JOINT SCRUTINY CO-ORDINATING COMMITTEE AND ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM AGENDA

HARTLEPOOL
BOROUGH COUNCIL

Friday 29 September 2006

at 2.00 pm.

In The Council Chamber

MEMBERS: SCRUTINY CO-ORDINATING COMMITTEE AND ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM:

Councillors S Allison, Barker, Belcher, Brash, Clouth, R W Cook, Fleet, Gibbon, Griffin, Hall, James, Laffey, Lauderdale, Lilley, A Marshall, J Marshall, Preece, Rayner, Shaw, Wallace, Wistow, Wright, Worthy and Young

Resident Representatives:

Mary Green, Evelyn Leck and Linda Shields

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. **RESPONSES FROM THE COUNCIL, THE EXECUTIVE OR COMMITTEES OF THE COUNCIL TO REPORTS OF THE SCRUTINY CO-ORDINATING COMMITTEE**
   No items.

4. **CONSIDERATION OF REQUEST FOR SCRUTINY REVIEWS FROM COUNCIL, EXECUTIVE MEMBERS, NON EXECUTIVE MEMBERS AND SERVICE DEPARTMENTS**
   No items

5. **FORWARD PLAN**
   No items

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

No items.

7. **CONSIDERATION OF FINANCIAL MONITORING/CORPORATE REPORTS**

No items

8. **ITEMS FOR DISCUSSION**

8.1 Draft Response to Hartlepool PCT – Consultation on Proposed Management Arrangements – *Scrutiny Support Officer* (to follow)

8.2 Hartlepool PCT – Consultation on Proposed Management Arrangements – *Scrutiny Support Officer*

9. **CALL-IN REQUESTS**

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

JOINT SCRUTINY CO-ORDINATING COMMITTEE AND ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM REPORT

29 September 2006

HARTLEPOOL BOROUGH COUNCIL

Report of: Adult and Community Services and Health Scrutiny Forum

Subject: Draft Response - Hartlepool PCT: Consultation on Proposed Management Arrangements.

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1. PURPOSE OF REPORT

1.1 To present the Adult and Community Services and Health Scrutiny Forum response to Hartlepool PCT's consultation in relation to its proposed management structure.

2. BACKGROUND INFORMATION

2.1 Hartlepool PCT was recently confirmed as a statutory body following the Department of Health exercise, "Commissioning a Patient-Led NHS". In determining its future management arrangements Hartlepool PCT consulted key stakeholders including this Overview and Scrutiny Committee to seek views in relation to its proposed management structure.

2.2 The Adult and Community Services and Health Scrutiny Forum met on September 19 2006 to consider the proposals. This meeting followed the Forum's previous submission to the Strategic Health Authority (SHA) in March 2006, recommending the continuance of 'true' (i.e. one to one) coterminosity between the PCT and the Borough Council which is also a view unanimously supported by the Borough Council at its meeting on 16 February 2006.

3. INTRODUCTION – SETTING THE SCENE

3.1 On 28 July 2005, Sir Nigel Crisp, Chief Executive of the NHS, issued a policy document – "Commissioning a Patient-Led NHS" in which he set out his views

on the next steps in creating a Patient Led NHS. The document builds upon the "NHS Improvement Plan" and "Creating a Patient-Led NHS". It was described as seeking to create a step change in the way services are commissioned by frontline staff to reflect patient choices. The document outlined a programme of reform to improve health services. It included proposed changes to the roles and functions of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs), which would have implications for the configuration of these organisations.

3.2 The SHA submitted its proposals for the implementation of "Commissioning a Patient Led NHS" during October 2005, to an "expert panel" specifically established by the Secretary of State to examine all proposals. Their proposal, so far as Durham and the Tees Valley was concerned, was for a single PCT for County Durham and Darlington and a single PCT for "Teesside" through merging the existing PCTs for Hartlepool, North Tees, Middlesbrough and Langbaurgh.

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

(a) 1 option for a SHA coterminous with the boundaries of the Government Office of the North East Region.

(b) 2 options for PCTs:-

(i). Option 1 – two PCTs: a County Durham and Darlington PCT and a Teesside PCT.

(ii). Option 2 – six PCTs, retaining the five Tees Valley unitary authority PCTs and a single County Durham PCT.

3.4 However, the consultation document included a proposal for a single management team which does not appear to be consistent with the Secretary of State's decision. The SHA consultation document states:

"There has been previous experience of sharing director posts across two PCTs in the area and this has proved unworkable. The existing PCT chief executive community does not believe that it would be possible to work effectively in this way."
The consultation refers to management working practices which would be the same under both options, thus it is arguable only one genuine option was consulted upon.

3.5 The consultation period commenced 14 December 2005 with a completion date of 22 March 2006. During the consultation process strong support was expressed from the main public sector bodies in Hartlepool to retain a Hartlepool PCT with its own management team. This includes Hartlepool Partnership's response: 'Locality Plus' – Retaining a Co-terminus PCT in Hartlepool **(Appendix 1)** and also Hartlepool Borough Council. The Adult and Community Services and Health Scrutiny Forum response to the consultation process is attached at **Appendix 2.**

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

3.7 The Department of Health's Acting Permanent Secretary wrote on the 16 May 2006 **(Appendix 3)** to the Chief Executive of the Strategic Health Authority to explain that the Secretary of State's decision was subject to a number of conditions (outlined below).

(i) All PCTs must retain and build on current partnership arrangements, including Local Area Agreements already established in partnership with local authorities. They should also consider the use of joint appointments with local authorities where appropriate.

(ii) A strong locality focus must be retained, and where necessary, locality structures should be put in place. Funding plans to reduce health inequalities and address poverty in socially and economically deprived areas such as Easington and Chester le Street must be maintained and PCTs should ensure patient and public involvement and Practice Based Commissioning arrangements are maintained and improved.

(iii) All PCTs must also deliver their share of the 15% management cost savings, strengthen commissioning and ensure robust management of financial balance and risk.

(iv) The SHA should consider whether shared management teams would benefit PCTs in meeting these criteria. The Department would be very supportive of plans for joint management teams where you believe that to be the best solution.

(v) Where joint management teams are proposed, the SHA should also consider shared PEC arrangements and how clinical time spent on corporate business could be minimised, allowing them to focus instead on service redesign, bringing benefit to patients in their locality.

(vi) Where recommendations were made in the consultation reports setting out conditions that should be applied to the new configuration, the new

PCTs and SHAs should consider these conditions and determine how they should be taken forward and monitored.

3.9 Following the announcement, the Strategic Health Authority wrote to all NHS PCT Executives and Chairs on 23 May 2006 to consider the conditions set out in the Acting Permanent Secretary's letter and 'to work with Chief Executives within their cluster to begin to identify the shared management arrangements that will deliver Primary Care Trusts that are fit for purpose for the future.' **(Appendix 4).** This letter effectively ruled out consideration of the establishment of a Hartlepool PCT with its own management team prior to any discussion with the council or public. There has been no subsequent consultation on this option.

3.10 Thereafter, the Strategic Health Authority wrote on the 30th May 2006 **(Appendix 5)** to all Local Authority Chief Executives to outline the savings requirement from the twelve PCTs. The twelve PCTs have to reduce management expenditure by £10 million without impacting on service delivery. For the Tees Valley PCTs this amounts to approx £2 million and, for Hartlepool specifically, the savings requirement is £376k.

3.11 The Department of Health has given PCTs guidance on how those efficiency savings can be made and these conditions limit even further the way in which the PCTs can release savings. For example no savings can be made from management costs relating to the implementation of Choosing Health i.e. no management savings can be made from areas relating to Public Health. The Forum was also advised that any savings made as a result of PCT deficit reduction can be considered so savings against vacant managers posts can not be counted twice. However, in the absence of any source and having noted that this point is not within the October guidance on savings the Forum is still seeking clarification in relation to this point.

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

3.13 In the absence of any formal proposals the Adult and Community Services and Health Scrutiny Forum met on the 23 June 2006 to consider a series of options that the Local Authority could assume that PCT Chief Executives considered and those that involve greater integration with the Local Authorities, which the Forum assumed were not considered as a serious consideration by the PCT Chief Executives as no formal discussions took place with the Local Authority in relation to the way in which the 15% savings can be made.

3.13 Hartlepool PCT finally presented its proposals to the Forum on 19th September for its management structure (outlined below) which it believes will enable the organisation to deliver its share of the 15% management cost savings, strengthen commissioning and ensure robust financial management of financial balance and risk.

4. BASIS FOR CONSULTATION

4.1 Hartlepool Council has obtained legal advice from leading counsel on the duties of the SHA and PCT to consult under the terms of the Health & Social Care Act 2003 and Health Scrutiny Regulations This advice was communicated to these bodies by the Chief Executive in letters dated 28 July 2006 and 11 August 2006. The SHA rejected the view that it had a legal duty to consult. The PCT did not express a view on its legal obligations or otherwise but agreed to consult. The Adult and Community Services and Health Scrutiny Forum has necessarily conducted this enquiry in line with the legal advice received by the Council that the PCT Consultation in relation to the proposed management structure comprised a substantial change in the provision of health services which necessitates a formal consultation process involving the local authorities and the Patients and Public Involvement Forums. The requirement for such consultation enables a Health Scrutiny Committee to refer disputed matters to the Secretary of State for consideration before any changes can be implemented.

4.2 Whilst Hartlepool PCT did not accept that management arrangements are subject to a formal statutory consultation both parties agreed to proceed with the investigation in the spirit of partnership working whilst operating within their respective legal frameworks. While Members of the Adult and Community Services and Health Scrutiny Forum considered that the timetable proposed by HPCT (3 weeks) was too short to allow due process, it nevertheless wished to interpret its statutory duty as flexibly as possible in the circumstances. Consequently, the Forum agreed to expedite the process by hosting a special joint meeting with its management committee, Scrutiny Co-ordinating Committee. This meeting was arranged with the minimum notice that could be given in order that at least an interim report could be submitted to the authority's Cabinetat its meeting on 9th October.

5. OVERALL AIM OF THE SCRUTINY INQUIRY

5.1 The overall aim of the Scrutiny Inquiry was to provide a response to the Hartlepool PCT in relation to it's proposed management structure.

6. MEMBERSHIP OF THE ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM

6.1 The membership of the Adult and Community Services and Health Scrutiny Forum 2006/07 Municipal Year was as detailed below:-

Councillors: Barker (Vice-Chair), Belcher, Brash, Fleet, Griffin, Lauderdale, Lilley, Rayner, Wistow (Chair), Worthy and Young.

Resident Representatives: Mary Green and Evelyn Leck

7. METHODS OF INVESTIGATION

7.1 Members of the Scrutiny Forum met on 19 September 2006 to discuss and receive evidence in relation to this inquiry. A detailed record of the issues raised during this meeting is available from the Council's Democratic Services.

7.2 Due to the limited time available during which to undertake this inquiry, the key method of investigation involved detailed reports supplemented by verbal evidence by representatives of Hartlepool Primary Care Trust.

SCRUTINY FINDINGS

8. CHALLENGES FACING HARTLEPOOL PCT

8.1 Members were informed about the major challenges facing Hartlepool PCT which are outlined below. The Forum was advised that it is within the context of these challenges that the management options for Hartlepool PCT have been developed.

8.2 **Management Cost Savings** – The Forum was informed that Hartlepool PCT has been unable to find the necessary 15% savings while retaining management capacity and the skill base that it requires to achieve Fitness for Purpose. However, it has not been provided with any data to demonstrate how it has reached this conclusion. In addition the Forum considered that there is an over-emphasis on meeting the 15% management saving criteria without an indication of how the other conditions (as detailed in the Acting Secretary's letter) will be achieved.

8.3 **Joint/Shared Management** – Hartlepool PCT informed Members that the SHA, in line with the Acting Permanent Secretary's letter, is considering the feasibility of shared management arrangements among PCTs. However, as noted above the SHA in May did not consider or invite PCTs to consider any other option. Further, given the high priority placed on achieving financial targets Members were informed that the SHA may favour one shared management team, including Chief Executive and Executive Directors for Hartlepool, Stockton, Middlesbrough and Redcar & Cleveland. While Members were informed that this would drive out the required savings by drastically reducing staff, no financial details were provided to support this.

8.4 While the Forum acknowledged the challenging nature of the financial targets facing Hartlepool PCT, Members considered that there was an over-emphasis on the financial savings and joint management at the expense of the other conditions which the Acting permanent Secretary's letter of May asked them to meet..

8.5 **Budget Deficit** - Hartlepool PCT has never balanced its books since its inception in 2001 without repayable aid from the SHA known as brokerage. The size of the deficit has increased until it currently stands at £6 million. The Department of Health and the SHA require this deficit to be cleared by 2008 and a surplus to be generated. Forum Members expressed significant concern around the financial situation of the PCT, particularly in light of the increasing underfunding per year of over £4 million.

8.6 Members were informed that every health organisation has a statutory duty to break even each year - failure to do is increasingly likely to result in Boards/senior officers being removed and turnaround teams brought in to run the organisation. In view of this the Forum was alerted to the possibility that the SHA may question Hartlepool PCTs long-term viability as a stand-alone organisation. The deficit has led directly to an Audit Commission Public Interest Report (PIR).

8.7 **Fitness for Purpose** - As an unreconfigured organisation, Hartlepool PCT is subject to an extensive Fitness for Purpose assessment, currently being undertaken by McKinsey & Co. Although a full report is awaited, Forum Members were informed that it is becoming clear that the assessment considers that the PCT has neither sufficient management capacity nor capability to face new challenges, especially with regard to commissioning.

8.8 **Commissioning Services** - Hartlepool's role as a commissioner of services will become a much more significant part of its function in the future. The Forum was advised that in common with its neighbour PCTs, the organisation has neither the capacity nor the expertise to fulfil this role effectively.

8.9 The PCT suggested that a sensible way forward is to establish a Tees-wide commissioning structure, which, once the member PCTs have identified their own health needs, would commission requisite services on behalf of all.

8.10 Members of the Forum however expressed significant concerns around the extent to which the PCT would be delegating its powers to a joint sub committee. It was concerned that this might lead to a loss of local accountability and responsiveness to local health needs Members considered that this was not in the best interests of the health and wellbeing of the residents of Hartlepool, given the extent and widening nature of health inequalities in the town together with the need to be responsive to local choices and preferences

for the planning and delivery of health services alongside local authority and community services.

8.11 **Joint working and Locality Focus** - The Forum was advised that Hartlepool PCT was keen to retain the ability to make policies and decisions that are driven by the needs and wishes of Hartlepool's communities and residents. As such, any management team must be able to carry out the decisions of the HPCT Board. In addition, the PCT wished to protect and retain its ability and capacity to work jointly and meaningfully with its partners, including HBC.

8.12 In light of the evidence presented to the Forum, however, members expressed concern that a joint management team, including a joint Chief Executive would in practice be compromised in it's ability to carry out decisions relating to healthcare in two localities. Forum Members highlighted the Acute Services Review as one example where a Joint Acting Chief Executive of both Hartlepool PCT and North-Tees PCT would have to support two competing localities in respect of Maternity and Paediatric Services. The Forum was not convinced that this arrangement was workable

8.13 The Forum was informed that while the future of management is undecided, the position of the Non-Executive Chair and Non-Executive Directors are not. Hartlepool PCT will have a dedicated team of Non-Executives appointed by the NHS Appointments Commission.

9. FUTURE MANAGEMENT OPTIONS FOR HARTLEPOOL PCT – OPTIONS ASSESSMENT

9.1 The Forum heard that despite best efforts, HPCT's Senior Management Team cannot find a way to maintain a separate management structure dedicated solely to the Hartlepool PCT Board, which achieves the necessary 15% savings, satisfies Fit-for-Purpose criteria and enable delivery of the financial recovery plan. Consequently, the following two options were suggested as a possible way forward by the PCT:-

(1) **Option 1 –** One management team servicing four PCT Boards.

(2) **Option 2 –** Two management teams, one servicing Hartlepool and North Tees PCT, the other Middlesbrough and Redcar & Cleveland

9.2 The following options assessment was presented by Hartlepool PCT:-

(a) Option 1 – One Tees Valley Management Team

Advantages

(i). Easily achieves 15% management savings – and more – that can be invested in front-line services.

(ii). Very likely to gain approval from SHA

(iii). Could ease pressure on financial recovery plan.

Disadvantages

(i). Concerns that management team would find it hard to give proper focus to each Board's wishes.

(ii). Risk that the four PCTs will become clones of one another, rather than organisations that develop to meet their own area's health demands

(iii). Risk of the need for extra locality staff, which would add a layer of bureaucracy and lessen the financial benefits.

(iv). Risk of power centralising in Middlesbrough, as the centre of the patch.

9.3 While Members recognised the challenging nature of the financial savings to be achieved by the PCT, the Forum considered that there are considerable risks to the partnership working which has led to a number of innovative approaches to meet local healthcare needs in Hartlepool if the PCT was to become subsumed within a Tees-wide PCT.

(b) Option 2- Management Team shared with North Tees PCT

Advantages

(i). Hartlepool and Stockton currently enjoy a good working relationship, both between Chairs and officers.

(ii). Director posts would become more demanding, but would reduce the risk of extra locality deputies.

(iii). Non-Executive Directors would find it easier to maintain control over individual PCT strategy.

(iv). Protects jobs in Hartlepool better than Option 1.

(v). Properly thought through, will protect ability to work jointly with HBC regarding service delivery, joint commissioning and health improvement.

Disadvantages

(i). Does not drive out savings equivalent to Option 1: meeting targets will still be challenging.

(ii). May need to persuade the SHA.

(iii). Assumes that North Tees PCT agrees – its own Board has yet to take a view.

9.4 The Forum learnt that Hartlepool PCT considers that the proposals seek to ensure that commissioning is strengthened both locally by working with Local Authority colleagues and Practice Based Commissioning (PBC) Groups at a larger population level to bring about a step change in commissioning skills and capacity. The details of these proposed arrangements were significantly less well developed in the presentation than those at the Tees wide level

9.5 In addition, the PCT informed Members that local management of community services will be maintained under the proposals presented by facilitating integrated/joint management of front line community services where appropriate. However, the proposed Tees Management arrangement (appendix 7 refers) demonstrates a joint appointment across a proposed 'north of the tees' management structure.

9.6 The Forum was advised that local management of community services will be complemented by the development of a joint role of Associate Director/Director of Health of Improvement in each PCT/LA area that addresses local issues effectively for both PCTs & Local Authorities. The forum was told this arrangement would ensure that the 15% savings target is achieved whilst maintaining/enhancing capacity and skills by the creation of more shared functions, where this will be more efficient and effective. In addition, this proposal ensures that redundancies are kept to a minimum. We recommend that the council seek detailed proposals of how this arrangement would work in order to determine that its own requirements of this role can be met

9.7 While accepting that option two did strengthen commissioning Members were disappointed to note the lack of information in relation to PBC and firm proposals demonstrating how the PCT under this option proposed to maintain local understanding and networks that will deliver a locally sensitive shift to PBC. The Forum was keen to ensure that PBC leads to improvements in

services for patients and that the proposals ensured that the PCT would engage appropriately with the wider Hartlepool agenda.

9.8 Furthermore, Members expressed concern around the ability of a joint management team to deal with differing, and potentially competing local needs.

10. HARTLEPOOL PCT MANAGEMENT PROPOSALS

10.1 The Forum was advised that under the proposals presented to the SHA HPCT Board will be:-

(a) Hartlepool PCT will be a statutory body with its own Board with a Chairman & Non Executive Directors appointed by the Appointments Commission.

(b) HPCT will receive its own financial allocations to meet the health and health care needs of its population and will need to meet its statutory duties to achieve financial balance and the re-payment of previous deficits.

(c) HPCT Board will consider how it can best meet its duties and responsibilities, and where appropriate may decide to work collaboratively with other organisations, including other PCTs or Local Authorities. **Appendix 6** shows the Board and proposed Sub Committees for consideration by the 4 Tees PCTs' Boards.

10.2 The PCT informed Members that after careful consideration involving discussions with a range of stakeholders and the initial feedback following the Fitness for Purpose Review, Hartlepool PCT is proposing that the best way to meet all the requirements of PCTs and partner agencies is to create two management teams, incorporating some Tees wide functions where appropriate.

10.3 The proposal is shown in **Appendix 7** and the PCT advised Members that it demonstrates a significant presence at a senior level north of Tees, supported by some Tees wide functions where this is the most effective way to undertake these. Further, the PCT informed the Forum that several areas must have senior local leaders in each PCT/LA area and indeed may lead to the creation of joint posts, subject to further discussion and agreement over governance and funding arrangements etc. This is shown in **Appendix 8**. In summary the PCT stated that for Hartlepool this option will enable the PCT to create senior posts focussed on areas of work with direct relevance to Hartlepool Borough Council. However, no detail of these proposals is yet available to enable the Forum to form a view on whether they might meet the conditions in the letter from the Acting Permanent Secretary

10.4 In respect of the Professional Executive Committee (PEC) arrangements the Forum was informed that national guidance on the role and establishment of PECs is awaited and discussions are underway with PEC Chairs in Hartlepool and North Tees to develop proposals for consideration by both Boards and given the emergence of 2 effective Practice Based Commissioning Groups (in Hartlepool and North Tees) the option of having a single PEC for North of Tees is being considered. The PCT confirmed that views will be sought on this.

10.5 Having considered the PCT proposal for a revised management structure Members expressed concerns around the complex nature of the arrangements being proposed as the proposal results in a move away from a two layer structure of PCT and SHA to a multi-layered structure with PBC Boards, PCT Boards, Joint Management Teams and a number of Tees Wide Sub-Committees. Consequently Members questioned the actual level of managerial efficiency to be gained by a restructure that increases the number of layers from two levels to five.

10.6 The Forum recognised that good partnership working across public sector agencies within localities is essential in reducing health inequalities and improving health outcomes for local people. While recognising the challenges facing Hartlepool PCT, Members were keen to ensure that future progress would not be hindered by the new structures and wished to preserve close working in vital areas of service. They have yet to receive sufficient evidence to demonstrate that this condition will be met by the PCT re-configuration and that the Council will be able to relate its own working arrangements to them. Consequently, it has yet to be convinced that even the existing levels of joint needs identification, joint commissioning or joint service delivery can be maintained and still less improved.

10.7 Members further considered that any reduction in influence over the establishment of local priorities would, if not carefully managed and closely integrated within the local governance structures reduce the scope for local innovation, the impact of which could be considerable at a time when inequalities in health are widening.

10.8 In relation to the proposal to establish two management teams north and south of the Tees Members expressed concern at the loss of local accountability as decision-making is devolved to the 'Joint Strategic Planning and Commissioning Committee' as the accountable body.

10.9 In light of all these issues, the Forum considers that the proposal needs to developed further to clearly outline how local responsiveness will be maintained to deal with differing local needs. This need is highlighted in particular by the Acute Services Review where a joint management team must support both Hartlepool and North-Tees PCT Boards in their respective acceptance/rejection of the Darzi proposals.

10.11 Members therefore reached the view that the loss of a locally-focussed PCT in favour of a Joint Management Structure will make health improvement in Hartlepool more difficult to achieve. Members consider it vital to preserve joint working in Hartlepool and reinforce the community and public health agenda. Members consider that the direction in 'Delivering the NHS Improvement Plan' [2005] which 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 refers) is a possible way forward that must be explored to ensure Hartlepool PCT remains integrated within the local governance structures.

11. CONCLUSIONS

11.1 The Adult and Community Services and Health Scrutiny Forum concluded:

(a) That healthcare in Hartlepool has benefited from the existence of a true co-terminous PCT;

(b) That the SHA proposals to reconfigure Hartlepool PCT did not take into account all the conditions laid down by the Acting Permanent Secretary including the need to 'retain and build on current partnership arrangements';

(c) That these proposals are not fully developed in that respect and have not been prepared in partnership with the local authority;

(d) That local accountability and local decision making is essential to tackle health inequalities and poverty in a socially and economically deprived area such as Hartlepool;

(e) That the Adult and Community Services and Health Scrutiny Forum is undertaking this inquiry on the basis of legal advice received by Council that established that the management structure comprises a substantial change in the provision of health services as outlined in the Health Scrutiny Guidance;

(f) That Hartlepool PCT is consulting with this Health Scrutiny Forum in an informal capacity;

(g) That the PCT is consulting on proposals that based on *"previous experience of sharing director posts across two PCTs in the area…has proved unworkable."* [Source SHA Consultation Document].

(h) That the following challenges were facing Hartlepool PCT in developing its management proposals;

(i). Hartlepool PCT has stated that it has been unable to find the necessary 15% savings while retaining management capacity and the skill base that it requires to achieve Fitness for Purpose;

(ii). The SHA, in line with the Acting Permanent Secretary's conditions, is considering the feasibility of shared management arrangements among PCTs;

(iii). Hartlepool PCT has never balanced its books since its inception in 2001 without repayable aid from the SHA known as brokerage. The size of the deficit currently stands at £6 million. The Department of Health and the SHA require this deficit to be cleared by 2008 and a surplus to be generated;

(iv). Hartlepool PCT has been under-funded for a number of years now which has led to the deficit.

(v). That every Health organisation is under a statutory duty to break even every year. Failure to do so may result in turn-around teams being brought in to run the organisation and may even threaten the long-term viability of Hartlepool PCT as a stand-alone organisation;

(vi). The deficit has led directly to an Audit Commission Public Interest Report (PIR);

(vii). As an unreconfigured organisation, Hartlepool PCT is subject to an extensive Fitness for Purpose assessment. Although a full report is awaited, the assessment considers that the PCT has neither sufficient management capacity nor capability to face new challenges, especially with regard to commissioning;

(viii). Hartlepool's role as a commissioner of services will become a much more significant part of its function in the future. However, the PCT considers the organisation has neither the capacity nor the expertise to fulfil this role effectively and therefore suggested establishing a Tees-wide commissioning structure which, once the member PCTs have identified their own health needs, commissions requisite services on behalf of all;

(ix). Hartlepool PCT is keen to retain the ability to make policies and decisions that are driven by the needs and wishes of Hartlepool's communities and residents;

(x). The PCT has stated that it wishes to protect and retain its ability and capacity to work jointly and meaningfully with partners, especially Hartlepool Borough Council;

(i) That Hartlepool PCT has stated that its Senior Management Team cannot find a way to maintain a separate management structure dedicated solely to the Hartlepool PCT Board, which achieves the necessary 15% savings, satisfies Fit-for-Purpose criteria and enables delivery of the financial recovery plan;

(j) That the Forum questioned the actual managerial efficiency gains to be accrued from a structure that was being increased from two layers to five;-

(k) That two options were proposed as a possible way forward by the PCT, namely;

(i). one management team servicing four PCT Boards; (Tees Wide) and;

(ii). two management teams, one servicing Hartlepool and North Tees PCT, the other Middlesbrough and Redcar & Cleveland;

(l) That the proposals seek to ensure that commissioning is strengthened both locally by working with Local Authority colleagues and Practice Based Commissioning (PBC) Groups at a larger population level to bring about a step change in commissioning skills and capacity;

(m) That under the proposals presented to the SHA HPCT Board will be:-

(i). Hartlepool PCT will be a statutory body with its own Board with a Chairman & Non Executive Directors appointed by the Appointments Commission,

(ii). HPCT will receive its own financial allocations to meet the health and health care needs of its population and will need to meet its statutory duties in this regard.

(n) That Hartlepool PCT is proposing to create two management teams, incorporating some Tees wide functions where appropriate. (Option 2 refers);

(o) That both options pose considerable risks to the partnership working which has led to a number of innovative approaches to meet local healthcare needs in Hartlepool;

(p) That local influence is greatly diminished under the proposals as powers of decision and spending are delegated to a Tees-wide commissioning organisation;

(q) That the proposed management structure proposed by HPCT adds further layers of complexity to its governance arrangements;

(r) That good partnership working across public sector agencies within localities is essential in reducing health inequalities and improving health outcomes for local people;

(s) That the proposal to establish two management teams results in a loss of local accountability as decision-making is devolved to the 'Joint Strategic Planning and Commissioning Committee' as the accountable body;

(t) That the proposal needs to developed further to clearly outline how local flexibility will be maintained to deal with differing local needs;

(u) That it is vital to preserve joint working in Hartlepool and reinforce the community and public health agenda; and,

(v) That the direction in 'Delivering the NHS Improvement Plan' [2005] which 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 refers) is a possible way forward that must be explored to ensure Hartlepool PCT remains integrated within the local governance structures.

12. RECOMMENDATIONS

12.1 The recommendations of the Scrutiny Forum are sought in relation to this report.

13. ACKNOWLEDGMENTS

13.1 The Committee is grateful to all those who have presented evidence during the course of this Scrutiny Inquiry. We would like to place on record our appreciation, in particular of the willingness and co-operation we have received from the below named:-

Chairman of Hartlepool PCT;

Officers representing Hartlepool PCT;

Hartlepool Borough Council's Chief Executive; and

Hartlepool Borough Council's Chief Solicitor.

COUNCILLOR GERALD WISTOW,

CHAIRMAN OF THE ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM

September 2006

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BACKGROUND PAPERS

The following background papers w ere consulted or referred to in the preparation of this report:-

(i) Report of Hartlepool Partnership entitled 'Locality Plus – Retaining a Coterminus PCT in Hartlepool'

(ii) "Locality Plus" - Hartlepool Borough Council's Health Scrutiny response to the County Durham and Tees Valley Strategic Health Authorities consultation document on new Primary Care Trust arrangements in County Durham and the Tees Valley.

(iii) Letter from Acting Permanent Secretary Hugh Taylor to David Flory –Dated 16 May 2006.

(iv) Letter from SHA to PCT Chairs and Chief Executives – Dated 23 May 2006.

(v) Letter from David Flory SHA Chief Executive to Local Authority Chief Executives - Dated 30 May 2006

(vi) Report of the Director of Adult and Community Services entitled 'PCT Reconfiguration – Tees Valley' presented to the Adult and Community Services and Health Scrutiny Forum held on 23 June 2006.

(vii) Report of the Chairman of Hartlepool PCT entitled 'Hartlepool PCT – Future Board and Management Arrangements' presented to the Adult and Community Services and Health Scrutiny Forum held on 19 September 2006.

'LOCALITY PLUS'

RETAINING A COTERMINOUS PCT IN HARTLEPOOL

INTRODUCTION

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

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

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

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

"Hartlepool PCT remains in its current form and develops

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

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

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

This document is structured in the following way:

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

PART I: The DISTINCTIVE POSITION of HARTLEPOOL

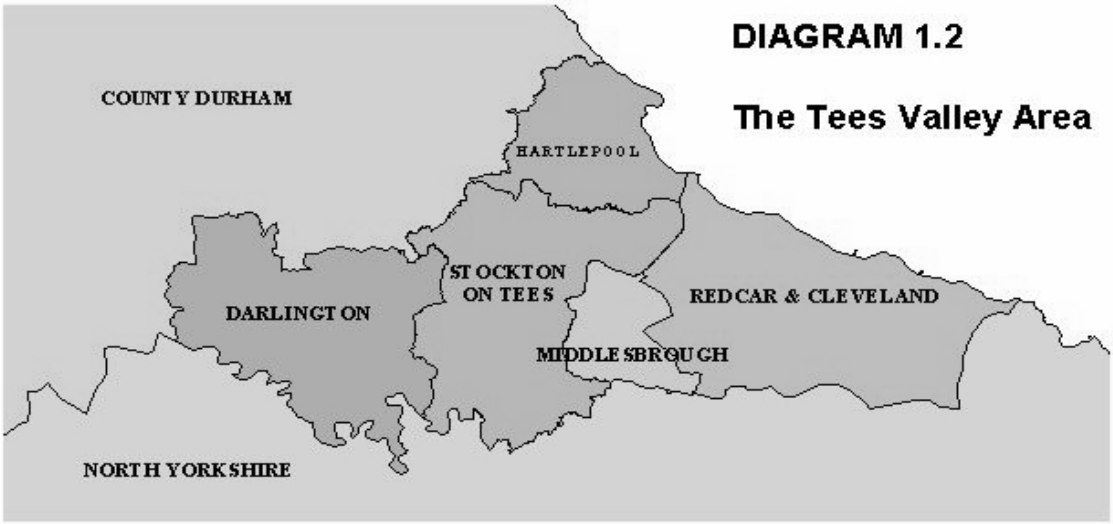
It is important to emphasise the *distinctiveness* of Hartlepool. The town is not a recent creation - the first recorded settlement was at the Saxon Monastery in 640AD, and the first charter for the town was issued in 1145. The town as it is today has grown around the natural haven that became its commercial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

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

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

DIAGRAM 1.2

The Tees Valley Area



This geographical distinctiveness of Hartlepool has some major implications for *Commissioning a Patient-Led NHS*. First, Hartlepool is a compact, sustainable settlement within which most of the needs of the residents in terms of housing,

employment, shopping and leisure can be met. Secondly, this has resulted in a very strong sense of 'belonging' – a distinct sense of civic pride.

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

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

PART II ACHIEVEMENTS of the HARTLEPOOL PARTNERSHIP MODEL

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

The Community Strategy

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

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

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

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

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

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

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

of serious concern to the partners and – more importantly – make health improvement for the people of Hartlepool more difficult to achieve.

The Local Area Agreement

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

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

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

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

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

Policy Networks

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

- The '*Foresight Group'* is an informal meeting which originally comprised the PCT CEO, the Cabinet member with the portfolio for social services, and the Director of Social Services. It now includes the Cabinet members with responsibility for Children and Adult services, the Acting Director of Social Services, and the Assistant Director of Social Services. The purpose of the group is to look at the strategic development of health and social care across Hartlepool.

- The PCT Management Team and the Borough Council SSD Directorate Team meet regularly as a Joint Directorate.

- The Cabinet of Hartlepool BC and the Board of the PCT meet as the Joint Forum to discuss shared concerns, priorities and new policy developments.

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

Joint appointments and collaborative working

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

PART III PLANS and ASPIRATIONS

Although our achievements in Hartlepool have been substantial, we have no intention of lessening the pace of change. The main vision and blueprint for the future is the '*Vision for Care'* agenda that has been developed jointly by the PCT and Borough Council on behalf of the H&CSG of the Hartlepool Partnership. It has been endorsed by the Board of the PCT, Borough Council Cabinet and the Hartlepool Partnership. A fundamental element of the vision is the development of multi-disciplinary, multi-

agency teams working together, focusing on a whole person's needs, sharing information and budgets, and using the same systems and procedures. *Vision for Care* has been given high priority by all of the partners involved, with a large amount of management time dedicated to ensuring its implementation. The PCT has invested in a Director of Partnerships, Vision for Care, who is working with the partners to drive the policy forward.

Notwithstanding the uncertainty about the current provider activities of PCTs, the drive for multi-disciplinary working will still need to be addressed and commissioned. Given the pending shortage of community nurses, we see an integrated workforce approach as an essential part of the future equation, and this implies a closer relationship with social care and the wider local authority. Indeed, this seems to be the conclusion coming from DH – the recent publication '*A Workforce Response to LDPs: A Challenge for NHS Boards*' has asked NHS Boards to improve the integration of health and social care staff, and develop strategies for redesigning staff roles to counter staff shortages in community nursing.

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

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

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

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

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

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

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

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

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

PART IV TEES PCT OPTION: RISK ASSESSMENT

Strengths of the Tees PCT Model

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

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

The main gain that could be expected from a single Tees PCT is that of greater commissioning leverage, and we acknowledge that a smaller stand alone PCT like Hartlepool would not possess such leverage. This is an important issue, but should not be overstated. First, the PCT has long recognised the need to work collaboratively across Teesside in a number of areas around strategic planning and collaborative commissioning, and proposals would have been coming to the PCT Board to enter into a Tees and Easington Commissioning Consortium even if CPLNHS had not been forthcoming. We see no reason why a stand alone Hartlepool PCT could not enter into sensible collaborative commissioning arrangements with a wider Tees PCT under some federative arrangement.

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

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

Strengths of the Hartlepool PCT Model

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

The Strength of Coterminosity

We have already demonstrated that Hartlepool PCT is an embedded partner at strategic level [in the Hartlepool Partnership] and at neighbourhood level. All are agreed that coterminosity between local authority and PCT boundaries is important, but it seems to be more important to some than others. CPLNHS notes that: '*As a general principle we will be looking to reconfigured PCTs to have a clear relationship with local authority social services boundaries; this does not need to mean a rigid 1:1 coterminosity.*'

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

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

Capitalising on the 'Out of Hospital' Agenda

CPLNHS states that one of the purposes of the consultation and White Paper on health and care services outside hospital will be to consider how to develop a wider variety of local services and models of provision in response to patient needs. It is said that: '*The White Paper will undoubtedly explore different service models. This may mean that SHAs and PCTs will want to refine proposals on service provision.*' All of this is expected to lead to '*more diverse community services providing earlier intervention and diagnosis, better support for people with long-term conditions, more day case procedures, and more effective care for people discharged from hospital*'.

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

Engaging with Practice Based Commissioning

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

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

There will also need to be sufficient local flexibility to deal with differing local needs and the capacity and willingness of GPs to engage with the PBC agenda. This is especially true in Hartlepool, where although there is agreement to work on a single

town wide commissioning group, many of the practices are currently unsuitable for practice development and the provision of a wider range of services. We believe there is still an important role here for a PCT that is coterminous with *both* the local council and the PBC governance forum. This role would consist of:

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

Engaging with Payment by Results

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

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

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

The Hartlepool Model: Mixed Mode Commissioning and Subsidiarity

Some of the functions of the NHS are best designed and delivered locally, whereas others require the influence and impact that larger commissioning units can bring. There is evidence [7] that matrix structures in which different levels of a Primary Care Organisation are vested with specific responsibilities for service commissioning can be effective. In such a model, the planning and commissioning of extended primary

care services, for example, would lie with PBC, the planning and commissioning of locality wide services [like intermediate care] would rest with the local PCT and council, and services requiring a wider population based perspective [acute and specialist services] may best be dealt with at a supra-PCT levels such as that proposed for Teesside.

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

Financial Savings

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

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

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

Conclusion

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

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

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LOCALITY PLUS

Hartlepool Borough Council's Health Scrutiny Committee's response to the County Durham and Tees Valley Strategic Health Authority's consultation on new Primary Care Trust arrangements in County Durham and the Tees Valley:

Ensuring a patient-led NHS.

Locality Plus

Hartlepool Borough Councils Health Scrutiny Committee's response to SHA consultation on PCT Reconfiguration

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's Health Scrutiny Committee.

SUMMARY

Hartlepool Borough Council's Health Scrutiny Committee thanks the SHA for providing the opportunity to comment upon the possible reconfiguration of local PCTs. Unfortunately however, we believe the consultation process is flawed for the following reasons:

- The Secretary of State required the SHA to consult on two options, the second of which was to retain the five Tees Valley unitary authority PCTs. This is not the second option presented for consultation by the SHA. Your Option 2 is the retention of the four 'unitary' PCT Boards and Professional Executive Committees (PECs), with centralised management and administration for the (now defunct) Teesside area. It is also proposed that management and administration for Darlington PCT, part of the Tees Valley City Region, be centralised within the proposed County Durham PCT.

- Your consultation document states: *"There has been previous experience of sharing director posts across two PCTs in the area and this proved unworkable. The existing PCT chief executive community does not believe that it would be possible to work effectively in this way."* This effectively dismisses your Option 2 as being a viable option.

- The above comments from your consultation document refer to management working practices which would be the same under both options. Consequently, if Option 2 is not viable neither is Option 1, thus we have no viable options to consider.

We consider there is an over-emphasis on financial savings within the consultation document at the expense of the other criteria, particularly given Sir Nigel Crisp's statement that *"we will be looking to reconfigured PCTs to have a clear relationship with local authority social services boundaries".*

The SHA should request that the Secretary of State makes the North East a special case in so far as the level of financial savings are concerned, so that the 'true coterminosity' option she proposed for consideration can be considered on a level playing field with other regions of the country. In other areas of the country the concept of true coterminosity has been accepted, with savings being made in PCTs other than those based upon unitary council boundaries. The North East is unique in having such a high proportion of unitary councils (10 out of 16 PCT areas) that it might not be possible to achieve the required savings from the remaining areas.

The consultation document implies that Option 1 is favoured over Option 2 in that it does not require reductions in employee costs to achieve the £6 Million savings proposed. However, no alternative options to achieve that level of saving have been considered. e.g.

- A Strategic Health Authority is no longer necessary. The Government has centralised regional administration for planning, transportation, housing, etc. within regional government offices, with some democratic input from their regional assemblies. Strategic health can be administered in the same manner, with the North East acting as a pilot. What level of saving would this approach achieve?

- How much will be saved if the Secretary of State's proposed option of true coterminosity is implemented? Economies will be obtained by merging local authority and PCT commissioning teams, with management being provided by the local authority and/or joint appointments.

- Sir Nigel Crisp's letter of 28 July 2005 states: *"Under practice based commissioning GPs will not be responsible for placing or managing contracts. That will be done by PCTs on behalf of practice groups, with back office functions including payment administered by regional/national hubs."* Back office savings have not been included in the consultation paper.

The assessment of the options against the required criteria presented in your consultation document does not include an assessment of Option 2 against the improve commissioning and effective use of resources criterion.

Under our assessment of the Secretary of State's proposed option of true coterminosity, it is shown to be a relatively stronger option than either of those assessed by the SHA.

The following statement made in your Submission to the Secretary of State, October 2005, is even more relevant today given the proposals within the White Paper Our Health, Our Care, Our Say for greater integration of PCT and local authority commissioning services:

"This option (Option 1) *is contentious because of the risks that we may not be able to meet our partners' needs for close working in vital areas of service provision such as older people, children and people with mental health problems and learning difficulties, or we may not be able to main a close and local relationship with GPs and other clinical and social care staff in the community."*

Given the reasons set out above, Hartlepool Borough Council's Health Scrutiny Committee recommends and strongly urges the SHA to recommend to the Secretary of State that she authorises the implementation of the true coterminosity option for Hartlepool and the Tees Valley. For the avoidance of doubt this requires five PCTs based upon the five unitary authority boundaries, each consisting of a Board, a PEC, management and commissioning teams integrated with those of their local authority, and where they can be shown to be the most efficient and effective providers, back office functions and direct service provision.

BACKGROUND

Hartlepool PCT commenced operation in April 2001 and was awarded 3-star status in 2005. It has a coterminous boundary with the local authority. Hartlepool Borough Council has been given an "excellent' (now 4 star) Comprehensive Performance Assessment (CPA) rating for each of the last 4 years. The Local Strategic Partnership, which is chaired by Iain Wright MP with the Mayor as vice-chair, has been given the top rating by the Government Office for the North East (GONE). Hartlepool is therefore a high performing 'city state', achievements of which the town is proud and which should not be put at risk without due consideration of the consequences.

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

The full Hartlepool Borough Council, at its meeting on 16 February 2006, resolved as follows:

- To support a continued Hartlepool PCT with a management team based in Hartlepool working closely with the Council and through Hartlepool Partnership in order to minimise management costs and increase local control over decisions about health services.

- That Scrutiny Co-ordinating Committee should establish whether Option 2 in the current SHA consultation document meets this objective.

- That Scrutiny should consider whether the SHA consultation document treats Options 1 and 2 even-handedly, as required by Ministers, in expressing the unanimous view of PCT Chief Executives that option 2 is *"unworkable".*

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

HARTLEPOOL

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

The Borough of Hartlepool covers an area of over 36 square miles and has a population of around 90,000. It is bounded to the east by the North Sea and encompasses the main urban area of the town of Hartlepool and a rural hinterland containing the five villages of Hart, Elwick, Dalton Piercy, Newton Bewley and Greatham. The Borough comprises part of the Tees Valley ´city region`, formed by the five boroughs of Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland, Stockton-on-Tees, and their hinterlands.

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

The creation of Hartlepool Borough Council in 1996 was a tangible and highly popular recognition of this distinctiveness, and a reaction to the unpopularity of the former Cleveland County Council. It is worth noting that both options upon which the SHA is consulting would recreate these old Cleveland County Council (previously Teesside) boundaries. As well as acquiring unitary status, Hartlepool Borough Council has also developed one of the few elected mayor systems in the country, a highly successful development which has reinforced a culture of civic pride. The Borough also has its own MP, Iain Wright, who plays a leading role in supporting partnership working across the Borough.

Hartlepool faces many problems associated with deprivation. The English Indices of Deprivation 2004

rank Hartlepool as being the 11th (concentration), 12th (average score), 15th (extent) and 18th (average rank) most deprived district nationally, and there are multiple symptoms of social and economic decline such as unemployment, crime and major health issues. Priority is attached to these issues through the Hartlepool Partnership and, for example, through the proposed spending profile for neighbourhood renewal funding in the period to 2008.

The view within Hartlepool is that these problems need to be, and are being tackled in partnership, and is the reason why we have titled this paper **Locality Plus**. Health is one of the most important partners. Serving one of the most deprived areas in England, Hartlepool PCT has been designated as a Spearhead PCT charged with delivering the public health targets earlier than other areas, a task that can only be achieved through joint working with other local partners.

ACHIEVEMENTS

Our Local Strategic Partnership (LSP) is known as the Hartlepool Partnership. This key Boroughwide strategic planning mechanism consists of a network of partnerships and statutory, business, community and voluntary sector partners working in the best interests of the residents of the Borough. It is afforded a very high priority by its 40+ members and is chaired by the town's MP, Iain Wright with our elected Mayor as vice chair. Hartlepool PCT is a core and vital member of the Partnership.

Our Community Strategy provides the Partnership's vision for Hartlepool. It serves to:

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

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

Jobs and the Economy
Develop a more enterprising, vigorous and diverse local economy that will attract investment, be globally competitive and create more employment opportunities for local people.

Lifelong Learning and Skills
Help all individuals, groups and organisations realise their full potential, ensure the highest quality opportunities in education, lifelong learning and training, and raise standards of attainment.

Health and Care
Ensure access to the highest quality health, social care and support services, and improve the health, life and expectancy and wellbeing of the community.

Community Safety
Make Hartlepool a safer place by reducing crime, disorder and fear of crime.

Environment and Housing
Secure a more attractive and sustainable environment that is safe, clean and tidy; a good infrastructure; and access to good quality and affordable housing.

Culture and Leisure
Ensure a wide range of good quality, affordable and accessible leisure and cultural opportunities.

Strengthening Communities
Empower individuals, groups and communities, and increase the involvement of citizens in all decisions that affect their lives.

Although Health and Care is the most evident way in which health issues are integrated into a wider strategy, it is evident that all the themes impinge upon the health and wellbeing of Hartlepool residents. The Health and Care theme is the responsibility of the Health & Care Strategy Group (H&CSG), a multi-agency group chaired by the Chief Executive of the PCT, which sets the strategic direction for the development and provision of health and care services across all care groups. It oversees the work of the planning groups, local implementation teams and partnership boards, and, through the Local Delivery Plan, links to the community strategy and other plans across the LSP. There are seven planning groups that feed into the H&SCG:

- welfare to work (for people with disabilities)
- supporting people
- mental health LIT

- older persons NSF LIT
- health inequalities
- learning disabilities partnership board
- children and families planning group

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

Our track record of achievement within Hartlepool has resulted in our being awarded a Local Area Agreement (LAA) with 'single pot` status. Single pot recognition has been based upon several factors:

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

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

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

This unique opportunity to develop a locality-wide single pot strategy amongst local partners will be significantly undermined if a local PCT is no longer sitting round the table. We intend to vigorously pursue the Next Steps agenda laid out in the Carolyn Regan letter of 5 October 2005 and believe we are in a very strong position to do so given the right partnership configuration. Within the Hartlepool Partnership we are committed to working across boundaries and we look to the SHA and Government to encourage us in this mission.

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

- The Foresight Group is an informal meeting which originally comprised the PCT CEO, the Cabinet member with the portfolio for Social Services, and the Director of Social Services. It now includes the Cabinet members with responsibility for Children and Adult services, the Directors for Children's Services and Adult and Community Services and the Assistant Director for Adult Care. The purpose of the group is to look at the strategic development of health and social care across Hartlepool.

- The PCT Management Team and the Council's Adult and Community Services Department Management Team meet regularly as a Joint Directorate.

- The Cabinet of Hartlepool BC and the Board of the PCT meet as the Joint Forum to discuss shared concerns, priorities and new policy developments.

The Council firmly believes that the loss of the current, coterminous Hartlepool PCT will seriously weaken these important mechanisms and reduce significantly future opportunities to develop increased democratic accountabilities. The next phase of our governance agenda is to develop more formal arrangements to underpin our relationship, and this will be difficult to achieve under either option as the both involve the creation of a Teesside PCT.

These networks have already had an impact with a commitment to exploring the scope for joint appointments. The two statutory agencies already have a jointly appointed, managed and funded Director of Public Health, as well as a joint Head of Mental Health and two joint commissioning posts for learning disability and mental health services. We are currently considering a joint appointment at assistant director level, for adult health and social care, and intend to explore further opportunities for joint appointments and collaborative working, in relation to support arrangements as well as commissioning requirements.

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

Notwithstanding the uncertainty about the current provider activities of PCTs, the drive for multi-disciplinary working will still need to be addressed and commissioned. Given the pending shortage of community nurses, we see an integrated workforce approach as an essential part of the future equation, and this implies a closer relationship with social care and the wider local authority. Indeed, this seems to be the conclusion reached by the Department of Health. The recent publication '*A Workforce Response to LDPs: A Challenge for NHS Boards*` has asked NHS Boards to improve the integration of health and social care staff, and develop strategies for redesigning staff roles to counter staff shortages in community nursing.

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

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

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

- single point of entry
- common assessment
- shared information
- managed transitions between services

- co-location of health, social care and voluntary services
- round the clock support

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

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

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

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

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

We believe the strengths of the stand alone Hartlepool PCT will be difficult to replace by a locality arrangement made by a distant Teesside PCT, as proposed under both options in your consultation document.

We have already demonstrated that Hartlepool PCT is an embedded partner at strategic level through the Hartlepool Partnership and at neighbourhood level. All are agreed that coterminosity between local authority and PCT boundaries is important, but it seems to be more important to some than others. Commissioning a Patient Led NHS (CPLNHS) notes that: *"As a general principle we will be looking to reconfigured PCTs to have a clear relationship with local authority social services boundaries; this does not need to mean a rigid 1:1 coterminosity".*

Your consultation document acknowledges the coterminosity principle, but in practice has disregarded it in favour of what you believe is a stronger commissioning function. Not all SHAs take such a line. The Cumbria and Lancashire SHA submission to the Secretary of State, for example, describes the coterminosity principle as "*fundamental and immutable*", and goes on to propose the retention of coterminosity for Blackpool PCT and Blackburn with Darwen PCT. Similarly, the South Yorkshire SHA submission rejects the concept of a South Yorkshire PCT in favour of 4 PCTs coterminous with the 4 local authorities.

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

The White Paper Our Health, Our Care, Our Say is expected to lead to more diverse community services providing earlier intervention and diagnosis, better support for people with long-term conditions, more day case procedures, and more effective care for people discharged from hospital. We have demonstrated through such initiatives as our highly acclaimed Connected Care model, that the Hartlepool partners are already at an advanced stage in this respect, and the PCT is keen to work with its partners to develop the emerging out of hospital agenda.

Around 80% of the commissioning resources of the PCT are health focused and commissioned with other PCTs, whilst 20% has a joint NHS/local authority commissioning approach, an important contribution which we wish to see increased. We are now working together in developing person centred services rooted in a preventive model. It is crucial that this work continues and we believe a Hartlepool PCT is best placed to carry it forward.
The PCT is supportive of the shift to Practice Based Commissioning (PBC), and our view is that it is vital that the close understanding and trust between the PCT and GP constituency is sustained during this important phase of change. The PCT PEC is also anxious that a local PCT remains in existence in order to deliver a locally sensitive shift to PBC, and there is concern that local understandings and networks will be lost in a wider configuration. The PCT has a sound relationship with local clinicians and it is important that this is not put in jeopardy by unsuitable structural change.

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

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

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

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

Demand management has already been identified as a top priority in the Local Delivery Plan (LDP) of the PCT for 2005/6 – 2007/8. The introduction of practice based commissioning will also introduce incentives to manage the demand for hospital activity and develop community based services, but it is through a constellation of local partners, PCT, GPs and the local authority, that this can become a reality. The LDP recognises the need to strengthen primary and community services in order to reduce reliance upon secondary care, but also states that "*Partnership work is essential to achievement; many of the targets cannot be achieved without a multi-agency approach".*

OPTION ASSESSMENT

Option 2 in your consultation document is based on the premise that a PCT merely consists of a PCT Board and its Professional Executive Committee (PEC), but clearly this cannot be correct as any definition of a PCT must include its employees. Whilst your incredibly narrow definition enables you to claim you are consulting upon two options, in practice there is only one option dressed up as two. As a consequence we consider the consultation process to be flawed.

The consultation document states for Option 2*: "There has been previous experience of sharing director posts across two PCTs in the area and this*

proved unworkable. The existing PCT chief executive community does not believe that it would be possible to work effectively in this way." This statement effectively dismisses Option 2 as being viable.

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

The four Teesside PCT Boards proposed under Option 2 will be responsible and accountable for their own actions, but how will they be held to account for the financial consequences of their decisions if management arrangements are pooled? For example, if Hartlepool's Board makes decisions, which results in them incurring a financial deficit, will it be picked up by the other partners? If so, how will Hartlepool's Board be held to account?

Sir Nigel Crisp requires £250 million of savings in overhead costs across the country. The SHA state this equates to £6 million for County Durham and the Tees Valley. Your consultation document implies that Option 1 is favoured over Option 2 in that it does not require reductions in employee costs to achieve the £6 Million savings proposed. However, no alternative options to achieve that level of saving have been considered, e.g.

- A Strategic Health Authority is no longer necessary. The Government has "centralised" regional administration for planning, transportation, housing, etc. within regional government offices, with some democratic input from their regional assemblies. Strategic health can be administered in the same manner, with the North East acting as a pilot. What level of saving would this approach achieve?

- How much will be saved if the Secretary of State's proposed option of true coterminosity (five complete PCTs on coterminous boundaries with the five unitary authorities of the Tees Valley) is implemented? Economies will be obtained by merging local authority and PCT commissioning teams, with management being provided by the local authority and/or joint appointments.

- Sir Nigel Crisp's letter of 28 July 2005 states: *"Under practice based commissioning GPs will not be responsible for placing or managing contracts. That will be done by PCTs on behalf of practice groups, with back office functions including payment administered by regional/national hubs."* Back office savings have not been included in the consultation paper.

The £6 Million saving requirement could be fulfilled through a combination of savings from the true coterminosity option, integration of the SHA within the Government Office for the North East, and back office savings as yet not costed.

Alternatively, the SHA could request that the Secretary of State makes the North East a special case in so far as the level of financial savings are concerned, in order that the true coterminosity option she proposed can be considered on a level playing field with other regions of the country. In other areas of the country the concept of true coterminosity has been accepted, with savings being made in PCTs other than those based upon unitary council boundaries. The North East is unique in having such a high proportion of unitary councils (10 out of 16 PCT areas) that the required savings can not be made within the remaining areas.

Your October 2005 submission to the Secretary of State and your consultation document include assessments of Option 1 and Option 2 (although there is no assessment of Option 2 against the improve commissioning and effective use of resources criterion), but contains no assessment of the true coterminosity option requested by the Secretary of State. Consequently, we set out below our assessment of true coterminosity against your assessments.

1 Secure high quality, safe services

There is no evidence to suggest that PCTs are unable to commission safely. Much of the quality and safety issue relies on the way providers deliver services, and that is their own responsibility. The NHS has many audit and quality frameworks for which SHAs are accountable, rather than PCTs. The inference from the consultation document and the presentation of it is that safety concerns are more about the lack of resource in the acute provider sector and not the commissioning agencies. Further integration with Council

commissioning services should produce more efficient and effective commissioning.

2. Improve health and reduce inequalities

It is recognised nationally that good partnership working across public sector agencies within localities is essential in reducing health inequalities. True coterminosity with integrated commissioning will enhance partnership working. Your consultation options have the potential to damage past achievement and hinder future progress.

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

The consultation document recognises good arrangements currently exist and therefore will continue with true coterminosity. The fact you recognise that the larger PCTs you propose would have to set up local arrangements to attempt to preserve relationships, suggests local arrangements such as ours, are the ideal.

4. Improve public involvement

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

5. Improve commissioning and effective use of resources

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

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

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

6. Manage financial balance and risk

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

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

Only true coterminosity will fulfil this criterion.

SUMMARY

Criteria	1	2	True
1	✓	x	✓
2	✓	x	✓
3	x	x	✓
4	x	✓	✓
5	✓	x	✓
6	✓	✓	x
7	x	x	✓

(NB the crosses and ticks are relative measures.)

* Assessment taken from SHA submission to Government, October 2005

\+ Assessment taken from current SHA Consultation document, December 2005

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.

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.

DH Department of Health

David Flory
Chief Executive
County Durham and Tees Valley SHA
Riverside House
The Waterfront
Newburn
Newcastle-upon-Tyne
NE15 8NY

Richmond House
79 Whitehall
London
SW1A 2NS
Tel: 020 7210 3000
Direct Line: 020 7210

16 May 2006

Gateway reference: 6550

Dear David,

***Commissioning a Patient-Led NHS*: Primary Care Trusts**

Thank you for your hard work over the last few months and your report on the outcome of the local consultations.

I know that this has been a testing and difficult time for you and your staff and I wanted to put on record my thanks for the strong leadership you have shown in seeing this through.

The Secretary of State has carefully considered the proposals made by the SHA, along with advice from the External Panel. She has listened carefully and noted the views of a range of local stakeholders and, on balance, has decided that the future configuration of PCTs within your area should be as set out below:

- County Durham PCT,
- Darlington PCT,
- Stockton-on-Tees PCT,
- Hartlepool PCT,
- Middlesbrough PCT, and
- Redcar and Cleveland PCT.

The Secretary of State's decision to establish the new PCTs is made on the basis that they and the new SHAs will be subject to the following conditions:

- All PCTs must retain and build on current partnership arrangements, including Local Area Agreements already established in partnership with local authorities. They should also consider the use of joint appointments with local authorities where appropriate.

- A strong locality focus must be retained, and where necessary, locality structures should be put in place. Funding plans to reduce health inequalities and address poverty in socially and economically deprived areas such as Easington and Chester-le-Street must be maintained and PCTs should ensure patient and public involvement and Practice Based Commissioning arrangements are maintained and improved.

Department of Health

- All PCTs must also deliver their share of the 15% management cost savings, strengthen commissioning and ensure robust management of financial balance and risk.

- The SHA should consider whether shared management teams would benefit PCTs in meeting these criteria. The Department would be very supportive of plans for joint management teams where you believe that to be the best solution.

- Where joint management teams are proposed, the SHA should also consider shared PEC arrangements and how clinical time spent on corporate business could be minimised, allowing them to focus instead on service redesign, bringing benefit to patients in their locality.

- Where recommendations were made in the consultation reports setting out conditions that should be applied to the new configuration, the new PCTs and SHAs should consider those conditions and determine how they should be taken forward and monitored.

I attach maps and tables which show the current and future PCT configuration in each SHA and nationally. Our aim, as you know, is for the new PCTs to be established on 1 October 2006.

Ambulance Trust Configuration

We have now considered the feedback received on the consultation on ambulance trust configuration. I am pleased to be able to tell you that the Secretary of State has agreed that from 1 July 2006 there will be 12 ambulance trusts in England, with a move to reduce to 11 trusts later. Feedback from most areas did not indicate any significant reasons to change our original proposals. However, in a few areas we have responded to concerns by modifying the detail of the configuration. Full details of the final configuration is set out in the enclosed map and table.

Some concern was raised in the consultation that local responsiveness and flexibility could be lost through having larger trusts. The Secretary of State has therefore decided that ambulance trusts will be required to ensure that their services are meeting the needs of all localities and populations within their boundaries. A direction to this effect will be issued to the new trusts at the time of establishment.

An announcement will be made this week on the designate Chairs and designate Chief Executives of the new ambulance trusts.

You will wish to be aware that Lord Warner has today written to MPs of all English constituencies to set out the future PCT and ambulance trust configurations and enclosing a copy of this letter.

Department of Health

I have also written to the Government Offices for the Regions to inform them of the new configurations. I would be grateful if you could communicate these decisions to your other local stakeholders, with immediate effect, in particular to those local authorities that have social services responsibilities.

Yours ever,

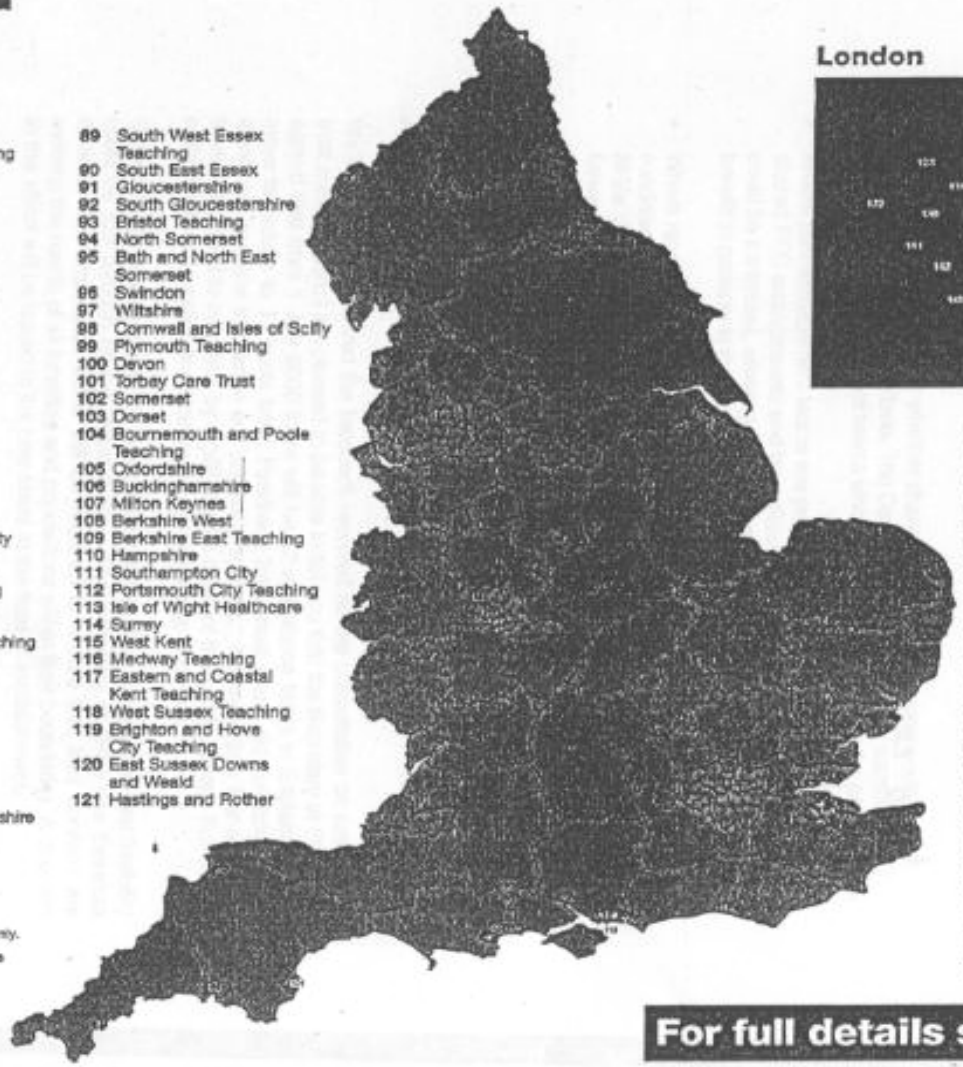
HUGH TAYLOR
ACTING PERMANENT SECRETARY

cc. Chair, County Durham and Tees Valley SHA,
Chief Executive Designate, North East SHA
Chair Designate, North East SHA
Chief Executives, Local PCTs
Chairs, Local PCTs
Local MPs

Primary Care Trust Configurations

NHS

England



KEY

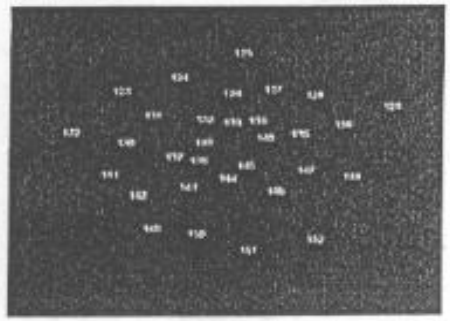
1 Northumberland Care Trust
2 Newcastle
3 North Tyneside
4 Gateshead
5 South Tyneside
6 Sunderland Teaching
7 County Durham
8 Hartlepool
9 Darlington
10 Stockton-on-Tees Teaching
11 Middlesbrough
12 Redcar and Cleveland
13 Cumbria
14 North Lancashire
15 Blackpool
16 East Lancashire
17 Sefton
18 Central Lancashire
19 Blackburn with Darwen Teaching
20 Wirral
21 Liverpool
22 Knowsley
23 Halton and St. Helens
24 Ashton, Leigh and Wigan
25 Bolton
26 Bury
27 Rochdale, Heywood and Middleton
28 Warrington
29 Salford Teaching
30 Trafford
31 Manchester
32 Oldham
33 Tameside and Glossop
34 Stockport
35 West Cheshire
36 East Cheshire
37 North Yorkshire and York
38 Bradford and Airedale Teaching
39 Leeds
40 Calderdale
41 Kirklees
42 Wakefield
43 Barnsley
44 Sheffield
45 Rotherham
46 Doncaster
47 East Riding of Yorkshire
48 Hull Teaching
49 North Lincolnshire
50 North East Lincolnshire
51 North Staffordshire
52 Stoke on Trent Teaching
53 Shropshire County
54 Telford and Wrekin
55 South Staffordshire
56 Wolverhampton City
57 Walsall Teaching
58 Dudley
59 Sandwell
60 Heart of Birmingham Teaching
61 Birmingham East and North
62 South Birmingham
63 Solihull
64 Coventry Teaching
65 Herefordshire
66 Worcestershire
67 Warwickshire
68 Derbyshire County
69 Derby City
70 Bassetlaw
71 Nottingham City
72 Nottinghamshire County Teaching
73 Lincolnshire Teaching
74 Leicester City Teaching
75 Leicestershire County and Rutland
76 Northamptonshire Teaching
77 Peterborough
78 Norfolk
79 Cambridgeshire
80 Suffolk
81 Great Yarmouth and Waveney Teaching
82 Bedfordshire
83 Luton Teaching
84 West Hertfordshire
85 East and North Hertfordshire
86 West Essex
87 Mid Essex
88 North East Essex
89 South West Essex Teaching
90 South East Essex
91 Gloucestershire
92 South Gloucestershire
93 Bristol Teaching
94 North Somerset
95 Bath and North East Somerset
96 Swindon
97 Wiltshire
98 Cornwall and Isles of Scilly
99 Plymouth Teaching
100 Devon
101 Torbay Care Trust
102 Somerset
103 Dorset
104 Bournemouth and Poole Teaching
105 Oxfordshire
106 Buckinghamshire
107 Milton Keynes
108 Berkshire West
109 Berkshire East Teaching
110 Hampshire
111 Southampton City
112 Portsmouth City Teaching
113 Isle of Wight Healthcare
114 Surrey
115 West Kent
116 Medway Teaching
117 Eastern and Coastal Kent Teaching
118 West Sussex Teaching
119 Brighton and Hove City Teaching
120 East Sussex Downs and Weald
121 Hastings and Rother

Map is for illustrative purposes only.

Map shows proposed boundaries of PCTs. Actual boundaries to be prescribed by statutory orders. Names of PCTs subject to final approval.

Teaching status to be confirmed.

London



LONDON

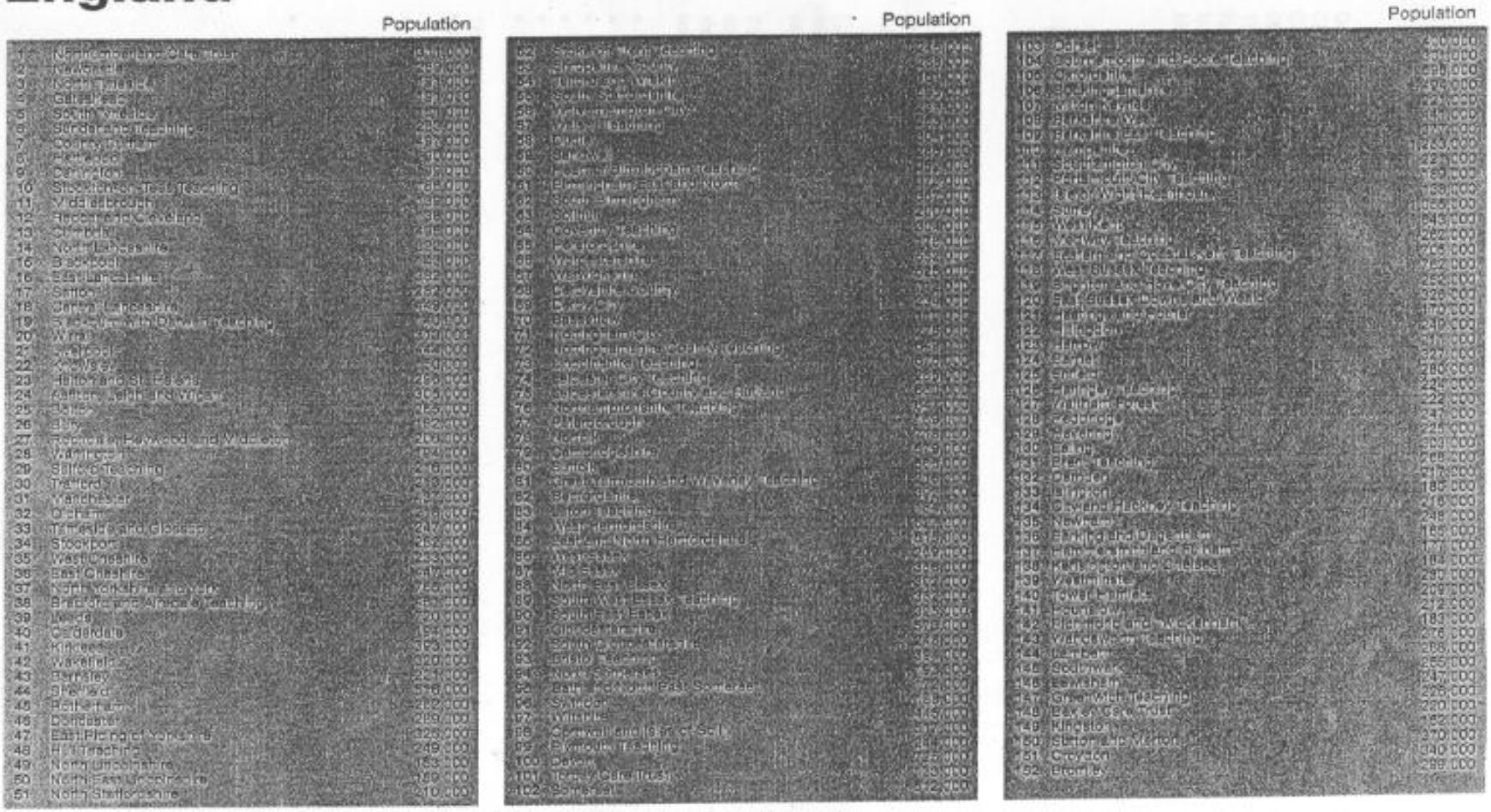
122 Hillingdon
123 Harrow
124 Barnet
125 Enfield
126 Haringey Teaching
127 Waltham Forest
128 Redbridge
129 Havering
130 Ealing
131 Brent Teaching
132 Camden
133 Islington
134 City and Hackney Teaching
135 Newham
136 Barking and Dagenham
137 Hammersmith and Fulham
138 Kensington and Chelsea
139 Westminster
140 Tower Hamlets
141 Hounslow
142 Richmond and Twickenham
143 Wandsworth Teaching
144 Lambeth
145 Southwark
146 Lewisham
147 Greenwich Teaching
148 Bexley Care Trust
149 Kingston
150 Sutton and Merton
151 Croydon
152 Bromley

For full details see overleaf

Primary Care Trust Configurations

NHS

England



Population sizes are approximate. Source – Population – Mid-2004 Resident Population Estimate (2001 Census Based), Office for National Statistics.

Northumberland, Tyne and Wear NHS
Strategic Health Authority

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DF/LB/LTR951

23 May 2006

To: All Local NHS PCT Chief Executives

Cc: All Local NHS Trust Chief Executives
All Local NHS Trust Chairs
All Local NHS PCT Chairs

Dear Colleague

Commissioning a Patient-Led NHS: Primary Care Trusts

Following Hugh Taylor's letter of 16 May 2006 and the meeting with Chairs and Chief Executives on 18 May 2006, we are writing to set out the next steps to develop effective management arrangements for Primary Care Trusts in North East England.

We would ask each Primary Care Trust Chief Executive to now consider the conditions set out in Hugh Taylor's letter and to work with Chief Executives within their cluster to begin to identify the shared management arrangements that will deliver Primary Care Trusts that are fit for purpose for the future. Given the 15% management savings that are required of each individual PCT, we are keen to receive the new principles you would propose for your cluster in relation to:

- streamlined governance arrangements;
- the integration of corporate and managerial functions across Primary Care Trusts;
- strengthened commissioning functions, including practice based commissioning;
- maintaining a locality focus and continuing to develop the health improvement agenda;

In relation to all of these areas you will need to ensure that your initial cluster discussions address the need to:

- deliver the 15% management cost saving in each PCT and in each cluster;
- minimise duplication as far as possible;
- demonstrate maximum efficiency;

- make effective use of scarce skills and the management capacity available within the given resources;
- support effective partnership working with many stakeholders;
- establish strong primary care organisations which will be fit for purpose for the future.

We look forward to receiving your initial submission by Monday 5th June 2006. In some clusters, you may wish to provide a range of options with an identified preferred option.

It is the responsibility of the Strategic Health Authority to ensure that effective managerial arrangements are in place for the Primary Care Trusts in North East England. We will consider your initial submissions along with work currently being undertaken at the SHA so that optimum managerial arrangements can be put in place across the North East as soon as is practical. We will, of course, continue to discuss these arrangements with you as they develop.

Yours sincerely

David Flory

David Flory
Chief Executive

Karen Straughair
Chief Operating Officer

APPENDIX 2

County Durham and Tees Valley NHS
Strategic Health Authority

Teesdale House
Westpoint Road
Thornaby
Stockton on Tees
TS17 6BL

Direct line: 0191 210 6410
Ref: MC/sf

Tel: 01642 666700
Fax: 01642 666701

30 May 2006

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

Dear Mr Walker

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

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

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

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

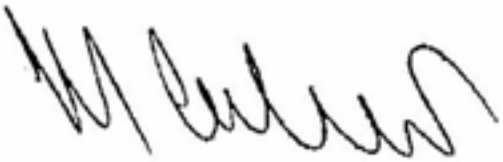
No decisions at this stage, have been made on the ways in which expenditures can be reduced – but it is unrealistic to believe that a £10 million cut by PCTs can be achieved without a reduction in management jobs.

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

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

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

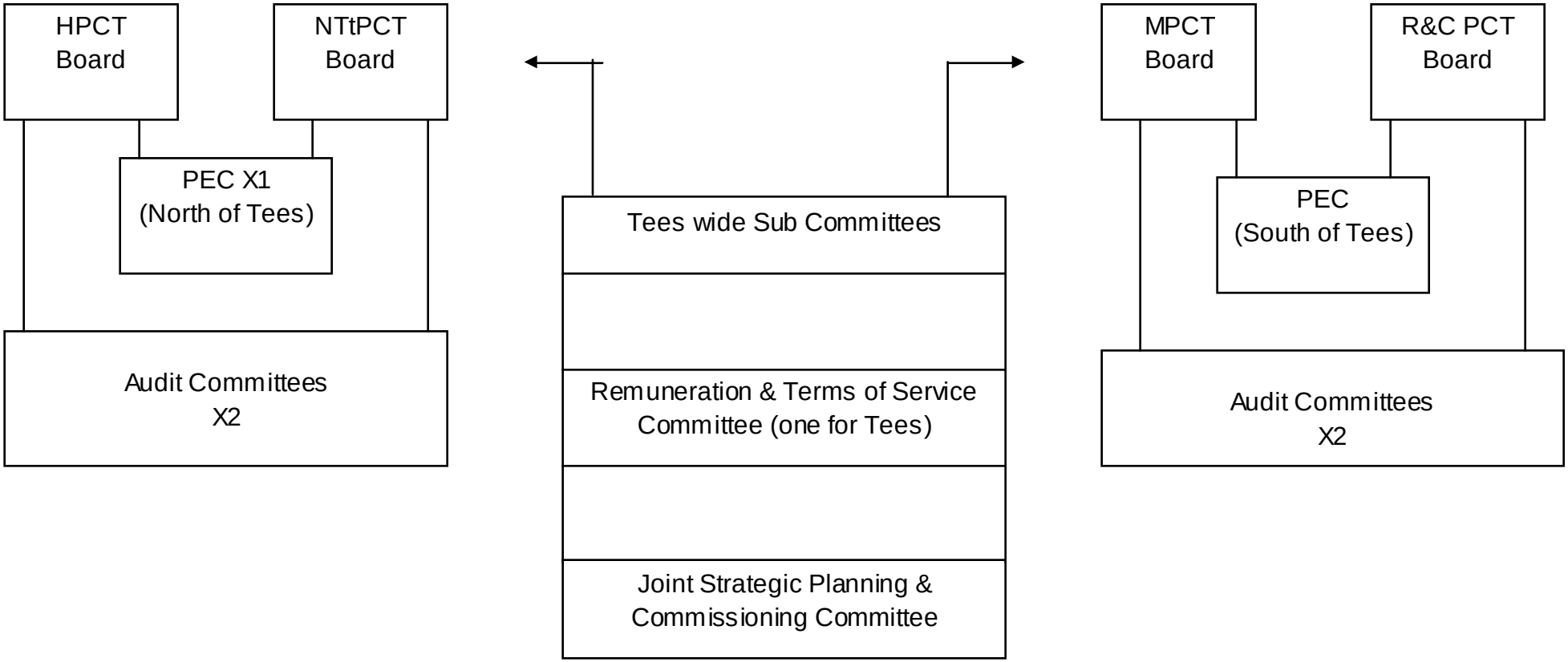
Yours sincerely



Peter D Carr
Chair
Northumberland, Tyne & Wear SHA

Michael Cardew
Chair
Co Durham & Tees Valley SHA

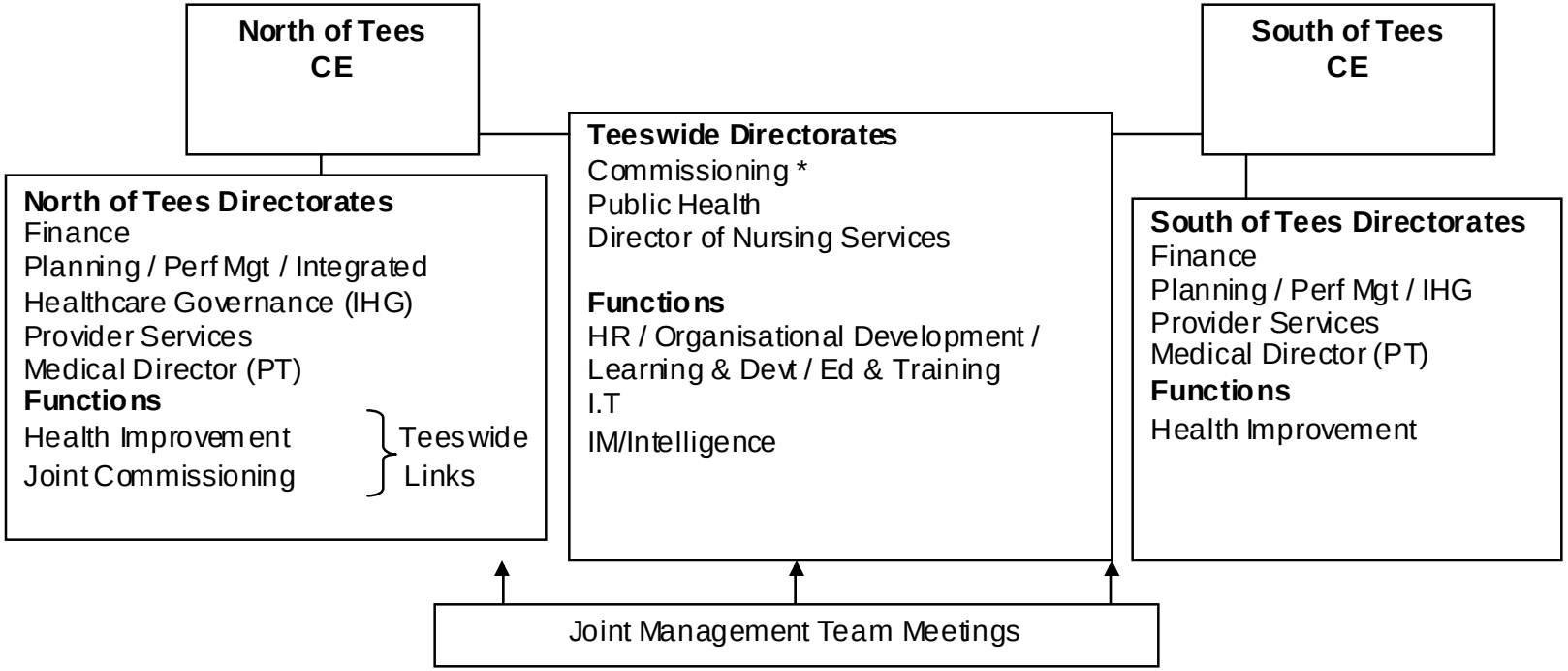
BOARD / SUB COMMITTEE ARRANGEMENTS



Each Board will develop relevant partnership arrangements with its coterminous LA as appropriate but as a minimum will ensure appropriate senior involvement at LSP, Children's Trust and a range of other Partnership Boards.

TEES MANAGEMENT ARRANGEMENTS

Appendix 7



Notes

The future commissioning role in PCTs needs significant development and strengthening to become 'fit for purpose'. A Tees wide approach will enable the most effective use of skills and resources to be made on behalf of all 4 PCTs. This function will include contract negotiations (increasingly legally enforceable), supply side management, capacity planning, monitoring of clinical outcomes and clinical effectiveness of services, performance management of providers. The team will work closely with Public Health and Practice Based Commissioning utilising Health Needs Assessment to better inform commissioning decisions. The links with PBC Groups will be essential as PBC will be locally based, focussing on needs and how to meet them and the results reflected in service contracts negotiated by the Commissioning Team. The links with Local Authority colleagues will also be essential. The scope is to be confirmed, but is likely to include Acute Services, Tier 3 and 4 Mental Health Services, Primary Care and Community Services. The work of the Directorate will be overseen by the Joint Strategic Planning & Commissioning Committee, on behalf of 4 PCTs.

Appendix 8

HARTLEPOOL – LOCAL MANAGEMENT ARRANGEMENTS

Service		Health	Commissioning	
Associate Director / Head of Adult Services	Associate Director / Head of Children's Services	Associate Director of Public Health / Health Improvement	Head of Commissioning - Children	Head of Commissioning - Adults
			Practice Based Commissioning Group	

Notes

•Consideration to be given to the further development of Integrated Management and possible Joint posts with HBC
•Specialist support will be provided to these staff/functions from North of Tees and Teeswide teams, including information and analysis, performance management, HR, communications, finance, etc
•Scope of 'Joint Commissioning' posts to be determined but will include areas such as drug and alcohol, LITs, Tiers 1 & 2 Mental Health, Pathways of Care, Continuing Care, Demand Management and will need to work very closely with PBC Group and the Tees wide Commissioning Directorate

JOINT SCRUTINY CO-ORDINATING COMMITTEE AND ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM REPORT

29 September 2006

Report of: Scrutiny Support Officer

Subject: Hartlepool PCT: Consultation on Proposed Management Arrangements.

---

1. PURPOSE OF REPORT

1.1 To provide Members with a copy of Hartlepool PCT's consultation document in relation to the proposed management structure.

2. BACKGROUND INFORMATION

2.1 Members of the Adult and Community Services and Health Scrutiny Forum at their meeting on 19 September 2006 received a comprehensive presentation from representatives of Hartlepool PCT and a report in relation to the proposed management arrangements.

2.2 As the consultation is being undertaken within a limited time period and the relative importance of the issue under consideration Members of the Forum agreed in conjunction with the Chair of Scrutiny Co-ordinating Committee to hold a further Joint Scrutiny Co-ordinating Committee and Adult and Community Services and Health Scrutiny Forum meeting today to formulate that response.

3. RECOMMENDATIONS

3.1 That Members consider this report and the associated appendices in conjunction with the draft response to Hartlepool PCT at item 8.1 on the agenda which will be forwarded to Members in due course.

Contact Officer:- Sajda Banaras – Scrutiny Support Officer
Chief Executive's Department - Corporate Strategy
Hartlepool Borough Council
Tel: 01429 523 647
Email: Sajda.banaras@hartlepool.gov.uk

Hartlepool PCT – Future Board & Management Arrangements

1. Purpose of Consultation

1.1. To seek the views of partners and stakeholders on the need to make changes to Hartlepool Primary Care Trust (HPCT) management, ahead of any Board decision.

2. Background

2.1. Hartlepool PCT was recently confirmed as a statutory body following the Department of Health exercise, "Commissioning a Patient-Led NHS". A vigorous campaign was waged in the town, including the Council, the Hartlepool Partnership, Iain Wright MP and many other stakeholders in the voluntary and community sector to retain a co-terminous PCT.

2.2. The Secretary of State's decision reflected the value she placed on the importance of co-terminosity in creating partnerships that would maximise healthcare benefits for patients and other service users. Among the conditions she laid down is that the PCT should actively work to maximise these benefits.

2.3. However, she also stated that:

- Hartlepool in common with all other PCTs, must deliver its share of the 15% management cost savings, strengthen commissioning and ensure robust financial management of financial balance and risk.
- The Strategic Health Authority (SHA) should consider whether shared management teams would benefit PCTs in meeting their criteria. It is explicitly stated that the Department would be very supportive of plans for joint management teams where the SHA believed this to be the best solution.

3. Challenges

3.1. **Management Cost Savings**

Hartlepool PCT, despite rigorous examination by its Finance Directorate, its Audit Committee and its present and former Acting Chief Executives, has been unable to find the necessary 15% savings while retaining management capacity and skill base that it requires to achieve Fitness for Purpose.

3.2. **Joint/Shared Management**

The SHA, in line with the Secretary of State's direction, is considering the feasibility of shared management arrangements among PCTs. Given the high priority placed on achieving financial targets it may well favour one shared management team, including Chief Executive and Executive Directors for Hartlepool, Stockton, Middlesbrough and Redcar & Cleveland. This would drive out the required savings by drastically reducing staff.

3.3. **Budget Deficit**

The PCT has never balanced its books since its inception in 2001 without repayable aid from the SHA known as brokerage. The size of the deficit has increased year-on-year until it currently stands at £6 million. The Department of Health and the SHA require this deficit to be cleared by 2008 and a surplus to be generated.

Every health organisation has a statutory duty to break even each year - failure to do is increasingly likely to result in Boards/senior officers being removed and turnaround teams brought in to run the organisation. It may even question its long-term viability as a stand-alone organisation.

A robust but extremely challenging plan is now in place, which minimises the front-line effects of what are pretty drastic savings. The deficit has led directly to an Audit Commission Public Interest Report (PIR), which is attached at Appendix 1.

3.4. **Fitness for Purpose**

As an unreconfigured organisation, Hartlepool PCT is subject to an extensive Fitness for Purpose assessment, currently being undertaken by McKinsey & Co. Although a full report is awaited, it is becoming clear that the assessment considers that the PCT has neither sufficient management capacity nor capability to face new challenges, especially with regard to commissioning.

3.5. **Commissioning Services**

Hartlepool's role as a commissioner of services will become a much more significant part of its function in the future. It is clear that, in common with its neighbour PCTs, the organisation has neither the capacity nor the expertise to fulfil this role effectively.

It has become evident that a sensible way forward is to establish a Tees-wide commissioning structure – a "purchasing organisation" which, once the member PCTs have identified their own health needs, commissions requisite services on behalf of all.

4. Joint working and Locality Focus

4.1. The ability to make policies and decisions that are driven by the needs and wishes of Hartlepool's communities and residents must be retained. Any management team must be able to carry out the decisions of the HPCT Board.

4.2. The ability and capacity to work jointly and meaningfully with our partners, especially HBC, must also be protected.

4.3. While the future of management is undecided, the position of the Non-Executive Chair and Non-Executive Directors are not. Hartlepool PCT

will have a dedicated and local team of Non-Execs appointed by the NHS Appointments Commission.

4.3.1 Non-Execs all have Board voting rights, and outnumber voting Executive Board members

4.4.2 The Non-Executive Chair, Steve Wallace, is appointed for a four-year term from 1st October.

5 Management Options for the Future

5.1 Despite best efforts, HPCT's Senior Management Team cannot find a way to maintain a separate management structure dedicated solely to the Hartlepool PCT Board, which achieves the necessary 15% savings, satisfies Fit-for-Purpose criteria and enable delivery of the financial recovery plan.

5.2 They have suggested two options as possible ways forward:

- **Option 1 –** one management team servicing four PCT Boards.
- **Option 2 –** two management teams, one servicing Hartlepool and North Tees PCT, the other Middlesbrough and Redcar & Cleveland

- **Option 1 – One Tees Valley Management Team**
- **Advantages**
  - Easily achieves 15% management savings – and more – that can be invested in front-line services.
  - Very likely to gain approval from SHA
  - Could ease pressure on financial recovery plan.
- **Disadvantages**
  - Concerns that management team would find it hard to give proper focus to each Board's wishes.
  - Risk that the four PCTs will become clones of one another, rather than organisations that develop to meet their own area's health demands
  - Risk of the need for extra locality staff, which would add a layer of bureaucracy and lessen the financial benefits.
  - Risk of power centralising in Middlesbrough, as the centre of the patch

- **Option 2 – Management Team shared with North Tees PCT**
- **Advantages**
  - Hartlepool and Stockton currently enjoy a good working relationship, both between Chairs and officers.
  - Director posts would become more demanding, but would reduce the risk of extra locality deputies.
  - Non-Exec Directors would find it easier to maintain control over individual PCT strategy.
  - Protects jobs in Hartlepool better than Option 1.

- Properly thought through, will protect ability to work jointly with HBC regarding service delivery, joint commissioning and health improvement.

- **Disadvantages**
  - Does not drive out savings equivalent to Option 1: meeting targets will still be challenging.
  - May need to persuade the SHA
  - Assumes that N. Tees PCT agrees – its own Board has yet to take a view.

6. Within the Options

6.1 Hartlepool PCT is an organisation whose assets are largely its dedicated staff, from Board level down, who work here and largely live in the town. It follows that the term "savings" is largely a euphemism for job cuts.

An argument has emerged which requires much consideration – where should the job cuts be made? Either option, or even a currently undiscovered option, will require job cuts and probably compulsory redundancies for Hartlepool PCT staff.

In common with Local Authorities and other public institutions, Hartlepool PCT has experienced significant wage inflation at senior management levels in recent years. With benefits and on-costs, the cost to a PCT of a Chief Executive can surpass £150,000 p.a.

The savings from reducing four teams of Executive Directors to one among four PCTs might very well find the savings required by itself. Even sharing between Hartlepool and Stockton takes us a significant way towards the 15% target. Conversely, cutting many jobs at lower grades – "coalface workers" – will help preserve senior management capacity.

- **A Preferred Option**

  It must be stressed that the PCT Board has not agreed the model below – it is the Chair's view that it would be quite improper to do so before the new Non-Exec team is in place. It has though been arrived at by much thought and work among the Chair, current Directors and the PCT's Acting Chief Executive.

The proposals seek to ensure that:

- Commissioning is strengthened both locally by working with LA colleagues and Practice Based Commissioning (PBC) Groups and also at a larger population level to bring about a step change in commissioning skills and capacity.
- Local management of community services is maintained to facilitate integrated/joint management of front line community services where appropriate

- A clear joint role of Associate Director/Director of Health of Improvement is jointly developed in each PCT/LA area that addresses local issues effectively for both PCTs & LAs
- The 15% savings target is achieved whilst maintaining/enhancing capacity and skills by the creation of more shared functions, where this will be more efficient and effective
- Redundancies are kept to a minimum

Proposals

HPCT Board

- Hartlepool PCT will be a statutory body with its own Board with a Chairman & Non Executive Directors appointed by the Appointments Commission, drawn from the local population.
- HPCT will receive its own financial allocations to meet the health and health care needs of its population and will need to meet its statutory duties in this regard
- HPCT Board will consider how it can best meet its duties and responsibilities, and where appropriate may decide to work collaboratively with other organisations, including other PCTs or LAs. Appendix 2 shows the Board and proposed Sub Committees for consideration by the 4 Tees PCTs' Boards

Management Arrangements

- After careful consideration involving discussions with a range of stakeholders and the initial feedback following the Fitness for Purpose Review, it is proposed that the best way to meet all the requirements of PCTs and partner agencies is to create two management teams, incorporating some Tees wide functions where appropriate.
- The proposal is shown in Appendix 3 and demonstrates a significant presence at a senior level north of Tees, supported by some Tees wide functions where this is the most effective way to undertake these.
- However, several areas must have senior <u>local</u> leaders in each PCT/LA area and indeed may lead to the creation of joint posts, subject to further discussion and agreement over governance and funding arrangements etc. These are shown in Appendix 4 and demonstrate how PCTs/LAs can jointly improve current working arrangements.
- For Hartlepool this will enable the PCT to create senior posts focussed on areas of work with direct relevance to HBC and enable more effective partnership working arrangements and address several officers' concerns about lack of capacity in HPCT.

Professional & Executive Committee (PEC) Arrangements

National guidance on the role and establishment of PECs is awaited and discussions are underway with PEC Chairs in Hartlepool and North Tees to develop proposals for consideration by both Boards and given the emergence of 2 effective Practice Based Commissioning Groups (in Hartlepool and North Tees) the option of having a single PEC for North of Tees is being considered. Views will be sought on this.

Conclusion

- This paper summarises the challenges facing new PCT Boards in meeting many demanding criteria.

- The proposals seek to address the needs and concerns expressed by many stakeholders and feedback is now sought on these to inform final proposals which will be considered by HPCT Board on 2 October 2006.

- The Board has undertaken no discussion or decision on the future shape of our management structures at this point. Notwithstanding this, there are three absolute conditions which must be fully addressed:

    - The PCT financial recovery plan must not be imperilled.
    - The 15% savings must be achieved in full
    - The PCT must become Fit for Purpose with regard to its future roles and responsibilities.

- We seek, and welcome, the views of our partners in Hartlepool ahead of Board discussion and decision.

Public Interest Report

July 2006

audit commission

Report in the Public Interest

Hartlepool Primary Care Trust

Audit 2005/2006

External audit is an essential element in the process of accountability for public money and makes an important contribution to the stewardship of public resources and the corporate governance of public services.

Audit in the public sector is underpinned by three fundamental principles.

- Auditors are appointed independently from the bodies being audited.
- The scope of auditors' work is extended to cover not only the audit of financial statements but also value for money and the conduct of public business.
- Auditors may report aspects of their work widely to the public and other key stakeholders.

The duties and powers of auditors appointed by the Audit Commission are set out in the Audit Commission Act 1998 and the Commission's statutory Code of Audit Practice. Under the Code of Audit Practice, appointed auditors are also required to comply with the current professional standards issued by the independent Auditing Practices Board.

Appointed auditors act quite separately from the Commission and in meeting their statutory responsibilities are required to exercise their professional judgement independently of both the Commission and the audited body.

Status of our reports to the PCT

The Statement of Responsibilities of Auditors and Audited Bodies issued by the Audit Commission explains the respective responsibilities of auditors and of the audited body. Reports prepared by appointed auditors are addressed to non-executive directors or officers. They are prepared for the sole use of the audited body. Auditors accept no responsibility to:

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Introduction

1 I am the auditor appointed by the Audit Commission for Local Authorities and the National Health Service in England and Wales to audit the accounts of Hartlepool Primary Care Trust (the PCT) for the financial year ended 31 March 2006.

2 Section 8 of the Audit Commission Act 1998 requires me to consider whether, in the public interest, I should make a report on any matter coming to our notice during the audit in order that it is considered by the audited body and brought to the attention of the public. This report is issued in accordance with that statutory requirement.

3 This report also incorporates a referral to the Secretary of State for Health under section 19 of the Act. This section of the Act requires me to make a referral where I have reason to believe that a health service body is proposing to take, or has taken, a course of action which is unlawful.

4 The purpose of this report is to bring to the attention of the public and seek the PCT's response to the issues relating to:

- the seriousness of the PCT's financial position and the deficit incurred at the end of March 2006;
- the adequacy of the PCT's action taken to improve its financial position in 2005/06; and
- the action that the PCT is proposing to improve its financial position for future years so as to meet its statutory financial duties.

PCTs' statutory financial duty

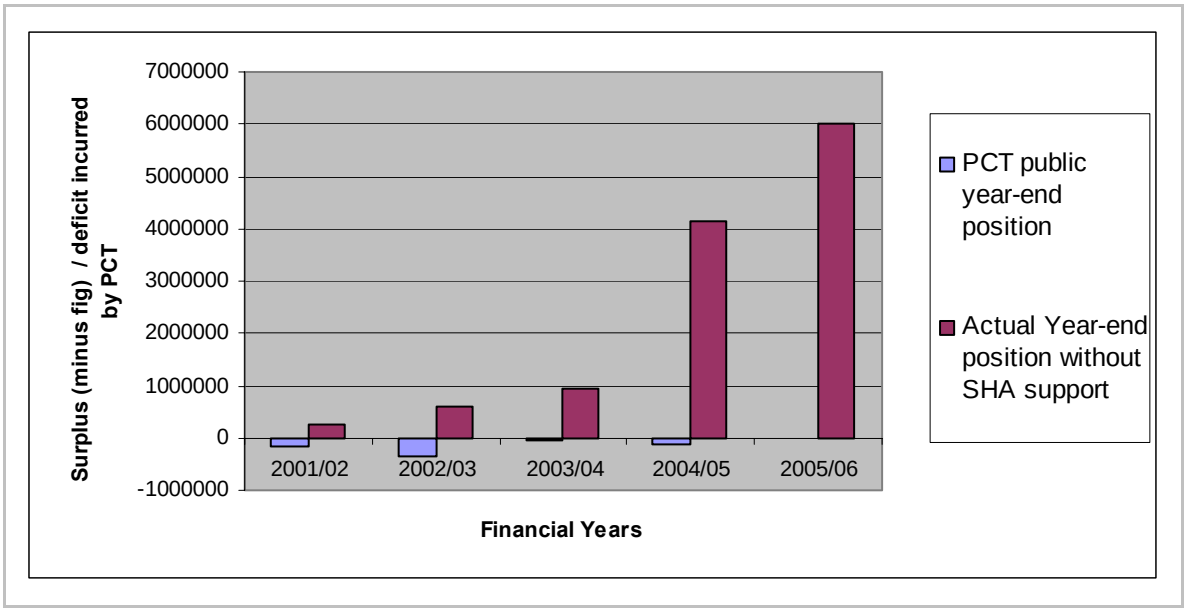
5 PCTs are required to operate within certain prescribed financial limits, the key one being the Revenue Resource Limit. The Revenue Resource Limit is set by the Secretary of State each year and Section 97(E) 1 of the National Health Service Act 1977 imposes a statutory duty on PCTs to ensure that their revenue expenditure does not exceed the limit set for each financial year. Each PCT, by living within its annual revenue limit should not therefore ever incur a deficit (ie spend more than it is given in income). In 2005/06, Hartlepool PCT has recorded a deficit of £5.98 million, and has thus failed to meet one element of their statutory financial duty. £4.3 million of this deficit relates to the repayment of financial support received from the SHA in previous years.

Financial years 2001/02 to 2004/05

6 The PCT's financial problems are not new. The PCT operates within a health economy which has had a series of problems over a number of years. Serious financial pressures have existed in a number of other PCTs and hospital trusts in the County Durham and Tees Valley area, and the Department of Health sent in expert teams to three other local NHS bodies in December 2005 to help them sort out their financial difficulties.

7 For the four years prior to 2005/06, the PCT met its annual Revenue Resource Limit, but only after repayable financial support from County Durham and Tees Valley Strategic Health Authority (the SHA). As shown in Figure 1 below, the level of this financial support has increased each year, and without it the PCT would have been in deficit every year from 2001/02.

Figure 1 Hartlepool PCT financial position 2001/02 to 2005/06



Source: PCT published accounts/PCT internal papers

8 My predecessor reported her concerns over the underlying financial health of the PCT to the Board in each Annual Audit Letter from 2001/02 to 2004/05.

9 The 2001/02 Annual Audit Letter referred to the urgent need to develop and agree with partners a robust and detailed financial recovery plan, to address the significant financial difficulties which were again emerging in subsequent years.

10 The 2002/03 Annual Audit Letter highlighted the need to significantly improve the PCT's underlying financial health, but noted that action was being taken to develop and implement a plan for financial recovery. In 2003/04, the Annual Letter recommended that the Board consider the effectiveness of its longer-term financial planning and budgeting. It also recommended reviewing the recovery plan in the light of additional financial pressures identified, and the continuing requirement for financial support from the SHA.

11 The 2004/05 Letter to the Board, issued in September 2005, reflected on a further significant deterioration in underlying financial health of the PCT. In common with a number of other PCTs, it had to respond to the challenges posed by the first year of payment by results, and working with a local Acute Trust on an early trial of Foundation Trust contracting arrangements. In 2004/05 there was a significant increase in the support required from the SHA to secure a balanced position, again reflecting the inability of the PCT to control its spending. A formal recovery plan had been agreed with the SHA in 2003/04, and reported to the Board in February 2004, as a condition of continued support, seeking to return to recurrent financial balance by the end of 2006/07. Despite this plan, spending continued to grow, with PCT controls being unsuccessful in keeping spending commitments within known income limits.

12 During 2005, the PCT reviewed the reasons behind the increased spending pressures to ensure that lessons could be learned for the beginning of 2005/06, and identified the following key issues:

- errors and weaknesses in the preparation of the 2004/05 budget (£2.3 million);
- additional activity by hospital trusts, which the PCT had not anticipated (£1.1 million); and
- new, unforeseen specialist packages of care (£0.7 million).

13 The PCT has suffered from a series of difficulties with chief officers in the past. A previous Chief Executive was suspended, his replacement then had to step down due to extended compassionate leave as a result of serious family illness, and the current Acting Chief Executive only came into post in July 2005. As a result of restructuring, the PCT did not have a substantive appointment to the Director of Finance post for most of 2003/04, and there were also vacancies in the finance, planning and primary care teams, which weakened the process of setting budgets for the year. With the appointment of a new Director of Finance early in 2004/05, and additional capacity throughout the PCT, errors in baseline funding assumptions of almost £1.9 million quickly became evident. During the year, other examples emerged where initial budgets proved to be unrealistic, and these were reported to the Board in April 2005.

The 2005/06 financial year

14 The PCT's financial problems continued, and worsened, during 2005/06. In March 2005, the Board approved a service and financial strategy, designed to ensure a return to financial balance over three years, building on the lessons learned from the financial difficulties in 2004/05. The PCT set a balanced budget for 2005/06, again relying on the provision of £4 million in repayable financial support agreed with the SHA, and the need for savings of a further £3.1 million.

15 In August 2005, the two SHAs in the North East began to plan how they would better work together, in advance of them merging in 2006. Various financial practices were harmonised, including whether or not financial support was offered to individual bodies. This had not been the practice in the Northumberland, Tyne and Wear SHA area; but had been common practice in the County Durham and Tees Valley SHA. The policy of the Northumberland, Tyne and Wear SHA was adopted, and as a result each organisation within the County Durham and Tees Valley area was required to meet its own statutory duties, without use of SHA support, and with the SHA intervening only where it felt it was appropriate and necessary. The effect of this change in policy was to make transparent the overspending in previous financial years, and the PCT had therefore to begin to forecast a deficit for 2005/06 of £4 million. This change also meant it was difficult for the PCT to change quickly its spending decisions given contracts with Trusts had already been agreed.

16 A forecast deficit of £4 million clearly represented a potential breach of the PCT's statutory duty, and following a series of conversations over preceding months, I wrote to the PCT Chief Executive in November 2005, noting the withdrawal of previously agreed SHA support, and the impact this would have on the savings and cost reductions required in 2005/06 to enable financial targets to be met. Throughout 2005/06, the PCT have acted openly in their dealings with me as Auditor. I made it clear that in my view the PCT were still obliged to try and meet the statutory duties placed upon it. In his reply, the Chief Executive concluded that there was little prospect of the PCT being able to achieve the statutory duty.

17 The financial report to the Board in August 2005, continued to report a likely year-end deficit of £4 million, reflecting the PCT's intention to deliver savings such that the deficit grew no bigger during 2005/06. This prediction remained in September 2005. However, during the period between November 2005 and December 2005, a further gap emerged between the activity the PCT had planned and budgeted for, and the actual activity being delivered by local hospitals. The PCT reported to the Board that these additional pressures could result in an additional £2 million in-year deficit, such that the year-end position was likely to be a £6 million deficit.

18 At this stage I was not satisfied that the Board accepted that it must seek to remedy its situation. I was concerned there was too much reliance on the withdrawal of the SHA support as an explanation for the PCT's financial problems.

19 I wrote to the PCT Chairman in December 2005, pointing out that there is no provision in law for a PCT to make a deficit, and that the PCT was likely to breach its statutory duties at 31 March 2006 by exceeding its resource limit. I reasserted my view that the PCT must take all reasonable steps to deliver its statutory duties by March 2006. The PCT invited me to attend Board meetings to express my concerns, and monitor the action taken by the Board.

The PCT's response to its financial problems

20 The PCT Board accept their responsibility for the financial position of the PCT. It is clear the Board is being kept fully aware of the financial position of the PCT and the requirement to return to financial balance. The Board is taking the decisions necessary to return the PCT to financial balance. It agreed changes to 2005/06 budget plans, and sought savings from headquarters' budgets, left posts vacant, and deferred previously agreed investment, such as in school nurses. However, the scale of the problem the PCT now faces is so significant that major action is necessary, and robust leadership of the financial recovery plan over the next two years will be necessary by the Board and the Professional Executive Committee (PEC).

21 As the financial pressure in 2005/06 became evident, the PCT examined the assumptions behind a lot of its budgeted activity with hospitals, and challenged local hospitals on their coding of treatment and the costs associated with that treatment. However, the PCT and local Trusts were unable to agree on significant items in their respective budgets, and were required to go to a conciliation process chaired by the SHA for disputed sums totalling £2.4 million. The outcome of this conciliation process was not favourable to the PCT.

22 In response to the recommendations in my December 2005 Letter, the Board now receive financial reports in a format that makes the financial position the PCT faces, and the risks associated with that position clearer. The reports set out the best and worst case financial positions, and the risk associated with the various savings schemes the PCT has in place.

23 Prior to 2005/06, the PCT did not have a single cost improvement plan. There were not costed, co-ordinated, and well managed series of schemes to deliver savings. There were a series of cost improvement targets, but often there was little to back up figures in terms of agreed actions. A plan was defined for 2005/06, although it failed to deliver the predicted level of savings. In response to the concerns of the Chief Executive, Director of Finance and myself, the PCT has developed a more robust cost improvement plan for 2006/07, which has involved operational managers in identifying a range of individual schemes and projects to reduce costs. The challenge still remains to deliver services in a different way that will realise these savings.

24 The monitoring of the delivery of cost improvement savings has also been weak in previous years. The PCT missed its 2004/05 cost improvement target by £563,000 and has done so by £1.98 million during 2005/06. However, responding to concerns raised by these failures, Board monitoring reports now show progress in achieving cost improvement in greater detail and support better decision-making.

25 Despite all the PCT's actions during 2005/06, the PCT has been unable to prevent a further deterioration in its financial position, and a further £1.98 million deficit being incurred. The PCT has a £5.98 million deficit at the end of March 2006.

26 The PCT continue to assert that problems with the new payment by results (PbR) regime, and the failure of other NHS bodies to act according to the PCT's interpretation of the guidance surrounding PbR, are the root cause of the additional overspend in 2005/06. I am not convinced by this argument. Whatever the cause, the duty remains on the PCT to meet its statutory duties.

Planned action by the PCT from 2006/07 onwards

27 The top priority for the Board is to achieve a balance of its income and expenditure in 2006/07, and to implement plans to effectively deal with the accumulated deficit. In view of the size of this task, the new SHA (the North East SHA) has agreed to accept a phased repayment of the £5.98 million debt over the two years 2006/07 and 2007/08. The PCT Board has developed and approved a revised recovery plan, to return the PCT to financial balance over the next two years, and the SHA has requested that in order to strengthen the recovery process, a Turnaround Director be appointed by the SHA to assist the PCT in achieving its financial targets. As a result the acceptance of a phased repayment of the debt by the SHA means that the PCT are receiving funds which would otherwise have been devoted to addressing the wider care needs of those in the other Tees PCTs and the North East generally.

28 In reviewing the underlying causes for the operational deficits incurred in each of the PCT's first four years, a recurring factor has been weaknesses in budget setting at the beginning of the financial year. Budgets have been overly optimistic and, crucially, have had little flexibility to respond to unforeseen events, or changes in the demand for healthcare. Where pressures have arisen the PCT has had very limited scope to change plans and cope with the financial impact of any spending variations.

29 A welcome development in the new 2006/07 recovery plan has been the Board's approval of a 'zero-based' budget for 2006/07. This enabled the identification of some £9.4 million of financial resources which could be redeployed, allowing the PCT to use them in support of service improvements, organisational change, and the creation of financial contingencies for unforeseen events. In this way, the PCT should be better able to withstand change and variations in patterns of expenditure arising during the year.

The budget has been developed alongside service plans, with the aim of ensuring predicted levels of service delivery through primary and secondary care are properly reflected in PCT budgets.

Conclusions

30 The PCT has a deficit of £5.98 million as at 31 March 2006, and is in breach of its financial duty to live within its revenue resource limit, and not incur deficits. There is no provision in law for PCTs to make financial deficits.

31 The major factor leading to the deficit was the historic spending pattern of the PCT, and its failure to match spending with income in previous years. This was masked by the previous policy of the County Durham and Tees Valley SHA to provide support, which in my view resulted in the PCT not seeking sufficiently robust solutions to its own financial problems. The withdrawal of £4 million previously agreed SHA support in August 2005 revealed the true nature of the PCT's underlying financial health. The PCT asserts this in-year change left them with limited room to amend already agreed contracts for 2005/06. I note, however, that the PCT continued to forecast it would not add to its historic deficit of £4 million, but due to a failure of its cost improvement plans to deliver predicted savings in 2005/06, it has added to that deficit by a further £1.98 million.

32 This highlights that action taken in previous years and during 2005/06 to contain and address long-standing financial difficulties has not been sufficient to prevent the financial position from deteriorating each year.

33 The PCT has developed a plan for returning to financial balance over the next two years. It is vital the PCT delivers on its agreed financial plans. The Board and the PEC must lead this process, and ensure they remain in constant control of the PCTs financial position, and take whatever actions are necessary to change the way staff, General Practitioners, and hospitals deliver care for the PCT, in order that budgets as well as service standards are met.

34 I am aware that management and administration changes for Teesside PCTs are currently being discussed and that some shared management arrangements may well occur in the future. This does not reduce in any way the importance of addressing the issues in this report. It will be a key role of the executive and non-executive directors to ensure that the issues faced by the PCT are addressed as far as possible before any restructuring takes place in the local health economy and that any management changes do not impede the delivery of financial balance.

Audit recommendations for action

35 Following discussions with the PCT in 2005/06, the Board has, for the last four months:

- received monthly reports from the Director Finance setting out the worst case financial position of the PCT, along with a detailed schedule of savings measures in place, and the probability of those sums being delivered;
- received a monthly progress report on delivery of savings against each item in the summary detailed above, along with explanations of variance, and proposed remedial action; and
- received monthly updates on the financial recovery plan, with a profiled budget for delivery by month, and allocation to a person responsible for delivery of each item. The Board should then receive a monthly exception report of those savings budget heads not delivering the profiled savings, and should require the nominated officer to attend Board and explain the variance.

36 I recommend that the Board:

- give the financial recovery of the PCT during 2006/07 and 2007/08 their utmost priority; and
- ensure that spending decisions taken by all staff, including GPs, deliver against the revised budgets they have agreed for 2006/07 and 2007/08.

The way forward

37 I will present this report to the PCT Board on 20 July 2006. The Board needs to consider the issues raised and recommendations made in the report and determine the action necessary in response, with timescales for carrying out the action, and inform me of those decisions.

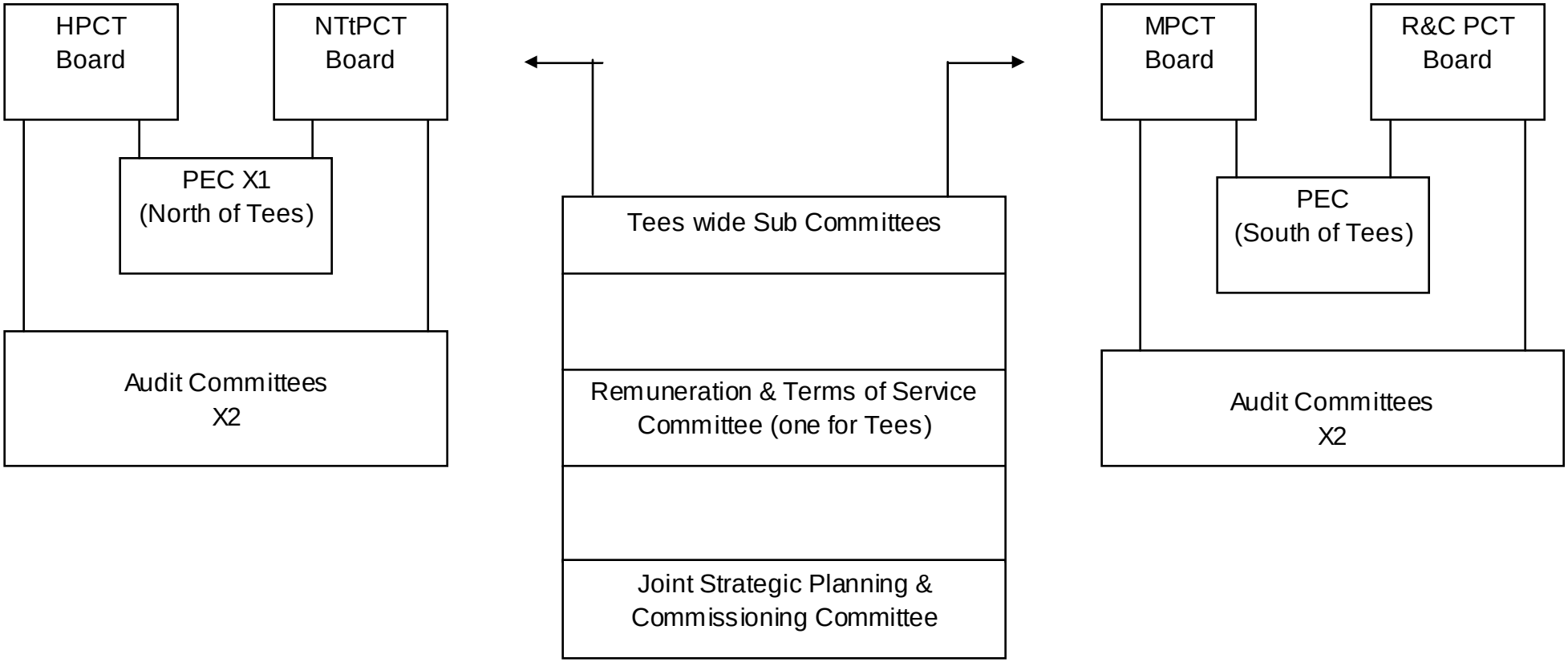
38 I will continue to monitor the PCT's financial position and progress in delivering sustainable financial recovery and consider whether I need to take further action in respect of the exercise of my formal powers under the Audit Commission Act 1998.

David Jennings
District Auditor

July 2006

Appendix 2

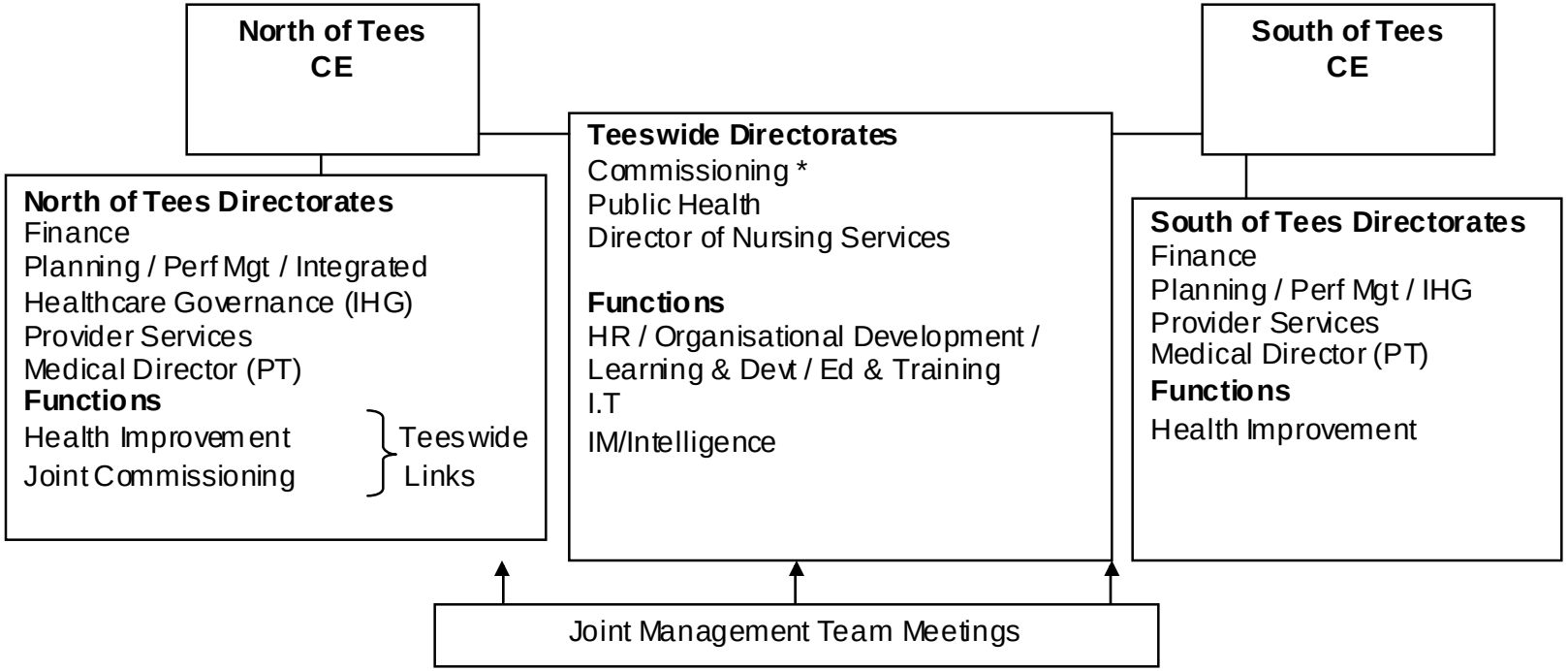
BOARD / SUB COMMITTEE ARRANGEMENTS



Each Board will develop relevant partnership arrangements with its coterminous LA as appropriate but as a minimum will ensure appropriate senior involvement at LSP, Children's Trust and a range of other Partnership Boards.

TEES MANAGEMENT ARRANGEMENTS

Appendix 3

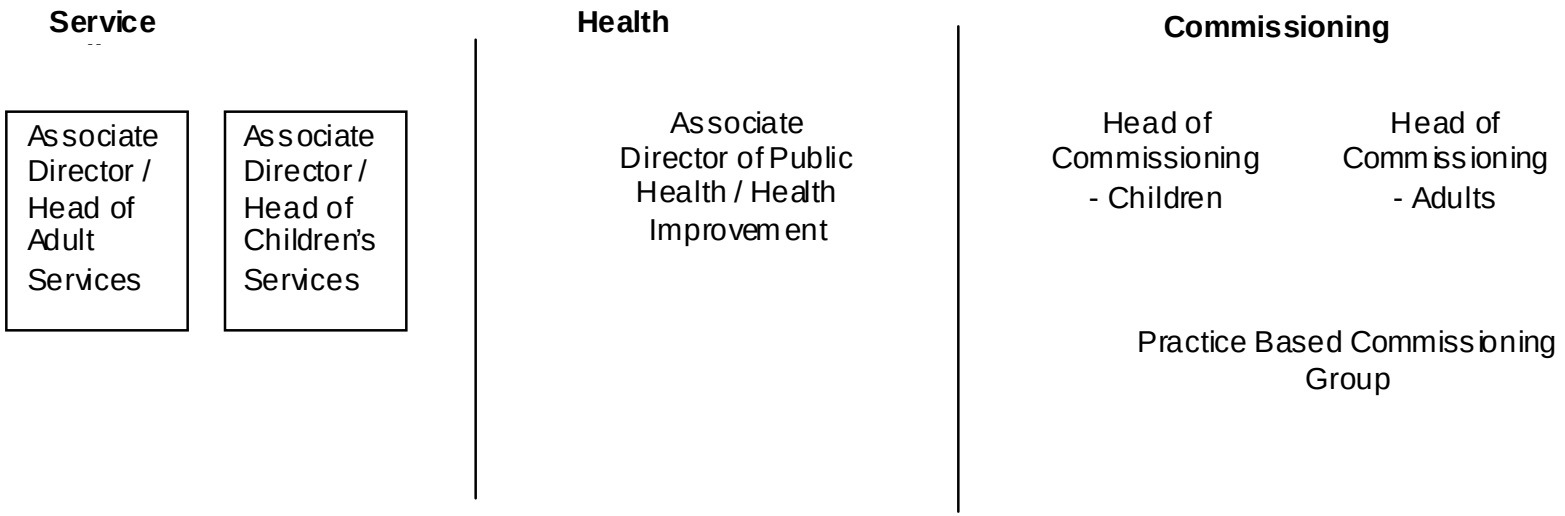


Notes

The future commissioning role in PCTs needs significant development and strengthening to become 'fit for purpose'. A Tees wide approach will enable the most effective use of skills and resources to be made on behalf of all 4 PCTs. This function will include contract negotiations (increasingly legally enforceable), supply side management, capacity planning, monitoring of clinical outcomes and clinical effectiveness of services, performance management of providers. The team will work closely with Public Health and Practice Based Commissioning utilising Health Needs Assessment to better inform commissioning decisions. The links with PBC Groups will be essential as PBC will be locally based, focussing on needs and how to meet them and the results reflected in service contracts negotiated by the Commissioning Team. The links with Local Authority colleagues will also be essential. The scope is to be confirmed, but is likely to include Acute Services, Tier 3 and 4 Mental Health Services, Primary Care and Community Services. The work of the Directorate will be overseen by the Joint Strategic Planning & Commissioning Committee, on behalf of 4 PCTs.

Appendix 4

HARTLEPOOL – LOCAL MANAGEMENT ARRANGEMENTS



Notes

•Consideration to be given to the further development of Integrated Management and possible Joint posts with HBC
•Specialist support will be provided to these staff/functions from North of Tees and Teeswide teams, including information and analysis, performance management, HR, communications, finance, etc
•Scope of 'Joint Commissioning' posts to be determined but will include areas such as drug and alcohol, LITs, Tiers 1 & 2 Mental Health, Pathways of Care, Continuing Care, Demand Management and will need to work very closely with PBC Group and the Tees wide Commissioning Directorate