ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM AGENDA

HARTLEPOOL
BOROUGH COUNCIL

Tuesday 19th September 2006

at 2.30 pm

in Committee Room "B"

MEMBERS: ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM:

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

Resident Representatives: Mary Green and Evelyn Leck

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

   3.1 To confirm the minutes of the meeting held on 6th September 2006 *(to follow)*

4. **RESPONSES FROM THE COUNCIL, THE EXECUTIVE OR COMMITTEES OF THE COUNCIL TO FINAL REPORTS OF THIS FORUM**

   No items

5. **CONSIDERATION OF REQUEST FOR SCRUTINY REVIEWS REFERRED VIA SCRUTINY CO-ORDINATING COMMITTEE**

   No items

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

No items

7. **ITEMS FOR DISCUSSION**

8.1 Hartlepool PCT – Future Board & Management Arrangements – *Scrutiny Support Officer*

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

ITEMS FOR INFORMATION

i) Date of next meeting Thursday 26th October 2006, commencing at 10.00 am in Committee Room "B".

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.

4 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

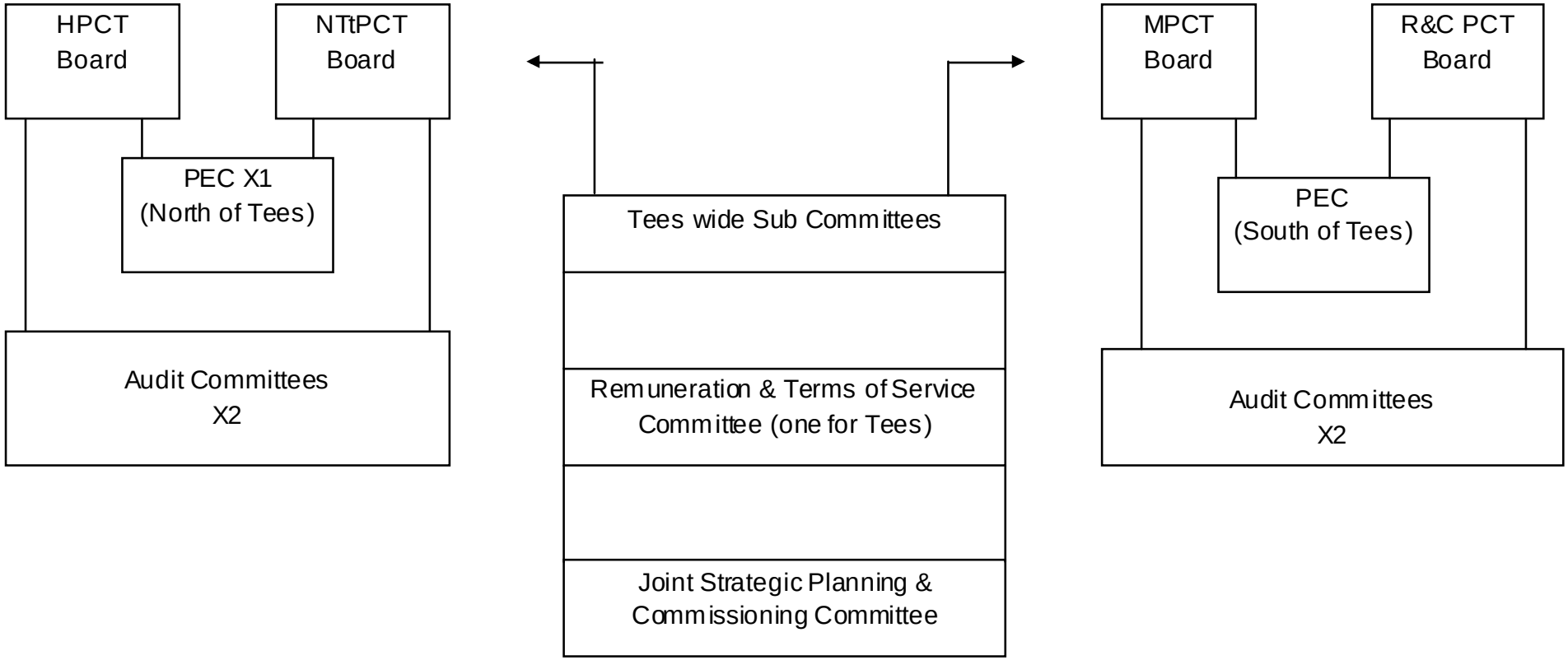
National guidance on the role and establishment of PECs is awaited and discussions are underway with PEC Chairs in Hartlepool and North Tees to develop proposals for consideration by both Boards and given the emergence of 2 effective Practice Based Commissioning Groups (in Hartlepool and North Tees) 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.

Appendix 2

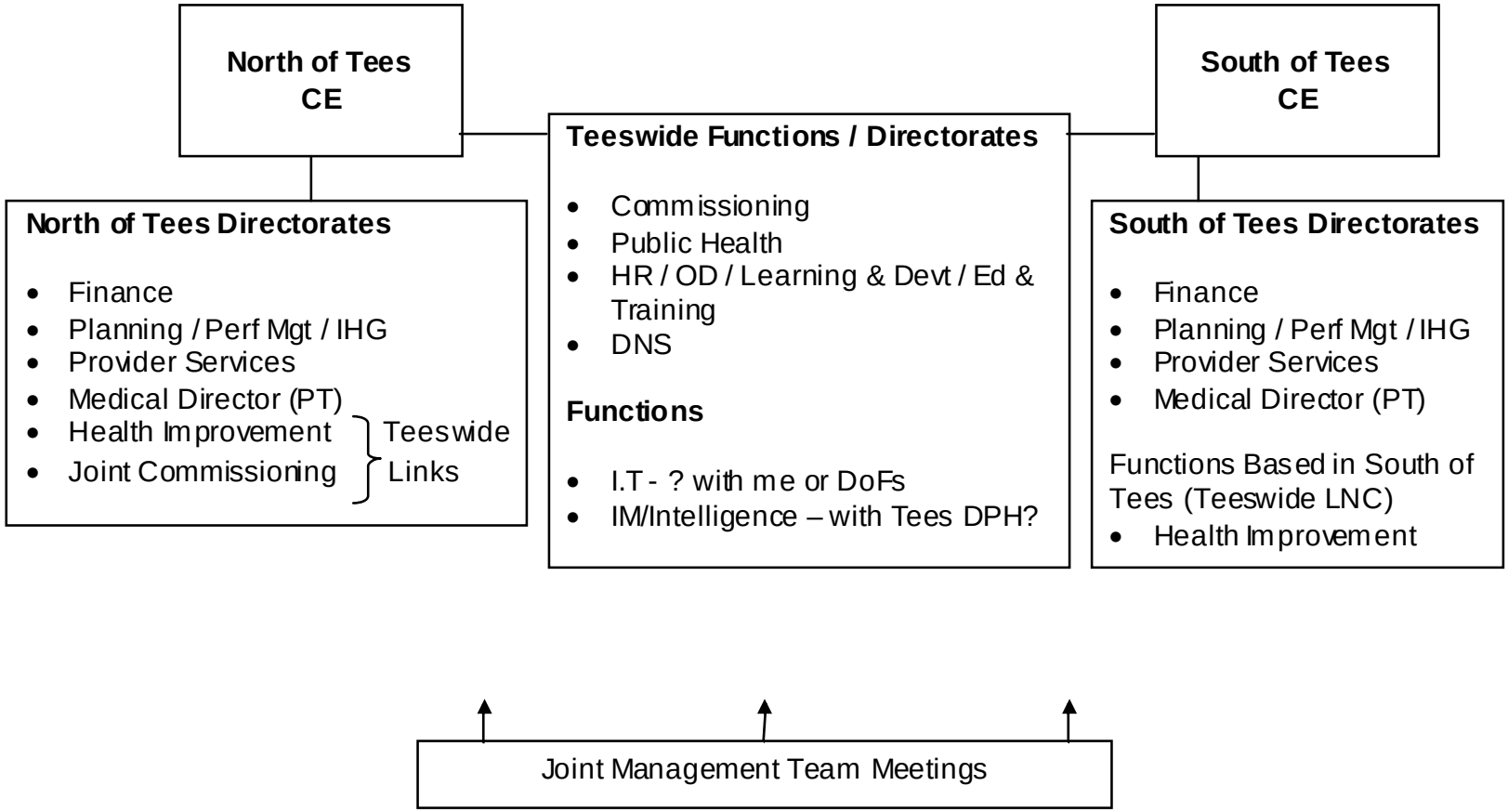
BOARD / SUB COMMITTEE ARRANGEMENTS



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.

Appendix 3

TEES MANAGEMENT ARRANGEMENTS



1. HARTLEPOOL – LOCAL
2. STOCKTON MANAGEMENT ARRANGEMENTS

Service Delivery		Health Improvement	Commissioning	
Associate Director / Head of Adult Services	Associate Director / Head of Children's Services	Associate Director of Public Health / Health Improvement	Head of Joint Commissioning - Children	Head of Joint 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

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:

- any director or officer in their individual capacity; or
- any third party.

Copies of this report

If you require further copies of this report, or a copy in large print, in Braille, on tape, or in a language other than English, please call 0845 056 0566.

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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

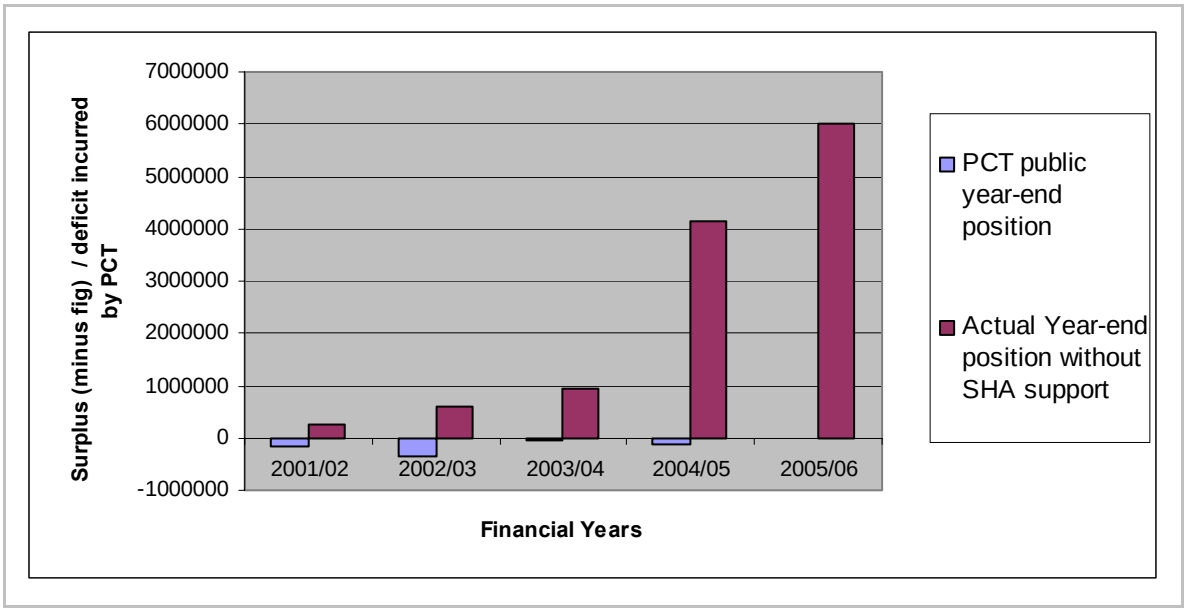
5 PCTs are required to operate within certain prescribed financial limits, the key one being the Revenue Resource Limit. The Revenue Resource Limit is set by the Secretary of State each year and Section 97(E) 1 of the National Health Service Act 1977 imposes a statutory duty on PCTs to ensure that their 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