COUNCIL
22nd February 2006

ITEM NO. .....4.....

CHANGES TO PRIMARY CARE TRUST ARRANGEMENTS IN DARLINGTON

Responsible Cabinet Member - Councillor John Williams,
Leader of the Council
Responsible Director – Ada Burns, Chief Executive

Purpose of Report

1. To inform members about the County Durham and Darlington Strategic Health Authority's consultation on new Primary Care Trust arrangements in County Durham and Tees Valley.

Summary

2. With regard to the re-structuring of PCTs in the North East, the NHS is consulting on two options. These options would alter the boundaries of the region's 16 existing PCTs to form either:

   (a) Option (1)

   Four PCTs covering:

   (i) North of Tyne and Northumberland
   (ii) South of Tyne and Sunderland
   (iii) County Durham and Darlington
   (iv) Teesside;

   or

   (b) Option (2)

   Twelve PCTs sharing the same boundaries as the region's ten unitary local authorities and two county councils. This would mean:

   (i) Two PCTs covering the counties of Durham and Northumberland
   (ii) Five PCTs covering the local authority areas of Tyne and Wear (ie: Gateshead, Newcastle, North Tyneside, South Tyneside and Sunderland)
   (iii) Five PCTs covering the local authority areas across Teesside (ie: Hartlepool, Stockton-on-Tees, Middlesbrough and Redcar and Cleveland) and Darlington.

3. By way of context, option (1) would mean:

4. One new PCT for County Durham and Darlington (serving c. 592,000 people). It would be formed by merging the six PCTs that currently serve: Durham and Chester-le-Street,

Sedgefield, Easington, Durham Dales, Derwentside and Darlington.

Information and Analysis

5. The current situation in Darlington is that Darlington PCT is coterminous with Darlington BC. For people living in County Durham and Darlington, hospital services are predominantly provided by the County Durham and Darlington Acute Hospitals NHS Trust. Patients also go to hospitals in Sunderland, Newcastle, Gateshead, Hartlepool, Stockton and Middlesbrough for both secondary and tertiary services. Mental health and learning disability services are provided by the County Durham and Darlington Priority Services NHS Trust, which is currently subject to a merger proposal with Tees and North East Yorkshire Mental Health NHS Trust.

6. The Darlington PCT is a three star PCT, that is equivalent to the "excellent or four star" rating the Council enjoys from independent inspectorates. It is an active player within the Darlington Partnership, within the Community Safety Thematic Partnership and in contributing to the delivery of the Council's scrutiny functions. Working relationships between key players with a role to play in improving health and tackling inequalities are sound, with some excellent initiatives underway.

7. Darlington PCT has been working with the five County Durham PCTs for some time to improve the "strategic commissioning" of hospital and other services. This is a response to the PCTs' assessment of their individual ability to commission effectively. The work pre-dates *Commissioning a Patient-led NHS.*

Why does the Department of Health think change is required?

8. The SHA's consultation document states that the main reasons for the proposed change are fivefold:

   (a) Ensure primary care organisations are large enough to make the best use of their budget when purchasing care and treatment from hospital trusts and other healthcare providers, but are still able to work closely with GPs to ensure that the right services are available to meet patients' needs.
   (b) Improve the range and quality of local healthcare, so patients get more choice and have better access to high-quality services.
   (c) Develop ways of improving health and encouraging healthy living.
   (d) Extend the southern boundary of the North East Ambulance Service to include Teesside.
   (e) Make big reductions in expenditure on management and administration. There is a target of a £14m saving across the North East NHS infrastructure.

Issue-based options appraisal

9. The DoH has set a number of criteria against which to judge the options:

   (a) Secure high quality, safe services.
   (b) Improve health of population and reduce inequalities.

(c) Strong relationships with independent contractors and their practices and roll-out practice-based commissioning.
(d) Improve public involvement and develop robust communications systems.
(e) Financial balance and the management of risk.
(f) Financial savings.
(g) Improve co-ordination with social services and other local authority services through greater congruence of PCT and local authority boundaries.

10. An objective assessment of the first six options in respect of these criteria is summarised in appendix 1. It is revealing to note that the SHA's consultation paper for County Durham and Tees Valley arrangements gives no formal analysis of criterion (g).

Further Analysis

11. There is a strong argument that, for Darlington at least, change is not required and that the DoH criteria, by which the options are to be assessed, are significantly flawed. They fail to take account of some aspects of the wider public service policy landscape.

12. Further, the Council in September 2005 agreed a report that sought representations to the SHA for the retention of a PCT with boundaries coterminous with the local authority. There is nothing in the consultation document to demonstrate that that position was not in the best interests of Darlington residents.

13.

(a) Insufficient weight is given to the strong government drivers for multi-agency commissioning within a local framework - for example, LAAs and Children's Trusts.
(b) No analysis is made of costs and other impacts upon other organisations (for example local authorities) as a result of PCT changes. For example, it is inevitable that the Council would need to develop and sustain relationships at regional PCT level as well as with localities under option (1).
(c) Insufficient weight is given to the joint commissioning work and pace of service integration with local authorities (currently approximately one third in value of total PCT commissioning in County Durham and Tees Valley, according to Darlington PCT).
(d) The arrangements required to achieve better co-ordination with Social Services and other local authority services through greater congruence of PCT and local authority boundaries is not fully considered.
(e) The value of local knowledge (at ward and neighbourhood level) is not given due weight, in thinking about developing practice based commissioning and greater public involvement.
(f) The possibilities of horizontal integration and multi-agency partnerships to deliver savings to the public purse under option (2) are not explored.
(g) A significant part of any savings made by reducing the number of PCTs would have to be re-invested in the establishment of locality arrangements to ensure that the PCT continues to be aligned with local plans and responsive to local need. The cost of these arrangements is not considered.
(h) The management costs of Darlington's PCT are just under 2% of its £130m budget. To put this in context, this is approximately half of the NHS average of 3.9%. Department

of Health figures also show that management costs within the private health sector are 20% higher than this NHS average and more than twice as high in the wider private sector. These facts are not considered.

(i) Since the PCT and Council in Darlington have become independent from county-wide authorities, both have made large, measurable improvements in performance. The former has improved to gain a three star quality rating. Some commentators have observed that, in this way, reducing the number of PCTs would be akin to "turning back the clock".

(j) Large-scale re-organisation in the NHS only three years after the last major changes will have a destabilising effect on service provision just as the benefit of the last changes are beginning to show.

(k) There are alternative ways of improving the ability of PCTs to undertake their commissioning role, which do not comprise wholesale re-structuring.

Legal Implications

14. This report has been considered by the Borough Solicitor for legal implications in accordance with the Council's approved procedures. There are no issues which the Borough Solicitor considers need to be brought to the specific attention of Members, other than those highlighted in the report.

Section 17 of the Crime and Disorder Act 1998

15. The contents of this report have been considered in the context of the requirements placed on the Council by Section 17 of the Crime and Disorder Act 1998, namely, the duty on the Council to exercise its functions with due regard to the likely effect of the exercise of those functions on, and the need to do all that it reasonably can to prevent, crime and disorder in its area. It is not considered that the contents of this report have any such effect.

Council Policy Framework

16. The issues contained within this report are required to be considered by Council.

Outcome of consultation

17. At a meeting of the Social Affairs and Health Scrutiny Committee on 31st January 2006, the unanimous support of Members was given to option (2), which would retain a coterminous relationship between the local authority and Darlington PCT. The following organisations were represented at the meeting:

(a) Darlington Partnership
(b) Darlington Learning Partnership
(c) Durham Constabulary
(d) Sure Start
(e) Darlington PCT Patient and Public Involvement Forum
(f) County Durham and Darlington Acute Hospitals NHS Trust PPI Forum
(g) Eastbourne Community Partnership

Conclusion

18. Darlington BC's response to the SHA's consultation must be informed by an understanding of a number of factors:

    (a) The social, health, equalities and financial impacts for both Darlington residents and the Council. Little work has been done in any of these areas.
    (b) A consideration of how best to future-proof the provision of health services in Darlington by endorsing the option that is most likely to lead to long-term stability of service provision in the borough.
    (c) An understanding that the Community Survey shows that public perception of the Council and partners' success in dealing with health issues has increased from 44% in 1998 to 58% in 2002 to 61% in 2005.

19. A proliferation of government-driven area initiatives, including the emergence of the Local Area Agreement framework, and the ascendance of the community engagement/user focus agenda suggests that localised services are the ones most fit for the future. This is particularly relevant in Darlington where reducing health inequalities is a key performance indicator for the Community Strategy Action Plan.

20. It is important to note that, although the suggestion of establishing a single management team servicing several coterminous PCTs is not mentioned in the consultation paper, some feel that this may be suggested as a way of finding efficiency savings if the argument for larger PCTs is lost. Current shared management arrangements between the Chester-le-Street and Durham Dales PCTs are described by many health professionals as not working. This view was echoed by the Chief Executive of Darlington PCT at a recent meeting of Darlington Partnership. There is no confidence that such shared management arrangements would work in Darlington.

21. A sentiment expressed at the recent consultation event facilitated by the SHA in Darlington on 16th January has received much support: why tear up arrangements that everyone acknowledges are working well?

Recommendation

22. In the light of both previous discussions and of the preceding and appended analyses, Council is requested to authorise the Leader of the Council in consultation with the Chief Executive to write to the Chief Executive of the County Durham and Tees Valley Strategic Health Authority, expressing the Council's strong preference for option (2). The Council's preference for this option is expanded with a desire to support the continuation of existing PCT management arrangements.

Reason

23. The recommendation is supported by the following reason: option (2), retaining current management arrangements, most readily provides a PCT structure that meets the needs of people in Darlington.

Ada Burns
Chief Executive

Background Papers

Select Committee on Health, Second Report – prepared 11 January 2006, Hansard.

Darlington Borough Council Paper, 15th September 2005, "Primary Care Trusts", Ada Burns, Chief Executive, Darlington Borough Council.

Consultation Paper on New Primary Care Trust Arrangements in County Durham and Tees Valley, County Durham and Darlington Strategic Health Authority.

Department of Health statistics:
www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Modernisation

David Plews: x2023.

APPENDIX 1

This table analyses each option against the Strategic Health Authority's listed criteria.

Criterion	**Option (1)**		**Option (2)**	
	+	-	+	-
Secure high quality, safe services.	+ Pools expertise in scarce commissioning skills. + Would encourage joint commissioning across clusters of local authorities for some specialised community care services. + Regional working would be straightforward.	- New arrangements would be needed to put in place locality-based partnerships - Additional layer of service level agreements may be required to ensure local needs are met. - Existing arrangements with local authority members and officers in planning and commissioning would be jeopardised.	+ Coterminous boundaries would facilitate easier partnership working with local authorities.	- May not be able to deliver financial savings required, whilst delivering high quality services. This is based on negative experiences of previous joint ventures between County Durham and Tees Valley PCTs. - Individual PCTs would require additional management support to gain the added value required from Practise Based Commissioning.
Improve health of population and reduce inequalities.	+ Larger PCTs would improve services through economies of scale and are better placed to provide simplified and consistent health improvement messages. + Better placed to streamline links with regional bodies to engage in emergency planning.	- Sensitivity to health inequalities in local neighbourhoods and super-output areas may be reduced.	+ Better placed for working with local authorities and LSPs. Many partners see these relationships as the key to reducing health inequalities in the future.	- Smaller pools of expertise available.

Criterion	Option (1)		Option (2)	
	+	-	+	-
Strong relationships with independent contractors and their practices and roll-out practice-based commissioning.	+ Better placed to deliver dedicated analytical support.		+ PCTs already working closely with contractors (eg: optometrists, dentists, pharmacists, GPs) + Thinking around Practise-Based Commissioning has to date been based around smaller localities than would be created in option (1).	
Improve public involvement and develop robust communications systems.	+ Economies of scale would ensure better resourcing of this work.	- Bigger PCTs may lose grassroots connections. - Destabilisation of local scrutiny processes.	+ Patient, carer and public involvement are strengths of current PCTs. + Initial views from local authority scrutiny committees and patient and public involvement fora indicate a preference for this option.	
Financial balance and the management of risk.	+ Better able to attract talented managers and, with larger budgets, more financially resilient.	- Risk management activity at a local, "micro" level may be compromised. - Budgets intended for some areas may be vired to other areas of greater need.	+ Local knowledge for effective management of localised risks.	- Less able to attract the highest quality staff and, with smaller budgets, less financially resilient.
Financial savings.	+ Fewer PCT boards means saving of £4m/year.	- Fewer boards mean worse democratic accountability.	+ Savings on boards amount to £2m/year.	- More savings required below board level. No work has been done to analyse options here.