured for drug agenda. Additional 'management staff' appointed across system including Treatment Centre.

Community Drug Centre expansion completed providing additional space for integrated and related facilities from a number of partners e.g. obstetrics, needle-exchange, user group, Childrens Services, Sure Start.

I.T. hardware and networks installed across criminal justice and treatment provision with central server. Problems with POPPIE software being addressed, training arranged including refresher training on new modules. NDTMS data submitted with nearly 100% quality from all providers. Process with NEPHO (Axscript) in place for EDT transfer by April 06. Consider purchase of Micase software for DIP/criminal justice analysis.

ETE support increased following review. New staff appointed locally, sub regional group established to improve P2W activity.

Day programmes and reintegration to be increased and evidenced as local packages maximise voluntary sector facilities and offer comprehensive packages of support and assist with re-integration into community.

Bespoke facility for 10 x under 25's available 2006 financed Housing Corporation and Supporting People revenue. Application for adult facility continues. HARP Protocol launched and joint training delivered. Furnished flats with support on line and valued by user group. Negotiations with key Housing providers to develop initiatives for drug using offenders resulted in consultant appointed to develop protocols and procedures by April 06.

Safer Hartlepool Partnership

SHP agreed Communication Strategy coordinated through Reassurance Task Group with regular items via media, internal bulletins, community news sheets and presentations. Following reconfiguration of services new publicity throughout drug treatment system with integrated SHP branding, DVD produced, websites will be enhanced 2006. Draft Treatment Plan developed through workshops and forums, consultation continues with reports and surgeries scheduled with Neighbourhood Forums, Hartlepool User Forum, Managers of services, PCT Board/PEC, Hartlepool Partnership and Community Network. Delays in establishing robust harm minimisation programmes and static needle exchange facilities

Planned spend 2005/6	**Likely spend 2005/6**	**Planned spend 2006/7**
71,000		321,253

Objective 1 Review Safer Hartlepool Structure for potential streamlining and improvement			
Actions and milestones for objective 1	**By when**	**By whom**	**Costs/budget**
Review relationships and activity across Partnership functioning	June	AM & Task group Chairs	
Propose and implement new structures, reporting mechanisms and operation	September	AM	
Objective 2 Appointment of Commissioning Officer			
Actions and milestones for objective 2	**By when**	**By whom**	**Costs/budget**
Develop job description and person spec	Jan06	CH	
Advertise post & interview	Feb 06	CH	
Appoint and induction	April 06	CH	
Objective 3 Review POPPIE programmes and consider expansion needs			
Actions and milestones for objective 3	**By when**	**By whom**	**Costs/budget**
Analysis of POPPIE use for monitoring and EDT returns	April 06	HL	

Safer Hartlepool Partnership

Training Audit for staff/modalities and produce relevant programme of courses and updates	June 06	HL	
Review hardware needs across services, identify investment programme and source	September 06	HL	
Introduce POPPIE as Case Management Tool, including transfer of paper records, support,	June 06	HL/KC	
Introduce via POPPIE electronic management systems e.g. clinic bookings, systems.	June 06	KC/HL	
Objective 4 Ensure I.T Programme in place for monitoring/analysis of DIP			
Actions and milestones for objective 4	**By when**	**By whom**	**Costs/budget**
Investigate with partners suitable software programmes	April 06	HL	
Commission and install as appropriate (Micase)	May 06	HL	
Transfer of all data and establish reports etc	June 06	HL	
Review and enhance as appropriate	December 06	HL	
Objective 5 Consult and publicise Treatment Plan and similar reports			
Actions and milestones for objective 5			
On agreement of Treatment Plan provide summary and copies of plan through variety of media press release, website, community news sheets	May 06	CH	
Schedule relevant mid year reviews and reporting mechanisms to key stakeholders	May 06	CH	
Agree and book regular community meetings/presentations to elicit issues and ideas for targeted work	May 06	CH	

Objective 6 Adopt and implement Housing Protocol across providers			
Actions and milestones for objective	**By when**	**By whom**	**Costs/budget**
Consider and agree protocols and processes for initiative for drug using offenders	April 06	SHP	

Safer Hartlepool Partnership

Training programme established and delivered for stakeholders in regard to initiative and processes	From June 06	CH/CC/BG	
Establish Officer group for coordinating referral and supporting care programmes	April 06	CH/CC/BG	

Objective 7 Formalise Harm Minimisation Strategy and Action Plans see planning grid 5
Objective 8 Develop range of Pharmacist and centre based facilities see planning grid 5

Safer Hartlepool Partnership

Planning grid 2: Workforce development

This planning grid should include objectives and action plans in relation to the required expansion and improvement of the treatment sector workforce, and recognise the step change in the training and professional development of these employees that is required to deliver the effectiveness agenda. This grid replaces grid 5 from the 2005/06 plan and should continue with any outstanding objectives.

Summary of self-assessment

Annual multi agency drug training programme in place supported by partnership contributions including HBC HR and Safeguarding Board investment. Courses free and open to all, including voluntary sector and residents groups. Specialist training and development also in place with Training Strategy developed in conjunction with providers and users groups.

Reconfiguration of services now have all posts appointed and has led to additional personnel across workforce some of whom do not have an extensive experience in the drug field, and mentoring, shadowing, volunteering programmes have been extended. Additional investment in 06/07 to increase capacity for Admin and criminal justice initiative.

GP's and Pharmacists have engaged in RCGP training and PCT development days. Consultant supporting PCT with programme to develop confidence and participation of GP's in Shared Care. Pharmacists and treatment agencies participating in development workshops etc.

User/Carer groups supported in attending Seminars, conferences and specific training such as Market Research, Stronger Voice, Committee skills.

Multi agency away days and regular information/induction events organised to assist in communication and awareness of changing agendas.

DANOS Audit underway, delayed with establishment of new Substance Misuse Service and Dual Diagnosis Team but needs further work in 06/07

Safer Hartlepool Partnership

Planned spend 2005/6	**Likely spend 2005/6**	**Planned spend 2006/7**
26,000		39,000

Objective 1 Continue DANOS assessment of all agencies and respond accordingly with support			
Actions and milestones for objective 1	**By when**	**By whom**	**Costs/budget**
Complete DANOS assessment purchase software	June 06	CH	
Consider recommendations and implement as appropraite	September 06	Managers	
Include training needs in Workforce Development Strategy and commission as appropriate	September 06	CH	
Objective 2 Review and enhance Workforce Development Strategy			
Actions and milestones for objective 2	**By when**	**By whom**	**Costs/budget**
Consider current Strategy in view of changes	June 06	CH	
Assessment of providers supervision, appraisal and training programmes. Include detail in SLA's	June 06	CO	
Review, commission or develop appropriate courses e.g. DDA, Ethnicity, Hidden harm, Parental use of drugs, Safeguarding.	September 06	CH	
Promote and support in house learning, NVQ,	September 06	CO	
Objective 3 Establish professional and quality forums			
Actions and milestones for objective 3	**By when**	**By whom**	**Costs/budget**
Expand secondment, mentoring and shadowing experiences	July 06	KC	
Develop protocols and practice to expand volunteering and work experience schemes	September 06	CH	
Promote workers forums, quality circles, professional development workshops	September 06	KC	
Objective 4 Increase GP participation			
Actions and milestones for objective 4	**By when**	**By whom**	**Costs/budget**

Safer Hartlepool Partnership

Update consultants programme for Shared care expansion to identify training requirements	May 06	PCT	
Arrange programme of developmental workshops and events and recruit to	June 06	PCT clinical lead	
Promote RCGP training courses with financial incentives and support to attend	Aug 06	PCT clinical lead	
Organise regular supervision/support meetings	September 06	PCT clinical lead	

Safer Hartlepool Partnership

Planning grid 3: User involvement

This planning grid should include objectives and action plans in relation to the involvement of users in the design of the local treatment system and their involvement throughout the implementation, monitoring, review and evaluation processes and the development of advocacy services. This grid replaces grid 8 from the 2005/06 plan and focuses on user involvement and should continue with any outstanding objectives

Summary of self-assessment

The user group development has been significant in terms of involvement with Partnership activity, integration with drug treatment services and within their own organisation as an autonomous group. Whilst the group at the forefront is Addvance there are several other service users groups involved in activity such as Addaction, the Treatment Centre are encouraging users in determining environment and delivery from the Community Drug Centre and DISC from their Hartlepool group have individuals involved in interviewing and service audits throughout the DISC organisation.

Recently the various groups have come together and formed Hartlepool User Forum which had existed in previous years but had declined of late. This Forum is currently being facilitated by community workers but have user Chair and Vice Chair and a programme of training and support which will speed the full ownership and operational responsibility to Users alone.

Funding and different training programmes have increased the confidence of the groups who now provide research for Partnership, are involved in training organised and from January 06 are going into communities stimulating discussion and assisting in raising awareness of issues from user perspective.

The relationship with Partnership is positive. User representatives are members of the Partnership, various task or sub groups. The SHP drug lead has regular meetings with user groups and Addvance particularly provide advocacy across the services including attendance with individuals if requested.

Previously when invited groups were not interested in representation on the Safer Hartlepool Partnership strategic groups wishing instead to deliver their services locally, increase their confidence and understanding of the structures. Developments indicate that there now needs to be further encouragement for user representation on SHP Exec and/or JCG. Invitation is also circulated to all Hartlepool user groups to attend Regional User Forums and events but again the concensus is that they see more relevance in spending energies here in Hartlepool.

The user groups and Hartlepool User Forum play a major part in quality reviews and development of Treatment Plans. Having contributed to the self assessment, identified need, service development and priority setting the draft Treatment Plan will be considered for further comment prior to final submission. Regular reports to and from Forum are scheduled for 2006/07

Safer Hartlepool Partnership

Planned spend 2005/6	**Likely spend 2005/6**	**Planned spend 2006/7**
% 90,000 (05/06 grid 8)		102,000

Objective 1 To maintain positive relationships with user groups and encourage increased participation in Partnership			
Actions and milestones for objective 1	**By when**	**By whom**	**Costs/budget**
Meetings through Forum to discuss representation and election to Exec and/or JCG	July 06	CH	
Training or support programme determined including shadowing posts or specific training courses	September 06	CH/HVDA	
Visits/Mentoring through other DAT's/Partnerships to increase confidence	September 06	NTA/CH	

Objective 2 Strengthen Hartlepool User Forum			
Actions and milestones for objective 2	**By when**	**By whom**	**Costs/budget**
Agree role of community workers, identify training needs and providers and other support required	June 06	LM/PH & Group	
Identify and encourage visits and mentoring to similar Forums to share best practice and increase confidence	June 06	LM/PH & Group	
Agree funding support and associated SLA, even if interim	April 06 onwards	CH	
Objective 3 Commission drop in and practical service			
Actions and milestones for objective 3	**By when**	**By whom**	**Costs/budget**
Review performance and service	February 06	JCG/CH	
Discuss and agree specification for continued service	February 06	CH	
Agree SLA targets and monitoring agreements	March 06	CO	

Safer Hartlepool Partnership

Assist in fundraising for improved facilities	Ongoing	All	
Objective 4 Encourage User group participation in Community Presentations			
Actions and milestones for objective 4	**By when**	**By whom**	**Costs/budget**
Facilitate/commission support to assist group to design and produce course material	May 06	CH	
Promote and agree initial presentations to 'safe' audiences	June 06	Addvance/CH	
Review and if necessary modify content and seek further support	Aug 06	Addvance/CO	
Arrange programme of presentations with evaluation	September 06	Addvance/CH	

Safer Hartlepool Partnership

Planning grid 4: Carer involvement

This planning grid should include objectives and action plans in relation to the involvement of carers in the design of the local treatment system and their involvement throughout the implementation, monitoring, review and evaluation processes and the development of advocacy services. This grid replaces grid 8 from the 2005/06 plan and focuses on carer involvement and should continue with any outstanding objectives

Summary of self-assessment Support services have been commissioned from a local self help group and although this group provides a range if interventions such as phone line, outreach information surgeries, 1-2-1 support and support group there is concern about the capacity of this small voluntary group and its ability to attract participation from the widest range of carers. Financial support has been given to assist the group with business planning and an independent assessment is in hand to determine future role. Without prejudice it is assumed that there will be continued financial support to the group for an element of services but investment will also be allocated for additional support and initiatives these will include proactive work to provide more support to partners and carers as well as engaging families in the treatment programme of the drug using individual

Planned spend 2005/6	Likely spend 2005/6	Planned spend 2006/7
% 90,000 (05/06 grid 8)		85,000

Objective 1 Review current provision of support and determine commissions			
Actions and milestones for objective 1	**By when**	**By whom**	**Costs/budget**
Consider evaluation report on current services and capacity of provider for growth	March 06	CH/JCG	
Agree any continued service from self help group including development programme to organisation and operation	March 06	CH	
Prepare specification for enhanced services to carers/significant others	June 06	CH/CO	
Commission services as appropriate (link to Hidden harm and Parental Use of Drugs)			
Objective 2 Strengthen support to children and families of drug using parents			
Actions and milestones for objective 2	**By when**	**By whom**	**Costs/budget**

Safer Hartlepool Partnership

Investigation and scooping of need with partners agencies	May 06	S.O'C/CH	
Production and Launch of new Protocol re Parental Use of drugs	May 06		
Training for all partners	May 06		
Design and commission initiatives and programmes	June 06	Ch	

Planning grid 5: Harm reduction strategy

This planning grid should include objectives and action plans in relation to the development of a comprehensive harm reduction strategy agreed across all partner organisations. Effective harm reduction initiatives will be delivered across all aspects of a comprehensive drug treatment system, often requiring pathways between primary and secondary care, may have workforce, infrastructure, and user and carer implications. This is a new grid and should bring together outstanding harm reduction objectives from the 2005/06 plan.

Summary of self-assessment

Advice, information and health checks available across services however response has been slow in responding to widest harm reduction strategy. Needle Exchange service is well used and has been able to increase numbers using exchange, offers paraphernalia and some intervention for crack users. By delivering to 12 – 14 sites across the town it has been an excellent outreach referral opportunity making links with those individuals that would generally be outside of our contact networks. By its nature the mobile unit has few facilities for intensive health checks and it is a priority to secure a static facility. Negotiations are in hand with Pharmacists to commission support on a range of services including needle exchange.

The reconfiguration of services has also delayed the vaccination and similar h.r. programmes. Although staff are now all trained, equipment ordered and there is an emphasis on achieving targets for vaccination there is much to be done to consolidate an effective comprehensive response on all harm reduction initiatives.

Planned spend 2005/6	**Likely spend 2005/6**	**Planned spend 2006/7**
New grid n/a	N/a	63,000

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Objective 1 Formalise Harm Minimisation Strategy and develop action plans			
Actions and milestones for objective 1	**By when**	**By whom**	**Costs/budget**
Agenda and formally agree HR Audit and Strategy	May 06	PP	
Development Workshops and consultation to share action planning	June 06	PP/CH	
Consolidate, launch and implement strategy and plans	July 06	PP	

Objective 2 Develop the range of services available from Pharmacists and other venues			
Actions and milestones for objective 2	**By when**	**By whom**	**Costs/budget**
Attend Pharmacist meeting to discuss proposals and identify interest	March 06	PCT	
Scope and Model specification for 3 tiers of provision with associated fee and protocol	April 06	PCT	
Identify and pilot with 1-2 interested pharmacists	June 06	PCT	
Evaluate, and promote to establish with additional pharmacists	Nov 06	PCT	

Objective 3 Address drug related deaths and confidential enquiries			
Actions and milestones for objective 3	**By when**	**By whom**	**Costs/budget**
Confirm remit and meetings of Shared Care Group, with regular reviews of cases etc	April 06	CH	
Agreement on protocols in light of best practice	May 06	PP	
Re establish regular contact and reporting from Coroners Office	June 06	CH	
Repeat overdose training for users, carers, front line staff. A&E	September 06	CH	

Safer Hartlepool Partnership

Planning grid 6: Drug-related information and advice, screening and referral by generic services

This planning grid should include objectives and action plans in relation to interventions that provide drug-related information and advice, screening, assessment, and referral to structured drug treatment services. These will be delivered by services who work with a wide range of clients including drug users, but their sole purpose is not simply substance misuse. This grid replaces grid 1 from 2005/06 and should continue with any outstanding objectives.

Summary of self-assessment There are extensive networks and contacts in place and good use is made of the voluntary sector facilities in offering surgeries, drop ins, and as venues for activity programmes in an effort to maximise resources but also assist with mainstreaming provision and providing the service user with the contacts for reintegration back into the community following treatment. Multi agency training and development events have encouraged non drug specific agencies to assume responsibility for delivering support. Literature, campaigns and presentations from service providers to as varied an audience as possible has increased the profile and understanding of drug issues. Common referral and screening proformas and processes agreed and operational in many tier 1 services and situations.

Planned spend 2005/6	Likely spend 2005/6	Planned spend 2006/7
52,000		257,561

Objective 1 Increase opportunities for community/neighbourhood advocates

Actions and milestones for objective 1	By when	By whom	Costs/budget
Support users and ex-users to provide/be involved in presentations to raise awareness of drug issues from users perspective	Ongoing	CH	
Recruit community activists to basic drug courses, followed by training and support on local information and confidence to be conduit back to services or Partnership	May 06	All	
Agree local programmes of information or surgeries for that community to raise concerns or queries with their activist. Organise route for activist to present and get response on issues community raise	May 06	NDC, Comm Network	

Safer Hartlepool Partnership

Objective 2 Expand Peer mentoring/Peer education programmes targeting areas of disadvantage			
Actions and milestones for objective 2	**By when**	**By whom**	**Costs/budget**
Advertise and promote success of current projects by use of peers in variety of settings	May 06	LH/DISC	
Recruit 20 to programmes targeting those areas with greatest drug culture/issues	June 06		
Training and support available with practical application	Aug 06		
Evaluation of enhanced initiatives	Dec 06	CH	
Objective 3 Increase awareness of identification, screening and referral process			
Actions and milestones for objective 3	**By when**	**By whom**	**Costs/budget**
Publicise process following reconfiguration	From April 06 ongoing	KC	
Workshops and training on identification of drug use and screening process	June 06 onwards	KC	
Follow up packs re referral process, proforms and comment, complaint, compliment forms	September 06	KC	
Personal contact to determine continued need , changes to personnel etc	December 06	KC	

Planning grid 7: Open access drug interventions

This planning grid should include objectives and action plans in relation to interventions which provide accessible services for a wide range of drug misusers referred from a variety of sources, including self-referrals. The aim of these interventions is to help drug misusers to engage in treatment without necessarily requiring a high level of commitment to more structured programmes or a complex or lengthy assessment process. Interventions comprise drug-related information and advice, screening, assessment, referral to structured drug treatment, brief psycho-social interventions and harm reduction services including needle exchange and aftercare. This grid replaces grid 2 from 2005/06 and should continue with any outstanding objectives.

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Summary of self-assessment The increased capacity of the Community Drug Centre has improved the opportunity for open access interventions.

There are more personnel available to respond and additional agencies who are now operating out of the drug centre including Addaction needle exchange, Addvance user group, 'Social Services' and health professionals. Investment particularly through DIP and NRF provides workers with a specific remit of engaging with individuals to encourage approaches to treatment. There are no waiting lists and capacity has also been increased in counselling and complimentary therapies to ensure as speedy a response when an individual is so motivated. The referral, triage and assessment processes are common to all the core agencies and have been streamlined to avoid repetitive and duplicated interviews and information exchange.

Investment in 2006/07 is identified to increase the range of psycho-social and other non-prescribing interventions to broaden the responses and elements of care package. Following the reconfiguration of services there will be improvement to all aspects of care planning, regular review and care coordination which although it has been operational is in need of strengthening and improved quality

Planned spend 2005/6	**Likely spend 2005/6**	**Planned spend 2006/7**
711,000		964,013

Objective 1 Target information, advice and outreach support to disadvantaged communities			
Actions and milestones for objective 1	**By when**	**By whom**	**Costs/budget**
Targeted promotion 4 x leaflet campaigns, 6 x presentations to Stranton, Belle Vue, Foggy Furze and Dyke House wards	June 06	All	
Establish 2 outreach surgeries for drop in and contact with bi monthly attendance	Aug 06	CO	

Objective 2 Increase community based harm minimisation services			
Actions and milestones for objective 2	**By when**	**By whom**	**Costs/budget**
Review and agree SLA for needle exchange including opportunities to establish static provision	April 06	CH	

Safer Hartlepool Partnership

Agree programme of community harm minimisation and vaccination programme across agencies	June 06	CH	
Review protocols/processes to update if necessary liase with Pharmacists and significant stakeholders	June 06	PH	
Deliver 40 x outreach sessions/clinics	March 07	PH	
Objective 3 Increase day programmes and aftercare support			
Actions and milestones for objective 3	**By when**	**By whom**	**Costs/budget**
Review and strengthen current provision with improved SLA	April 06	CH./CO	
Gap analysis of need and consideration of best practice and initiatives elsewhere	April 06	CH/CO	
Identify providers and commission with targets and reporting identified	June 06	CH/CO	
Formal review and reports to JCG and PMG	Ongoing	CH/CO	

Planning grid 8: Structured community based drug treatment interventions

This planning grid should include objectives and action plans in relation to interventions providing community based interventions (including those delivered within a prison setting) which will include comprehensive drug treatment assessment, care planning and review, community care assessment, care co-ordination for those with complex needs, integrated harm reduction activities, prescribing, structured psycho-therapeutic interventions and counselling, structured day programmes and liaison services with social care and acute medical and health services. This grid replaces grid 3 from 2005/06 and should continue with any outstanding objectives.

Summary of self-assessment The new Substance Misuse Service provides all prescribing and healthcare across the clinical treatment regimes and projects with common protocols, processes and integrated staff who will through training and shadowing develop an understanding of each specific initiative and ensure service delivery. The number of prescribers within the above practice specialist service has increased and now totals 5. Whilst Shared Care remains a priority for development in 2006/07 there has been some movement with two practices now supporting individuals referred out of the specialist service. The Dual Diagnosis service is established delivered through the Integrated Mental Health Team who have an operational base from the community drug centre. Wrap around services are pro active and through links to mainstream and independent sector comprehensive programmes of day activities and reintegration into community are coordinated.

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Planned spend 2005/6	**Likely spend 2005/6**	**Planned spend 2006/7**
741,786		951,359

Objective 1 Increase prescribing sessions and expand timetable to offer additional access			
Actions and milestones for objective 1	**By when**	**By whom**	**Costs/budget**
Encourage GP's and other medics to participate in Accredited RCGP training	Aug 06	PCT	
Recruit nursing staff to Prescriber courses and training	July 06	PCT	
Review and negotiate enhanced local payment regime to attract prescribers	September 06	PCT	
Objective 2 Maintain and as appropriate improve waiting time, retention and other treatment targets			
Actions and milestones for objective 2	**By when**	**By whom**	**Costs/budget**
Review regularly above practice SMS and other services to monitor performance	Ongoing	CH	
Identify gaps/blockages and poor performance on monthly basis			
Explore options within structures and processes for improvement through use of monthly management M of C meetings			
Implement improvements to ensure clinics, bookings, non prescribing support mobilised and individuals engaged at first contact			
Objective 3 Increase capacity for 'structured interventions'			
Actions and milestones for objective	**By when**	**By whom**	**Costs/budget**
Scope and map increased need and develop specifications for enhanced services	April 06	CH	
Commission additional counselling, psycho-therapeutic and day activities as appropriate	June 06		
Monitor demand and performance through provision of statistical data	Ongoing		
Review and assess for future development	January 07		

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Objective 4 Commission service for crack users			
Actions and milestones for objective	**By when**	**By whom**	**Costs/budget**
Analyse demand and gap in services including consideration of local research Dec 06	April 06	CH/JCG	
Prepare specification for response including complimentary therapies, counselling, cognitive behaviour	May 06		
Negotiate and Commission services including training and confidence building of staff in current services			
Discuss need for discrete service provision/team following delivery of support	Dec 06		

Planning grid 9: Residential and inpatient drug treatment interventions

This planning grid should include objectives and action plans in relation to residential specialised drug treatment which is care planned and care co-ordinated. These interventions may be aimed at individuals with a high level of presenting need and usually will require a higher level of motivation and commitment from the service user. This grid replaces grid 4 from 2005/06 and should continue with any outstanding objectives

Summary of self-assessment Protocol in place for commissioning of in patient facilities based on individual need rather than block booking.

Liaison strengthened between integrated mental health team and treatment services particularly within community drug centre.

Dual Diagnosis Team operational from September 05 and have active caseload.

Planned spend 2005/6	**Likely spend 2005/6**	**Planned spend 2006/7**
335,000	30,000	109,000

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Objective 1 **Review and enhance Dual Diagnosis Team/operation**			
Actions and milestones for objective 1	**By when**	**By whom**	**Costs/budget**
Review pilot operating since September 06	March 06	SC/PCT	
Confirm protocols pathways etc with improvement if necessary			
Negotiate finance and any enhancements with targets contained within SLA			

Objective 2 Agree process and framework for commissioning facilities and care packages			
Actions and milestones for objective	**By when**	**By whom**	**Costs/budget**
Examine best practice from elsewhere and guidance on commissioning	May 06	DDT/KC	
Audit caseload to scope needs for service	May 06		
Option appraisal of block booking or continued ad hoc use			
Ratify and promote process across services and implement with regular review			

Planning grid 10: Drug Interventions Programme

This planning grid should include objectives and action plans in relation to the delivery of the Drug Interventions Programme as outlined in Home Office guidance. This grid replaces grid 2b from 2005/06 and should continue with any outstanding objectives. The planning grid should cover those arrested, referred to and where appropriate, case managed via the CJIT (Criminal Justice Integrated Team) who are engaging offenders in interventions including rapid or dedicated prescribing, and referring into specialist treatment interventions as required (which may be delivered within the CJIT setting). The DIP Main Grant is intended to finance integrated community based drug interventions teams to undertake the case management of these offenders. This team will also seek to sustain treatment gains with the development and delivery of aftercare and holistic packages of support.

Summary of self-assessment

Safer Hartlepool Partnership

Drug Intervention Programme including Restrictions on Bail successful and in general achieving/over achieving against national targets. DIP services commissioned alongside 'generic' services to ensure integration of initiatives particularly with other criminal justice project such as Dordrecht and PPO.

Merger of criminal justice projects into one management body with operational officer groups and policy task group meeting regularly.

Rapid prescribing and agreed protocols ensure priority for DIP and ROB ith access to script often within 2-3 working days.

Additional resources secured for aftercare (Sports) and increased arrest referral in preparation for Tough Choices. Prison in reach service improving with improved communication between Magistrates and prisons with key workers.

Significant numbers of drug using offenders known to local agencies and have usually been in contact at some stage with treatment providers. Limited retention from this cohort in treatment has led to emphasis in 2006/07 for improvements by proactive and intensive contact and retention at first point of contact.

Local systems in place with data manager for recording activity and provision of analysis to inform planning pending the implementation of POPPIE and in 2006/07 consider purchase of Micase or similar.

Planned spend 2005/6	**Likely spend 2005/6**	**Planned spend 2006/7**
472,000		230,310

Objective 1 Commission DIP services			
Actions and milestones for objective 1	**By when**	**By whom**	**Costs/budget**
Review current service delivery and performance	Feb 06	CC	
Confirm/amend specification and negotiate SLA with targets	Feb 06	CC/CH	
Agree and establish monitoring requirements	March 06	CC/CH	
Objective 2 Review and as appropriate improve DIP process with emphasis on integrating Tough Choices operation			
Actions and milestones for objective 2	**By when**	**By whom**	**Costs/budget**
Collection of data	Ongoing	HL	
Formal audit, judgement of performance	July	HL/CC	

Safer Hartlepool Partnership

Meet with Providers to discuss gaps and issues	September 06	CC	
Design or modify response and implement	December 06	CC	
Objective 3 Increase intense support at first point of contact			
Actions and milestones for objective 3	**By when**	**By whom**	**Costs/budget**
Discuss contact process, analysis of + - success, and means of improving engagement	March 06	CC	
Identify 2-3 additional mechanisms and implement	April 06	CC	
Determine regular review dates and evaluation method	April 06	CC	
Review and improve	September 06 ongoing	CC	
Objective 4 Increase through-care and aftercare initiatives			
Actions and milestones for objective 4	**By when**	**By whom**	**Costs/budget**
Maintain and contribute to SLA's for current services	Feb 06	CC	
Review care plans, assess need and consult with service users on need	June 06	CC/EM	
Define demand, identify resources and develop specifications	July 06	CC	
Commission additional projects with targets and monitoring requirements	September 06	CH/CO	

CABINET REPORT

13th March 2006

Report of: The Chief Executive

Subject: HARTLEPOOL BOROUGH COUNCIL'S RESPONSE TO THE STRATEGIC HEALTH AUTHORITY'S CONSULTATION ON PCT RE-CONFIGURATION

SUMMARY

1. PURPOSE OF REPORT

To provide Cabinet with the opportunity to comment on the draft response to the PCT reorganisation proposals.

2. SUMMARY OF CONTENTS

The report incorporates the submission in response to the consultation proposals in respect of the PCT.

3. RELEVANCE TO CABINET

The options proposed by the Strategic Health Authority for the reconfiguration of Durham and Tees Valley Primary Care Trusts have damaging implications for joint working with the Council.

4. TYPE OF DECISION

Non-key.

5. DECISION MAKING ROUTE

Cabinet, 13 March 2006.

6. DECISION(S) REQUIRED

Cabinet is requested to:-

(i) Consider the draft response;
(ii) Identify any amendments or changes;
(iii) Delegate to the Chief Executive the authority to make any minor changes required prior to submission; and
(iv) Support the joint submission on behalf of the Tees Valley local authorities.

Report of: The Chief Executive

Subject: HARTLEPOOL BOROUGH COUNCIL'S RESPONSE TO THE STRATEGIC HEALTH AUTHORITY'S CONSULTATION ON PCT RE-CONFIGURATION

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1. PURPOSE OF REPORT

To provide Cabinet with the opportunity to comment on the draft response to the PCT reorganisation proposals.

2. BACKGROUND

The potential reorganisation of the PCT is an issue which is of significant importance of the local authority and the residents of Hartlepool.

The proposals for the reorganisation are being consulted on at the moment. The deadline for responses is 22 March 2006. Council, Cabinet and Scrutiny have considered this matter. Responses to the consultation are to be submitted by Adult and Community Services and the Health Scrutiny Forum (as a statutory consultee in the process and as part of the Joint Tees Valley Health and Social Care Scrutiny Forum) and a joint response from all Tees Valley Local Authorities (see draft at Appendix 1).

Due to the importance and potential impact of the reorganisation proposals it is also important that the motion agreed by Council, in respect of retaining a co-terminus PCT, is also included as a formal response to the consultation.

The draft submission attached provides a comprehensive response to the consultation proposals and communicates the views of Council, Cabinet (from previous meetings where this has been discussed) and Scrutiny.

3. RECOMMENDATION(S)

Cabinet is requested to:-

(i) Consider the draft response;
(ii) Identify any amendments or changes;
(iii) Delegate to the Chief Executive the authority to make any minor changes required prior to submission; and
(iv) Support the joint submission on behalf of the Tees Valley local authorities.

NEW PRIMARY CARE TRUST ARRANGEMENTS IN COUNTY DURHAM AND TEES VALLEY

JOINT RESPONSE OF THE TEES VALLEY LOCAL AUTHORITIES

INTRODUCTION

1. In considering the consultation document on the above issued by the SHA on 14th December 2006, the Tees Valley Local Authorities have taken into account a number of factors including

2.
   - the context within which the proposals are made
   - a comparison with approaches adopted elsewhere in the country
   - an analysis of the options against the 'fit for purpose' criteria
   - the impact that each option might have on local partnership working
   - the application of financial models, its impact on management structure and ways of saving resources that will have the least damaging effect on the effectiveness of the PCTs

CONTEXT

3. Whilst covered to a degree within the document and especially in some of the criteria it is important to recognise the back cloth to the proposals. The move to have Strategic Health Authorities coterminous with Government Office areas, which we would support, reflects the recognised need to ensure that all in the Public Sector work in partnership. Such partnership is most vital at local community level and the development of Local Strategic Partnerships, shared thematic strategic plans and the emerging Local Area Agreements are all symptomatic of the way the principal public sector agencies, dominated by Local Government and the NHS, now work together. This work generates shared priorities for local communities and gathers commitment to work proactively to achieve them.

4. The health and well being agenda is rightly recognised as a shared issue. No agency on its own can ever hope to make the kind of advance envisaged in reducing health inequalities especially in communities such as those in Tees Valley. Whatever structural solution is agreed it must be fit for this purpose above any other. The recent White Paper "Our Health, Our Care, Our Say" has developed this principle and identified roles for agencies. In particular in para 2.54 the following is stated :

   "Our plans to strengthen PCTs will ensure enhanced commissioning for health lies in the heart of their activities. Subject to the outcome of current local consultations on the proposed reconfiguration of PCTs and SHA boundaries we expect to see the development of greater coterminosity between health and local government bodies; both between PCTs and Local Authorities and between SHAs and Government Offices for the Region".

5. In addition to the development of health strategy Local Government and the NHS also share the responsibility of protecting and safeguarding the most vulnerable. This does not just rely on robust shared strategies but also on effective integrated implementation and performance management. Close relationships and straightforward communication channels are essential for this.

6. Although not directly related to the consultation, the future provision of health and social care in community settings is relevant. The continued provision of integrated

services often within shared management structures is vital to direct care to individuals and is the manifestation of strategic partnership.

COMPARATIVE APPROACHES

7. In other parts of the country proposals are being developed to rectify mistaken configurations of the past. Taking West Yorkshire as an example there is a single proposal to create 5 PCTs by merging the existing 15. This new configuration creates coterminosity with the 5 Local Authorities and creates a simplified partnership arrangement. Economies from this are self evident and reasonable. The North East has the highest level of Unitary Authorities and it might be expected that the preservation of coterminosity would have a similar priority. Other SHAs are only consulting on the one option because proposals are so well defined.

8. There are other examples where the merger of PCTs creates sensible coterminosity and partnership. Indeed the proposal within Durham (excluding Darlington) to create cotermintosity at the principal Council level is one of them. Also worthy of challenge is the related inflexible approach to how savings are to be made. There are clearly parts of the country much better placed to make savings because of their historic configuration. It should be noted that some SHAs seem to have regarded coterminosity with principal council areas as paramount rather than simple savings through merger.

ANALYSIS OF THE OPTIONS AGAINST THE FIT FOR PURPOSE CRITERIA

9. Although there is no explicit indication that the seven criteria are in any way weighted, it would seem that the one relating to improving commissioning and effective use of resources is seen as fundamental. David Flory has placed great emphasis on the need for PCTs to concentrate on this and has argued that PCTs must be able to break the dominance that hospital based NHS Trusts have in the debate about service distribution and quality. It is only through this that resources would be redirected to community and primary care from the acute sector.

10. The consultation document contrasts each option and assesses them against the seven criteria. A judgement is made in each case as to which option fits each criterion best. In reality the position is more complex as several criteria are interrelated. Indeed some rely on others to be fulfilled.

Taking each criterion in turn :

- **secure high quality, safe services**

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

- if it were the case that a larger PCT might facilitate improvement in provider care this would certainly be true for non acute care but only if LAs were directly linked into the framework. An overconcentration on the problems of the acute sector leads to a mistaken belief that all other aspects of health, social and childcare can be allowed to just fit in rather than having just as much priority

- it can also be inferred from both the consultation document and presentation of it that the concerns about safe care are rather more about the lack of resource in the acute sector rather than the ability of a commissioning agency to influence provider actions. If this were indeed the case then investment in the acute sector might well continue to rise rather than be abated as anticipated.

➢ **improve health of the population and reducing inequalities**

- one factor recognised as fundamental to reducing health inequalities across the nation and within localities is the ability of partner agencies across the public sector and beyond to work together with shared focussed priorities that match national policy. There seems little debate that coterminosity, as recognised in the Health White Paper, facilitates the necessary partnership arrangements whilst option 1 has the potential to damage past achievement and hinder future progress.

➢ **strong relationships with independent contractors and their practices and roll out practice based commissioning**

- existing PCT arrangements have fostered relationships with practitioners. Any change would inevitably jeopardise this. The very fact that it is recognised that a large PCT would have set up local arrangements to attempt to preserve relationships is to say that local arrangements are the ideal.

➢ **improve public involvement and develop robust communication systems**

- involvement of the public and users is the more effective if done locally and through well established mechanism that LAs and Partnerships are putting into place. Option 1 would inhibit this process or as a minimum make it more complex. In turn it is likely to reduce the effectiveness of the involvement.

➢ **financial balance and the management of risk**

- great emphasis is placed on the risk that any NHS organisation might encounter financial difficulties. It is also suggested that the size of the organisation influences its ability to avoid or deal with such difficulties. However this is very much opinion and there is no evidence to support the suggestion. Analysis of the 18 Trusts that have been identified for immediate turnaround support shows that 10 of the 18 organisations are NHS Trusts and 8 PCTs. It includes budgets in excess of £400m and as low as £85m; there is no evidence of the relationship between risk and size

- there are many other factors that influence the effectiveness of financial control

- there are several mechanisms available within the NHS that allow risk sharing and brokerage.

- in a larger PCT there would be serious concerns that a mechanism to alleviate overspending might unfairly prejudice the allocation of funds across existing PCT communities

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

- only a coterminous solution fulfils this criterion; option 1 would move PCTs away from close co-ordination

- it is important to emphasise that this criterion applies across a wider range of LA functions well beyond the traditional social services area. It is this very diversity that reinforces the need for close collaboration. Very few of the LA's main functions are unaffected.

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

- as this criterion appears to be fundamental from an NHS management viewpoint it is important that It receives a full and objective analysis. In the context of the White Paper and the general thrust of the well-being agenda the ambition to control better the commissioning of acute services and hence be able to invest in community/primary ones is laudable

- where there is a potential difference of viewpoint is in the assumption that a larger PCT can necessarily influence this agenda more effectively whilst, at the same time, collaborating with LAs in the shared commissioning agenda in predominantly non acute areas

- dealing firstly with acute commissioning, the size of PCT does not necessarily influence its ability to act. That ability is more influenced by the policies that apply to the NHS commissioning model and the powers delegated to PCTs. The role of the SHA is also pivotal in that the SHA actually safeguards the process. Commissioning within the NHS is securely governed by the DH and SHAs, commissioning in the private sector is governed by explicit contract. It seems a little surprising that the NHS admits its inability to control this process and also regards a larger PCT as the solution. Also surprising is that this view is not being taken consistently across all SHAs. Also called into question is the value of having both SHA and PCT level regionally with so few PCTs. Is it not possible that the loss of the SHA level might serve the financial purpose more appropriately

- it would seem that the concentration on acute commissioning can be allowed to jeopardise the longstanding and effective commissioning arrangements with LAs across the range of services for vulnerable people. A proposal to establish locality management of a PCT only seems to show that this arrangement is the preferred model. Even if locality management were established in a larger PCT there would remain a serious concern that LAs would be obliged to adopt PCT wide policies and approaches or conversely LAs would be expected to come to a consensus on issues they would prefer to be locally decided; management seniority and decision making scope at the local level would not match that of the local authorities; inevitably the senior roles of the larger PCT would be unable, particularly at Chief Executive level, to cope with the level of involvement with the individual local authorities that would be required to ensure maximum benefit from local joint planning and commissioning

- the preferred model for LAs is for existing PCTs to continue within their shared arrangements with LAs and for acute commissioning to be undertaken through partnerships between PCTs.

THE IMPACT ON LOCAL PARTNERSHIPS

11. The principle of coterminosity has influenced the development of public sector structures for many years. In the North East the principle has been adopted for some time and has successfully facilitated the development of partnerships across the main themes of the Community Strategy and emerging Local Area Agreements. The NHS has been an effective participant in these arrangements, often across all themes and not just health, adults and children. A fundamental part of this is the equivalence of membership. Invariably Chairs, Non Executive Directors, Chief Officers and Members are personally involved in the working of partnerships. This adds considerable weight to the development of strategy and the commitment to change.

12. If such membership were removed or, at best, severely limited from the PCT end it would seriously damage relationships and therefore the impact the Public Sector has in leading and achieving community development. The commitment to local initiative and drive in areas such as Health Inequalities is essential to optimise the local impact of national policy.

13. The introduction of LAAs, Public Service Boards and associated community based policy setting and delivery lends further weight to the argument for local focused partnership.

THE FINANCIAL MODEL AND ITS IMPACT ON STRUCTURE

14. The saving of overhead costs and its reinvestment in patient care is a prerequisite. The argument that is used to support the general principle of merging PCTs is that by a greater relative saving can be made by looking at Board level posts primarily.

15. The consultation takes as its starting point in terms of savings that a certain level of overhead savings must be achieved in each PCT ie no cross subsidy at any geographic level or flexibility As to level of saving. This produces the perverse outcome of option 1 being the preferred approach during consultation despite moving away from the otherwise preferred outcome of coterminosity and the perverse outcome of consultation on a second option which appears to produce, potentially, a single executive group servicing a number of PCT Boards, which appears to be of no benefit at all against the criteria.

16. It is by no means clear what specific structure would support either option. Indeed in structural terms they could be very similar, albeit with different numbers of Boards. The essential feature of interest to the Local Authorities is the existence of coterminous PCTs with individual Executive Board Members forming a local management structure that can make decisions, within the remit set by the SHA, in co-ordination with Local Authorities and other partners.

17. Whilst it is for the NHS to decide how it might implement a continuing coterminous solution it is possible to identify a range of options for economising and finding value for money. Some options rely on sharing across PCTs some with LAs. Examples include :

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

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

It is also noteworthy that levels of overhead (management and Administrative cost) vary wildly between existing PCTs as a proportion of expenditure. By reducing the level of cost to the best practice PCT in the Region a considerable saving would be made.

CONCLUSIONS

18. The Local Authorities believe that the body of evidence supports continuing coterminosity. They do so for the following reasons :

- it develops further the already well tried coterminosity model across the North East, now supported explicitly within the White Paper
- it quickens the pace of partnership working across the Public sector
- it meets the requirements to develop shared health and well being priorities
- the option' has the ability to strengthen NHS commissioning
- there is no evidence that larger organisations are better managed financially
- there are suitable ways available to find the required savings that should not, if well planned, infringe on the workings of PCTs as commissioners and partners at the local level

LOCALITY PLUS

Hartlepool Borough Council'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.

HARTLEPOOL
BOROUGH COUNCIL

Locality Plus

Hartlepool Borough Council's response to SHA consultation on PCT Reconfiguration

Page

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.

SUMMARY

Hartlepool Borough Council 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 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 the Tees Valley 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.