DERBY CITY COUNCIL

Review of the proposals for the reorganisations of Derbyshire Primary Care Trusts

Social Care and Health Commission

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1. Introduction

The Government is seeking to reconfigure the Primary Care Trusts (PCTs), the Strategic Health Authorities (SHAs) and the Ambulance Trusts to provide a patient led service and deliver at least 15% savings in management costs. The reconfigurations are the subject of a consultation process that began on 14 December 2005 and will finish on 22 March 2006. Nina Ennis, Chief Executive of Derbyshire Dales and South Derbyshire Primary Care Trust has been appointed by the Trent Strategic Health Authority to conduct public consultation on its behalf.

On 16 January 2006, Ms Ennis gave a presentation to the Social Care and Health Commission on the new NHS arrangements that included the options for the primary care arrangements in the Trent region. As the final PCT structure will have a major impact on the way health services are managed and ultimately delivered in the city, the Commission agreed to carry out a detailed review of the two options for Derby and agreed following terms of reference:

a) To examine the proposals for the reorganisation of Derbyshire PCTs
b) To enable the Commission to recommend the PCT structure that it considers will best provide for the needs of Derby residents

2. Background

The primary care trusts typically consist of a Chief Executive and 10 to 14 board members. PCT take the lead in assessing health needs, planning and securing all health services and improving health for the local population.

The PCTs manage services such as those provided by doctors, dentists and pharmacists, the people you would normally see when you a have a health problem. They also commission (buy) services from hospitals and walk in centres. They work with local councils and other agencies that provide local health and social care to make sure they meet the health needs of residents in their area.

PCTs are arguably at the centre of the National Health Service (NHS) and will get 75% of the NHS budget. Being local organisations, PCTs are considered to be in the best position to understand the needs of the local communities and ensure that the health and social care providers work effectively. To do this they must make sure that there is sufficient service capacity to meet the needs and that those services are easily accessible. It is argued that stronger PCTs are needed to design, plan and develop better services for patients, to work more closely with local government and to more effectively support general practice. In short PCTs need to strengthen their commissioning

function. The objective of this restructuring is to reduce the administrative burden and thereby release funding that can be used to improve services to patients. In order to achieve these objectives the Department of Health has asked the Strategic Health Authorities (SHAs) to put forward proposals for restructuring the PCTs within their areas.

3. Derby City and Derbyshire County Councils submission to the first stage consultation

Derby City Council and Derbyshire County Council submitted their responses to the Trent Strategic Health Authority's first stage consultation on 'Commissioning for a patient led NHS' in autumn 2005. Both authorities were in favour of two PCTs- one for the city and one for the rest of Derbyshire. They considered that this option would enable a better focus of health care and would best serve the very different requirements of Derby and Derbyshire residents.

Derby City included highlighted in its submission government's guidance to local health organisations on restructuring that identifies co-terminosity as an important criterion. The key components of the benefits of co-terminosity are:

- Local Strategic Partnerships
- Adult social services and community health services
- Practice based commissioning
- Public health
- Economies of scale

Derbyshire County Council supported two PCTs because it felt there are advantages with this option particularly around alignment with the respective LAAs, social services boundaries and children services agenda. It stated that a county PCT and city PCT would allow a focus on the differing health needs of the communities within Derbyshire such as those affecting inner city communities, the rural areas and former coalfield communities. The County Council has confirmed that this is still its preferred option.

Their details of their respective submissions are given Appendices 1 and 2.

4. Financial Implications

Finance is one of the most important elements of the whole exercise and therefore needs to be considered carefully together with the criteria produced by the Trent SHA it in its consultation document.

The Government wants to save £250m nationally from the reorganisation programme which will be cascaded down to the local level. Savings are calculated on a per capita basis and since the Trent SHA area has approximately 5% of the national population, it is expected to save 5% of the budget. This equates to approximately £13m saving in Trent which covers Derbyshire, Nottinghamshire and Lincolnshire. Of this £3m will need to be

saved from the SHA reorganisation and £10m from PCT's. The saving made from the reorganisation will be put into direct patient care.

However, there is currently no definitive answer to where the savings for the 15% are to come from. There are different interpretations on whether the savings are expected to be made across a region, on county area, or by each new PCT. The SHAs' are seeking clarification from the government.

The debate on the 15% savings has also taken place in Nottingham City Health Panel. In their response to the proposals for Nottingham they are arguing that they have already made savings through the formation of a single PCT from three Primary Care Groups. However, they believe 15% is applicable to all PCTs but do not yet have a plan for how this could be delivered. They agreed that if a doughnut model is put in place that would be the time for them to start lobbying over the 15% savings.

Nottingham's strongest argument is that the White Paper's focus on closer links between social services and PCTs, as they think it odd to deliberately break these up when government is saying that they should become stronger. They also feel that the focus on the city's specific needs (in particular health inequalities) would be lost should a county PCT be created. Members don't want Nottingham to become one pocket of deprivation amongst many in the county.

5. Objectives

Trent SHA responded to the Department of Health's request by asking PCT Chief Executives to work with their partner organisations and wider stakeholders to identify the best way of reconfiguring the PCTs and to develop options that it could consider. A Programme Board of Chief Executives was established which consisted of Chief Executives from all the health organisations in Derbyshire to consider the options for Derbyshire. The Board carried out consultation with key stakeholders such as Trust Boards, Borough/District Council Chief Officers, City and County Council Chief Executives and Directors of Social Services etc. At present there are eight PCTs in Derbyshire, two of which cover the city of Derby. The Board put together four options for Derbyshire:

- **Option one**: One PCT covering the whole of Derbyshire excluding Glossop, which would be linked to Tameside as part of Greater Manchester
- **Option two**:Two PCTs: Derby City PCT coterminous with the city council, and Derbyshire County PCT excluding Glossop, which would be linked to Tameside as part of Greater Manchester
- **Option three**:One PCT covering the whole of Derbyshire including Glossop
- **Option four**:Two PCTs: Derby City and Derbyshire County organisations coterminous with both city and county councils and including Glossop

This review concentrates on options two and option four, the two that specifically relate to Derby. The advantages and disadvantages of the two options as seen by Trent SHA are set out in a document prepared by the Trent SHA entitled 'Consultation on new primary care trust arrangements in Trent: Ensuring a patient-led NHS'. This document seems to favour a larger, single PCT. The document can be accessed via the following link: http://www.tsha.nhs.uk/consultations/pct-consultation.

6. Methodology

The Commission conducted a detailed review of the two options relating to Derby This involved collecting evidence from a number of sources including:

- Interviewing the Primary Stakeholder Groups
- Conducting public survey by sending out random questionnaires to 4000 households in the city of which more than 400 forms have been returned making the survey statistically significant to a 95% confidence level
- Posting the questionnaire on the Council's website and asking for views on the best option for Derby **(Appendix 8)**
- Consulting with Council's Advisory Committees and with the Younger and Older People's Forums
- Inviting comments from Members of Parliament **(Appendices 4 and 5)**
- Through Nina Ennis the Commission seeking views from a PCT Chief Executive from outside the city. Unfortunately no one was available to attend the meeting or provided a written submission
- Inviting comments from Derbyshire County Council on their preferred option
- The Commission has received a Committee report from Erewash Borough Council that supports two PCTs **(Appendix 6)**

A total of 33 individuals witnesses were interviewed in 27 separate meetings. All bar one witness were asked the same set of questions regarding, in their view, which of the two options they thought will best deliver the health needs for Derby people against the criteria listed in the SHA's consultation document and why. The exception to this was the Chair of the Strategic Health Authority whose interview focused mainly on the purpose and process for reorganising the PCTs in Derby.

The Commission considered all the evidence at a special meeting before recommending the PCT structure that it considers will best provide for the health needs of Derby residents.

7. Assessing the two PCT options for Derby and Derbyshire against the Criteria – A Summary of Responses

As part of the review, 32 witnesses representing the full range of stakeholders were asked for their opinions on the two PCT options that were under consideration by the Commission. 17 witnesses had an overall preference for two PCTs whilst 15 prefer one PCT for the whole county. The summary response of the witnesses has been categorised either as neutral or background information, or as in favour of one or other of the two PCT options. A summary of witnesses' views in respect of each of the criteria listed in the Trent NHS document 'Consultation on new primary care trust arrangements in Trent: Ensuring a patient-led NHS' are listed in the following tables and detailed notes provided in **Appendix 3**:

Table 1 Criterion 1: Secure high quality, safe services

Neutral Views or background information

- A number of witnesses stated that regardless of which option is selected, the services which they represented would be required to provide high quality safe services.

Comments in favour of two PCTs	Comments in favour of a single County-wide PCT
• One witness stated that in his experience of managing regional rather than nationally based services a smaller more specifically focused unit would be most effective. • The Central and Greater Derby PCTs already provide excellent services. They have a proven track record and can hit the ground running. They have driven standards higher, reduced waiting list and mortality from killer diseases. Despite financial pressures they have secured expensive drugs under clinical guidelines such as statins.	• There is no perfect structure but it is felt that a single County PCT would have the capability and capacity to commission the necessary services. It would have greater expertise and would reduce current levels of duplication and fragmented effort • The change is all about improving the commissioning of services. A large PCT would have more political and financial capability especially in commissioning services.

• One PCT for the whole county will not be able to provide the same level of service and could disadvantage patients from receiving the current high standards. A single PCT would not be able to cope with or understand urban issues and in any case would need to establish a specialist management team. • Previous experience shows that it takes several years following a reorganisation before the patients started to see the benefit. Therefore changes could damage service provision for the next few years. • Experience from local authority reorganisation leads people to believe that the City would lose out in a wider organisation. • Co-terminosity with the City Council has huge benefits. It enables the organisations to jointly identify needs of the population and to develop priorities and action plans. It also reduces the barriers for working in partnerships and pooling resources. • Local relationships are essential to ensure better standards of provision. Providers being closer to the people will ensure appropriate commissioning. In general it is better for the organisation to be located in the area it serves.	• The existing City arrangement does not permit movement of funds between the two City PCTs. • A small Derby PCT would not have the expertise and resources needed to commission services. • One PCT would have more capability, more resources to distribute and could promote consistency of services across the county. One quality standard would be safer and better for patients and public. • Having two PCTs meant there could be two slightly different agendas leading to the risk of mixed messages being given. • On balance one PCT with a divisional set up is to be preferred. A larger PCT equates to a more strategic approach combined with a minimisation of the post code lottery. • The promotion of equalities and the minimisation of duplication are better achieved by one. • A City PCT would struggle to achieve the leverage to commission for the local population. The one countywide PCT would need local structures to deal with relative

• It was stated that commissioning in the County has not developed due to lack of financial stability. • Local health professionals decide the best way to address inequalities. If a single PCT is established, it will take decision making away from the local area. • Derby being a unitary authority with a good sized population is about right for service delivery and addressing the particular needs of certain communities/areas. • There are benefits of the scale of economies of the one Derbyshire PCT model but these are counter balanced by the differences of need between urban and rural communities.	inequalities.

Table 2 Criterion 2: Improve health and reduce inequalities
Neutral Views or background information • Both options will need to have local area targeting and it would not be possible to operate a single large PCT effectively from one base, so multiple bases would be required. There will have to be locality planning whatever structure is chosen.

Comments in favour of two PCTs	Comments in favour of a single County-wide PCT
• There are distinct differences in the makeup of the population between city and county. Derby has higher levels of deprivation, significantly greater numbers of people from ethnic minorities and higher levels of health problems. Drug abuse in cities tends to be more prevalent – needing specialist services, similarly rough sleepers, asylum seekers and refugees. These could best be addressed by a City PCT. It is essential to target deprived wards – which can be best done by working at local level. LSP working and Local Area Agreements in Derby have been recognised as top in the region and nationally are highly rated. • There are clear differences in health needs between the county and the city. Diseases such as coronary heart disease and diabetes are more prevalent in the Black and Minority Ethnic communities. The shortest life expectancy in the county is found in Derby. It also has some of the most deprived wards of the region. We need to concentrate efforts at the local level to tackle inequalities. A Derby based PCT coterminous with the city boundary will be better positioned to deal with local needs. • Having local knowledge and people on the ground matters. We need to understand the nature of issues through local connections and links with the communities.	• One PCT would allow funds to be allocated to areas where there is most need. • One large PCT might be better placed to attract the high calibre staff needed to run it – smaller PCTs would struggle to do this. • Working with all the authorities in the county could enable better delivery of services. • Delivery has to be at local as well as strategic level. • Each authority has its area of expertise, the City Council in working with minority communities and the County in rural issues which will enable expertise to be shared though a large PCT. • Having separate PCTs would discourage new thinking as there could be the culture that 'this is how we've done things before' (= so why change). Derby's community pharmacists would not suffer by having one PCT and having one would promote consistency of approach.

A wider board structure would not give proper representation for Derby people and would lose focus. • The management of a local PCT is likely to be made up of local people. A large PCT is likely to have only one or two representatives from the city. For a large PCT, policy and strategic decisions would be made at the headquarters by the executive. The needs of the large Derbyshire population would come before those of Derby. There could also be logistical problems due to large area covered by the countywide PCT. • Locality planning could only be brought about from strategic Commissioning. Locality planning will not be a substitute for a local PCT. • Local networks are needed to ensure delivery of health without inequality. Local networks such as cancer network already exist especially to tackle major issues. • The Derby PCTs have already made a great deal of investment in the deprived areas of the city such as the Healthy Living Centre in Derwent and the primary care resource centres in Sinfin and Allenton. It proposes to establish a walk in centre at the DRI. • The coherence achieved in City would be at risk if one PCT for whole county option is chosen.	• One PCT would allow funds to be allocated to areas where there is most need. • One large PCT might be better placed to attract the high calibre staff needed to run it – smaller PCTs would struggle to do this. • Working with all the authorities in the county could enable better delivery of services. • Delivery has to be at local as well as strategic level. • Each authority has its area of expertise, the City Council in working with minority communities and the County in rural issues which will enable expertise to be shared though a large PCT. • Having separate PCTs would discourage new thinking as there could be the culture that 'this is how we've done things before' (= so why change). Derby's community pharmacists would not suffer by having one PCT and having one would promote consistency of approach. • One PCT would increase capacity for commissioning services. However there is recognition that PBC may increase inequalities.

Table 3 Criterion 3: Improve the engagement of GPs and the roll-out of practice based commissioning	
Neutral Views or background information • It doesn't make a difference which option is adopted as long as the right performance management procedures are put into place. All GPs would want the same for their patients - to provide high quality services at the point of need and at the lowest cost • Practice based commissioning is not presently well understood. It will have to be rolled out gradually through local successes. • It will be down to the capacity of individual practices and willingness to do commissioning	
Comments in favour of two PCTs	**Comments in favour of a single County-wide PCT**
• Practice based commissioning requires local intelligence and a knowledge of delivery to be successful. There is no advantage in gathering local intelligence and sending it to larger organisation to make the decisions. • Clinical governance will be damaged by adopting a county wide PCT. Its effectiveness will be lost. • Derby PCTs are effective in engaging clinicians and will expand services such as nurse triage and prescriptions. It will improve GP working conditions and allow them to tackle the needs of the whole community. A City PCT would like them to work in locality neighbourhoods.	• The bigger PCT will have economies of scale. PBC needs a huge infrastructure to support. Funding for this would be better provided from a Countywide PCT. It is questionable whether a smaller PCT would have the management capacity to support PBC. • Many remote GPs already have some services set-up at their practices. They will probably have more experience of working in this way and could help the City • If Practice Based Commissioning develops as intended it will deliver the local focus. At the strategic level, 'the bigger the better' for commissioning and

• Although some problems occur with GP services near borders, this option best when both PCT and GPs are working in common territories, for example serving the same families/clients and localities. • PBC is slightly more problematic as the GP surgeries are in some cases not coterminous with the city boundaries, however, that equally applies to those surgeries on the periphery of the county so it is a judgement of which will be more effective. A smaller number of GPs responding to a city wide PCT would achieve this. • GP practices can interface directly with a local PCT to understand local problems and provide a sharper focus. • A larger structure would have more resources but could lose local intelligence. Bigger isn't always better, otherwise why limit it at the county level and not have one health body for the whole region. • The GP agenda in the city is distinctly separate from the county. Two PCTs will allow the Derby PCT to focus on urban issues and can be more proactive. • Closer proximity to the location of the PCT base will make it easier for the GPs to work with the PCT and also make it easier to commission services. However, knowing what to commission is more important it will help to get the	achievement/sustaining of high standards. • One PCT might be more proactive as it could move money around within it to areas where it is most needed.

dlievry right. • PCT's should already be engaging the GPs in practice based commissioning. The location of the administration base will affect this provision. • The needs of inner city areas of Derby are different from the rest of the County, although Chesterfield has similar but not the same level of problems. • A Professional Executive Committee (PEC) could function at county-wide level in theory, but would be harder due to the ownership issue. Unsure of the impact at such a wide level. • A County population of 1million could feel very remote in terms of influencing and shaping local service delivery. • GPs and schools are a difficult relationship to nurture. Localism helps this. Practice based commissioning is about clustering services, the City is a good size to do this well.	

Table 4 Criterion 4: Improve public involvement
Neutral Views or background information • It is not thought that either a one or two PCT structure would make a great deal of difference. The public are not

interested in how the services are organised, they just want health care when and where they need it. There is a need to create public involvement as the lack involvement shows that people are either happy with the service they receive or think it is pointless to give their views as no one will listen to them.

- Local politicians should be more accountable, as their input is vital to the proper administration of public services.

- Some stability in the NHS is needed as public may not understand how the services are structured. Accountability is important, eg, the role of Overview and Scrutiny in holding the PCTs to account is valuable.

Comments in favour of two PCTs	Comments in favour of a single County-wide PCT
• More remote services might inhibit the development of public and patient involvement. Derbyshire is one of the longest counties and would require significant travelling. People will be reluctant to travel long distances to attend meetings. • Patient panels already exist. The need is to dovetail communication to government policy and increase patient choice. • Consultation with the business community has found that they feel their business will suffer if Nottingham and Leicester have PCTs coterminous with their boundaries but Derby doesn't. It will also send out wrong signals to potential investors. • DCP works well and has a good level of public involvement.	• A bigger organisation gives capacity to organise local structures in a better way. • Public involvement is determined by how individuals do it – not much influenced by structure. • Significant diversity agenda in Derby which need to be addressed. Needs vary in Derby and Derbyshire. • Having Social Services coterminous with 2 PCTs might lead to an inconsistent approach. One PCT would allow sharing of information between city and county.

• People associate/identify with the City before the County. The view is that public engagement would be more positive if health and social care is working for Derby. • Public service boards would help accountability to people. It is not thought that the PCTs are as accountable as Unitary Authorities, but that this option could improve this. • The City Council area panels consider local issues and have high attendances by the public. • The roll out of the Neighbourhood Agenda in Derby will give a much better ability to engage with the public and the involvement will be enabled by closer working relationships. • The smaller the organisation the better people can identify and relate to local issues. It would be difficult for Derby people to be interested in issues outside their area such Chesterfield and vice- versa. • Derby is a compact city and a model based on the city boundary is superior in a number of areas; it gives local perspective; better alignment of local agendas; and having Derby loyalty would give higher involvement. • One PPI forum for the whole county would be impractical and unwieldy. It is harder to reach certain communities in rural areas and therefore it may be necessary to set up	

number of forums. People are more likely to engage with local enterprises. A smaller, more concentrated patient's forum would be needed. • Stability and continuity is more powerful at a local level and more meaningful to people. To dismantle the work of the existing 2 PCTs makes no sense. Keeping a City PCT would be in line with this as people are beginning to understand their purpose. • This is an opportunity to engage with the needs of a diverse city. The Area and Neighbourhood working would support greater public involvement. • Objectively, practice based commissioning should achieve public involvement. At PCT level it mainly depends on how the involvement is delivered. However, people tend to relate to smaller areas rather than larger ones which suggests a separate Derby PCT would have an advantage. • Since Unitary status Derby CC has already got much closer to public in the way it works. Local knowledge/networks are essential.	

Table 5 Criterion 5: Manage financial balance and risk

Neutral Views or background information

- Providing the necessary financial procedures, robust monitoring and assessment processes are in place then it should not matter which ever option is chosen. Again experience dictates that for bigger enterprise, it is more likely that audit becomes superficial.
- Enormous risks are involved in the NHS. The need is to make decisions at a local level and therefore have to be flexible to be creative.
- This issue is far bigger than just PCT arrangements. 'I don't think structure affects this'.
- Great risks exist for PCTs with new contracts – either option will have issues.
- From the acute trust's point of view there could be advantages in having two PCTs as it would strengthen its negotiating leverage with the purchasers. But from the point of view of PCT budgets, one PCT would be better for financial management because of the critical mass, greater scope to equalise pressures and greater clout dealing with acute trusts. In response to the point that one PCT could be domineering re-acute trusts, the answer was that the SHA/ monitor would not allow unreasonable behaviour to occur.

Comments in favour of two PCTs	Comments in favour of a single County-wide PCT
• There are strong professional working links between the City Council and local PCT directors.	• There are arguments that Commissioning could be better for larger PCT due to economies of scale. It has more power to commission and roll out services

• Experience shows that the Derby PCTs have been able to work effectively with five other PCTs to negotiate services and therefore it shouldn't be a problem with two. Derby PCTs size being considerably larger than others hasn't caused problems in the past. • Derby PCTs have an excellent track record of financial management. There is least risk with this option. Derby PCTs have managed finance and risk effectively in the past and there is no reason to assume why this shouldn't continue in the future. It already has a good system with established procedures, protocols and trust between partners in the city which helps with risk management. • Derby is moving further towards area working and will be easier to integrate on co-terminosity. Why fix something that is not broken? • It is easier when working on common budget bases to prioritise where savings and/or investment should be made. When the boundaries coincide this, management is easier. However defining borders won't always meet requirements of all stakeholders. • One PCT for the city will also have advantages. It is applying the same principle for Derby becoming a unitary authority.	• Management of financial balance and risk would generally be better with just one PCT. Reducing from eight to one PCT is the best option as it gives the opportunity to move finance to areas where most needed. • Bigger organisations would allow a concentration of expertise and smoothing of risk. • The experience from being on the Police Board is that resource allocation is discussed all the time and the decisions are always made to spend on areas of need. • Capacity and expertise is needed to make decisions – these are best provided by one large PCT. • It would be easier to manage financial balance and risk with a single PCT. It would create a larger 'pot' for commissioning and would enable funds to be more easily directed to areas that needed them • Experience as Education Director shows larger schools have much more flexibility. A larger PCT could similarly have greater flexibility. • There will need to be local area management if one option was chosen.

• Derby is large enough to have one PCT for the city and not be pressurised by the Acute Trust. It is better to have a reasonable size organisation as large structures devolved down to smaller areas have to be pulled back together again. • The single Mental Health Trust has gone through a bad time balancing its budget. In light of that experience it is feared a single PCT would be riskier than having two. • There has to be a case for sensible amalgamation. 'The smoothing of risk with one large PCT' argument is not accepted. • The potential to move finance within the organisation could create a situation which was of advantage or of disadvantage to Derby – possibility that with one large PCT Derby could find itself deprived of funds. • There are concerns about the city losing out and therefore it is important to have the right arrangements in place to address these issues. People at the board level should be able to understand the needs of all patients across the county. They need to demonstrate the capabilities and knowledge of having a wider picture.	• When the Council's split in 1997 some vulnerable people lost out on their specific services. For example provision of schools for autistic children in Derby. This could be the case for health services for Disabled People.

Table 6 Criterion 6: Improve co-ordination with Social Services

Neutral Views or background information

- Either structure could deliver. Social Services are expected to be seamless across the city and county area. There is a need for strong integration at local level. The need is to balance opportunities with City/County Social Services. Working together would lead to service improvements.
- The distinction between the city and county is blurred with the boundary issues being less important.
- The wider county would benefit from good practices of partnership working in the city.

Comments in favour of two PCTs	Comments in favour of a single County-wide PCT
• Improving co-ordination is the critical mass in the whole proposition. The delivery of a co-ordinated service will be far more reliably achieved by co-ordinating an already successful team in Derby Social Services coterminous with PCT. The government white paper, LAA and DCP all support co-terminosity which is an important factor. • The clarity of vision applied to this issue is critical, the ability of Derby Social Services to focus locally and direct interface with a similarly focused PCT will give much better option for Derby City. • Coordination with two social services would be difficult with one PCT.	• There are examples of joint working with Derbyshire, eg, on Emergency Planning – a small number of people work on this so it makes sense to work together. • The health profession works well with the Social Services Departments' sensory teams but things still go awry. There would be more co-ordination with one PCT as hub for the whole county and less to go wrong. • From the point of view of the Acute Trust it would be better to have one PCT dealing with two social services departments, rather than two PCTs and two SSDs – the latter would require twice as much time to operate relationships. One PCT would promote a consistency of approach. With two PCTs, the Acute Trust would be

• There is evidence of the City's progress on the Public Health Agenda. The White Paper on Public Services sees closer partnership between the Adult Services Director and the Health counterpart. • There is already good partnership working in the city, such as on the Local Area Agreement. Derby PCTs work well with social services. It has pooled budgets such as for people with learning needs. The current situation is working well so why change. Partnership working would be made more difficult by one PCT having to work in many different areas. • Relationships are better handled when you are closer to people who make the decisions. It is easier to work together when you have common boundaries. • We are already undergoing changes in Children's Services and don't wish to go through another set of changes. Integration of Children's Services is a clear winner with a Derby based PCT coterminous with the city boundary. There are already good relations between the City Council and Derby PCTs and the system is working satisfactorily. • A county wide PCT would be disadvantaged working with two Social Services departments. • Successful commissioning is already occurring in Derby.	attending two meetings with policy/practice perhaps going in totally opposite directions. The Trust could not "join up" arrangements, whereas a single PCT could by talking consistently to the two SSDs. For discharges, particularly complex discharges, there are currently different community services according to where the patient lives. • One PCT would be optimum and could promote co-ordination with the Social Services Departments.

• Co-ordination with social services in the county will be different to the city. Good co-ordination will be achieved by having two organisations. • It could be difficult for the one PCT to make the split fairly between two separate local authorities. • Pooling of budgets is much easier with organisations based around similar boundaries. • One PCT for two local authorities goes against the ethos of integrating local services. • Two PCTs coterminous with two local authorities would improve co-ordination such as with the Children's Services agenda. • If the White Paper objectives are to be achieved, co-terminosity between Social Services Departments and the PCT is vital. • Having two would be more attune to the needs of the population and better retain the links in the City's localities. • Partnership working with the County Council has been shown to be robust, therefore no need for the one PCT option.	

Table 7 Criterion 7: Deliver at least 15% reduction in management and administrative costs

Neutral Views or background information

- This issue is important – it's the savings that will make/break the re-organisation. There is an agreement with the principle of saving management costs to re-invest in health care.

- This is the most challenging aspect of an informed response because there are so many unknowns. However, the ability of Derby PCTs to deliver to budget is a matter of record and there is no reason to think that this ability will not translate over to a PCT with city boundaries. The changes from 8 to 2 will make a cost saving.

- 15% savings will be a challenge for any PCT. The level of savings will be affected by severance costs of redundancies and increased salaries of a new senior management team. The primary aim of the reorganisation should be about improving the quality of life and not just about reducing costs.

- If there were fewer PCTs as a result of either option, savings would be possible. However we need to know on what basis the 15% is expected to be calculated. There is uncertainty as to what the 15% reduction actually means. Is this 15% for the SHA or each PCT? Savings on central staff would be offset by a need for greater locality planning, i.e. teams of second tier people.

- There probably won't be any saving during the first couple of years as the changes bed in.

- The need is to quantify the 15% savings in monetary value and the impact on local services.

- There is some legitimacy in saying greater savings will be made by having one PCT. However it is important to bear in mind that services should come first. Savings will need to be made across the region and not necessarily for each PCT.

Comments in favour of two PCTs	Comments in favour of a single County-wide PCT
• Savings have already been made through the merger of the two PCTs in the city. • Other locations in country have smaller population PCTs. Overall a 15% reduction should not be a problem with 2 PCTs. • On the 15% management cost, the health authority need to adjust their formula and could address this. • The unitary and county council's have been successful in delivering to budget and making savings, so why shouldn't Two PCTs. There will be some cross border services but they should be able to achieve the savings. • The more detached you are the more difficult it is to control a large budget. Making savings in services sensitive to local needs is most important. • The consultation document had not addressed this aspect adequately. There are concerns about the costs of redundancies/severance packages for high earners like the chief executives. Moreover having one PCT would probably mean paying the CE a higher salary. • There is a need to establish locality planning but this shouldn't create many administrative centres to cater for	• The headline figures will obviously save more by having one PCT. • Derby PCTs have already changed structure to make savings and will be expected to make further savings in 2008 for cancer services. • a single PCT could achieve economies of scale, although there may be a trade off against improved services. • It is more viable for large organisations to make 15% saving than for small ones. • 15% savings will be difficult to achieve in year 1 for the two PCTs, as jobs/salaries will be protected until 2007. It would probably be difficult for a small PCT to recruit and retain the high quality staff that it needs. • Quantifying savings is not easy and needs to be made across the board. One management structure should deliver greater savings. • It will be easier for a county based PCT to achieve the 15% reduction, as it reduces from six PCTs to one, than for the city PCT. • There is a need to consider strategic issues between

the different areas as this would defeat the objective. • 15% savings could be made overall in a reduction from 8 PCTs to 2. If the single PCT option was pursued the issues would still need to have a way to address the City's issues.	health and local authorities and social services. • The savings are about economies of scale. The big question is whether the 15% was actually achievable as the NHS does not have the capacity to absorb cuts of this level without redundancies. • One PCT would make major savings, but the establishment of a new local structure will be costly as will the cost of supporting Practice Based Commissioning.

Table 8 : Overall, which option serves Derby best

Neutral Views or background information

- 'I do not think there is any perfect structure – it is how to do things that matters'. Localism is essential whatever option is chosen.
- PCTs have been running for three years and it is not long enough to decide whether they are delivering effectively. Change is always costly. Good work shouldn't be undone.
- No-one knows who the non executive members of the PCTs are but they are chosen and appointed, not elected, so therefore not accountable.
- There is the contentious issue: is bigger always better? Some of the services are specialised and do not respect geographical boundaries.
- There is a natural instinct to keep structures coterminous with the city but it is important not to become too parochial. It is

important to consider that people get health services when they need it.

- 66% of the Acute hospital budget comes from the Derby PCTs. Although the PCT will seek to support the local hospital as far as possible, it has been given the power to commission services from elsewhere if it considers the local Trust not to provide good quality services.

Comments in favour of two PCTs	Comments in favour of a single County-wide PCT
• One PCT coterminous with Derby City boundary and one for the rest of Derbyshire is favoured. This option will best meet the needs of Derby people. • Public health will be undermined by having one PCT for the whole county. The patient voice will be lost. • Service needs for people from the ethnic minorities and in deprived communities may not be adequately met by a large PCT. • The experience of one Mental Health Trust for the whole County shows patients sometimes have to travel long distances to receive the treatment. • The NHS is about clinical governance which will be undermined with one PCT. • The City is the ideal size to support a PCT, approx 250k to 500k population.	• Some areas may need wider services, eg, Mental Health care. This could be provided with one PCT but would need a local organisational layer – like police – to provide local input. • Larger organisations can better manage overheads. • A bigger PCT will be better able to attract high quality staff. • A large organisation with greater commissioning power will be able to deliver this. • A larger PCT would have greater clout and is more likely to get better deals. • Some services are already delivered out of the county but the wish is to develop them locally, such as those for hearing impaired people.

• Partnerships could be damaged if a City PCT is not maintained. • A key question is whether we need bigger commissioning organisations or just better ones working more effectively with local government. • Best practice in authorities nationally seems to be joint PCT/unitary arrangements with an understanding of local issues. This allows targeted local interventions. Public may struggle to engage in one PCT for whole county. The greatest danger is making services too remote from the people of Derby. The professional networks in City are a strong base to build on. • The Health Minister has stated that she wished to see the co-terminosity of PCT's to relate directly to social service provision. There would have to be an outstanding case to be made for alternative provision. • A strong belief is that a Derbyshire PCT cannot deliver the service levels necessary to meet the expectations of the people of Derby City, whilst a single PCT coterminous with city boundary would address children and adult services for Derby. • A single Derbyshire PCT needs have to meet a diversity of working practices in the unitary, county and districts. The split option would enable closer integration and some	• Overall, Derby would probably be better served by one PCT for the whole of the county but the wish was expressed to have more information on how the structure would be organised. • Currently different PCTs fund differing services so disabled people get unequal services across the county. This may still be the case if we have 2 PCTs. • One County-wide PCT would have the capacity, expertise, cost effectiveness, focus, flexibility and would reduce duplication. • Under the new arrangements PBC would take on the local commissioning function and the (larger) PCTs would undertake the more strategic aspects. • The key factors were: service levels, equity of access to services, minimising boundary problems and distribution of resources in a mainly capitation driven funding system. Shifting resources within one organisation made it easier to deal with problems and deprivation. • A Derbyshire wide PCT would be able to have a higher quality of statistics than would a Derby PCT. • Localism is very important. The city would be smaller than the county. With joint working, eg over the strategies to

resultant cost savings to offset the economies of scale in whole or in part. • This option is preferable in terms of PCT liaison with Social Services, the Local Authority and the Community in Derby to be sensitive to the needs of Minority Ethnic Communities, particularly in the inner city areas of Derby. BME in the wider county tend to be more affluent so their health requirements are different. • The needs of PCTs areas are different. For example, health care needs in Allestree are different from those in Peartree/Normanton with a high ethnic minority population, new communities and language barriers. • Derby is a medium sized city, comparable to many other unitary authorities who are opting to have a single PCT coterminous with their boundaries.	meet central health targets, this imbalance in scale could mean the county perspective would prevail. With a separate PCT, there was the attraction that Derby would be making its own decisions. However the need for collaboration between two organisations means the county could always be present. • Collaboration over service commissioning is not a statutory requirement but is a matter of local initiative. It was a matter of choice for PCTs whether they agreed to contribute funding for a common approach or to invest their money differently.

8. Summary of comments from the local Members of Parliament

The three Members of Parliament whose constituencies fall wholly or in part of Derby were asked to give their comments on the options. They were offered the option to either give their comments in writing or to attend an interview session with members and give their views in person. Some of the key points made by the MPs are given below.

Rt. Hon. Margaret Becket MP, Derby South submitted her evidence in writing and supports two PCT- one for the city and the one for the remainder of Derbyshire. In her evidence, Mrs Beckett refers to the importance of having joined up working between a social services department and primary health care which she believes can best be achieved by a PCT that reflects the unitary nature of Derby city services. Mrs Beckett also points out that prior to Derby gaining unitary status, its services were provided by the County Council which was extremely disadvantageous for the city where some of the greatest areas of need and vulnerability are found. She also states that the nature and scale of the problems in Derby are exacerbated by the large and varied ethnic minority communities.

Mr Bob Laxton MP, Derby North gave evidence to the Commission at one of the interview sessions. Mr Laxton stated that he was hostile to one PCT that included Derby as it would not be able to give detailed attention and deal effectively with all the requirements of both urban and rural communities. He explained that there significant differences in health needs between the Derby city and the County residents. Diseases such as coronary heart and diabetes are more prevalent in the Black and Minority Ethnic communities. Derby also has variety of cultures and communities as well as high indices of poverty which are not replicated to the same level elsewhere in the county. Derby requires particular attention to its health problems. Mr Laxton therefore supports two PCT, one for Derby with boundaries coterminous with the city and one for Derbyshire.

Mr Mark Todd MP, South Derbyshire, provided a copy of his response to the Trent SHA as evidence. Mr Todd supports one PCT for the whole county that includes Derby and gives a number of reasons to support his choice. He states that the city body would need to establish new commissioning arrangements for all services which would increase management overheads and that the new body would be smaller than its county neighbour and therefore offer lesser rewards and would have difficulty in attracting and retaining better staff.

9. Views of the Derby Youth Forum

The views from younger people were provided by the Youth Forum Core Group who discussed the options at one of their scheduled meetings. The meeting at which PCT options were discussed was attended by seven young people aged 15 to 18 of which two were females and five males.

The young people recognise that the changes being discussed have massive implications and the reorganisation could produce cost savings such as by reducing the number Chief Executives. They felt the two PCT model approach was probably best as it fits with the current council and LEA models for Derby City and Derbyshire. They were worried whether under the new arrangements it might become a postcode lottery especially for people living near the boundaries and children might slip through the net. However, on reflection they felt that a two model approach was probably best.

10. Views of Derby Citizens – Summary of Public Survey Report

Members agreed to seek views of the local citizens on what they consider to be the best option for Derby. Due to tight constraints for conducting the review and submitting comments, QA Consultants were appointed to assist with the resident survey. QA Consultants have the postal address list for all addresses in the city and the expertise in conducting postal surveys. They already conduct the Council's citizen's panel survey, the Derby Pointer.

QA sent out surveys to four thousand Derby citizens (randomly selected citizens from the postal address file- PAF) during January and February 2006. In order to increase the response rate a £100 prize draw was offered to those who completed the survey.

The report produced by QA **(Appendix 7)** shows that a total 413 surveys was returned, allowing for the results to be statistically significant at the 95% confidence level.

Overall, the majority of respondents **(57%)** would prefer two PCTs – one covering the city of Derby and the other covering the rest of Derbyshire. Just over a quarter **(28%)** of respondents would prefer a single PCT that covers the whole of Derbyshire, including the city of Derby. A minority (11%) of respondents did not know which option they preferred and 2% did not want either option. Due to rounding error and 1% of respondents that did not select an option these totals are 98% only.

The respondents were asked to reasons for their preferences. The main reason that individuals preferred 'one PCT' was because they felt it '**would save money that could be used elsewhere**' (44%):

"One Primary Care Trust should be less expensive to run than two, thus saving money which should be able to be used in other needy places. I.e. More patient care and more nurses"

The second most cited reason was to '**reduce administration'** (25%) and this in turn led to the third most cited reason '**the reduction in administrative mistakes and conflict**' (19%).

The primary reason respondents selected 'two PCTs' was because they felt that '**Derby and Derbyshire had different needs and requirements**' (35%):

"The City of Derby *and* outlaying areas have different requirements. I feel these should be treated differently. This is a cost cutting service wanted by the government and there is no guarantee that any money saved will go back into NHS services"

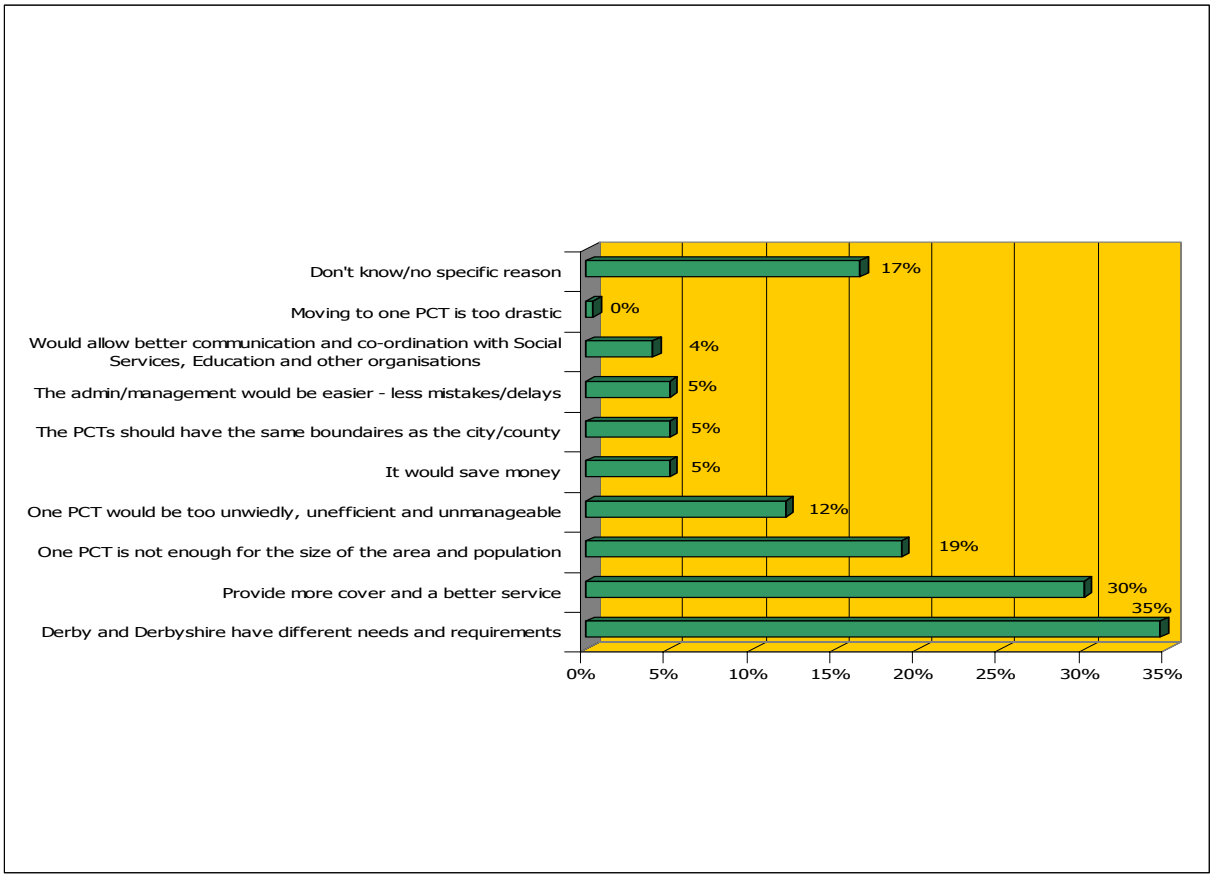
Respondents aged 50-64 (48%) were *more likely* than those aged 65+ (24%) to cite that '**Derby and Derbyshire have different needs and requirements'**.

The second most cited reason was that two PCTs would '**provide more cover and a better service**' (30%):

The report by QA research recommends that the Council seriously considers this option based on the views of the citizens of Derby, in conjunction with other evidence.

However, the Council would also need to address the concerns of the citizens who had cited reasons for one PCT:

- Saving money
- Reducing administration and ensuring there were no conflicts/mistakes
- Providing the exact same service across Derbyshire
- Sharing scarce and valuable resources
- Allowing better commissioning power
- Providing shorter waiting times
- Aiding communication with other services
- Providing economies of scale when buying supplies/services
- Avoiding duplication



Graph showing reasons for having two PCTs

11. PCT Reconfiguration Options in Other Strategic Health Authorities

This section looks at the options proposed by the other Strategic Health Authorities in England. Elements of each SHA's consultation document are common because a standard template is used. Importantly, the 7 criteria used in the Trent SHA document apply to each consultation. It is these same questions that were used during Derby's evidence-gathering interviews. In other respects the SHA documents vary, with differing levels of detail, content and layout. It is also apparent that some SHAs have had significantly different approaches and different emphasis on what is seen as fit-for-purpose.

In several parts of the country one-to-one 'mirroring' of a PCT to a single 'most purpose' authority has been seen as a beneficial and decisive factor. In **Greater Manchester** the SHA had "considered carefully whether it would be sensible to merge PCTs to span two or more local authorities" but concluded that a 1:1 "arrangement will deliver greater benefits than that which could be achieved through merging PCTs into larger entities that do not reflect local communities". 6 out of 10 of the metropolitan districts have an LA population less than that of Derby.

In **South Yorkshire** the sole proposal is reduction from 9 to 4 PCTs to achieve 1:1 co-terminosity with the 4 metropolitan districts. Barnsley MDC has 218,000 residents. Similarly in **West Yorks** the sole proposal is reduction from 15 to 5 PCTs to achieve 1:1 co-terminosity with the 5 metropolitan districts, including Calderdale with a GP-registered population of 194,000. Moreover, in **London** no consultation on PCT configuration is taking place. That was because the 2005 initial consultation was on "either the retention of borough-based PCTs; or reconfiguration of current PCTs to cover several boroughs" and the DoH external panel accepted the resultant recommendation to retain 1:1 arrangements. 19 of the 32 LBCs have a 2001 census population smaller than Derby's.

In some of these – plus other similar – proposals the logic is not solely based on working with social services departments. The health contribution to Local Strategic Partnerships, Local Public Service Agreements, Community Safety Partnerships and reduction of health inequalities are also given prominence and the 1:1 relationship a key means of achieving progress.

Clearly, retaining existing 1:1 PCTs cannot yield the £500k dividend produced by abolishing a board and team of executive/senior managers. Easier joint working is cited as contributing to the achievement of management and administrative costs:

West Yorkshire SHA response to Derby CC enquiry

"….. all PCTs are expected to deliver at least 15% savings on management costs – and even for those PCTs who may not have significant changes to their current management arrangements benefits will accrue from the following

- Better joint working arrangements with local authorities which will lead to health improvement, a reduction in health inequalities and joined up services for service users and carers;
- Improved commissioning of local health services as a result of the pooling of experience, expertise, skills and information to improve the process and share any risk;
- Improved locality working to support practice-based commissioning and to improve public involvement in the development of local health services;
- More joint working around specialist services and the management of clinical networks to share expertise and learning to benefit more people; and
- Improved education and training for primary care healthcare professionals through the more effective management of work placements and a wider range of experience".

The consultation document itself directly addresses this regarding the retention of **Calderdale PCT** (GP pop 194,000)

15% reduction in management and administrative costs:

"The primary care trust has developed a culture of tackling inefficiency and waste. Whilst there would not be the opportunity to make the immediate savings through the reduction in the number of boards, longer term savings will be made as national changes to management systems and information management and technology (IM&T) systems allow for a further streamlining of functions".

"The forthcoming white paper on out of hospital care will facilitate the development of different approaches to health and social care and this will give further scope for management and administrative savings".

The descriptions for 3 the 7 criteria are weighted toward 'larger', 'bigger' PCTs. However, that is from the current starting point that some SHAs have PCTs in double figures (see the yellow highlighted figures). Some SHAs seem to have interpreted the words as a trend, rather than bigger = fewest, when other factors have been weighed. For example with **Hull & East Yorkshire** the single proposal is for the two existing Hull PCTs merge to one (total pop 250,000) and the two existing East Riding PCTs merge to one (302,000), mirroring the two unitary councils. The other option of merging the 4 into (pop 552,000) was discounted as offering only a 'partial fit' to the fitness-for-purpose criteria. The combined population of that discounted option is barely half that of geographical county of Derbyshire.

When the **Derbyshire** proposals were discussed with Mr Sandford, Chair of the Trent SHA, he said : 'Savings are calculated on a per capita basis and it is expected that they will need to be made at the regional level as well as by each of the new PCTs. A separate PCT for Derby would have to make a saving of approximately £600,000. However, further clarification is being sought from the government'. Further: 'The two Derby PCTs will still have to find the same level of savings per capita. This will put greater pressure on the one Derby PCT'.

However, differentiated contributions to the 15% target are being contemplated by some SHAs. For example in Essex: "The target management cost savings for Essex is fixed. In this reconfiguration, if **Southend** and **Thurrock** needed £1 million each more for management costs, the other PCTs in Essex would have to deliver a £2 million greater share of the national savings target".

Similarly, regarding Luton (LA pop 184,000), Bedfordshire and Hertfordshire SHA specifically asks consultees: 'If we were to support a separate **Luton PCT**, should they be allowed to spend more proportionately on management costs than the other PCTs in Bedfordshire and Hertfordshire? The consequences of this are twofold: Luton PCT would spend proportionately

less on front line services and other PCTs in Bedfordshire and Hertfordshire would have to contribute more management cost savings'.

The various SHAs' consultations show, using the succinct wording from County Durham and Tees Valley SHA, that "Within a typical PCT the cost of providing a board consisting of a chairman, non-executive directors, a chief executive, executive directors and a professional executive committee is estimated at £500,000 per annum". On that basis, if the 6 PCTs outside Derby were merged into one, that would provide £2.5m savings before the search for other efficiencies.

As Mr Sandford's answers show, Trent SHA consider that Derby might be disadvantaged by size. It might also be considered that Derby has been disadvantaged compared to Luton, Southend and Thurrock as the option of differentiated savings has not - yet - been put forward. That proposition could find favour in the county as well as city area if it is explained that it would be a fair recognition of the large efficiencies already delivered by the integration of executive posts across the 2 city PCTs.

12. Conclusions

The reorganisation of the primary care trusts will have significant impact on the design and delivery of NHS health services in the city. It is therefore crucial to get the structure that best meets the needs of Derby residents.

The Commission sought evidence from a wide range of stakeholders on the two main options affecting Derby. Overall a higher proportion of people support two PCTs, one for the city and one for the rest of Derbyshire. Of the 32 witnesses who expressed a preference on the two options, 17 believed that two PCTs would better serve Derby residents whilst 15 witnesses supported a single PCT covering the whole of the County.

The public survey conducted by the Commission revealed that a significantly higher proportion of Derby citizens, 57%, support two PCTs whilst 28% prefered a single PCT for whole of Derbyshire.

The ability to make a 15% saving in management costs is an important element of the reorganisation. However, there is as yet no clear government direction on where the savings are going to come from and whether they will be expected to be delivered by the whole region or by each individual PCT. Since January 2003 the two PCTs in Derby have effectively been operating as a single organisation and have already made significant savings in their management costs.

There is currently no consensus on what is the optimum size of a PCT. However there are a number of PCTs in other parts of the country covering areas with a population that is smaller than the Derby PCT would be, and they are expected to deliver effective services.

The Social Care and Health Commission has considered extensive evidence on the two relevant options for the reconfiguration of the Derbyshire PCTs. The Commission considers that the residents of Derby would be best served by two PCTs, one for Derby, with its boundary coterminous with that of the City Council, and the other covering the rest of Derbyshire.

13. Recommendation

The Commission recommends that there should be two PCTs in Derbyshire, one for Derby, with its boundary coterminous with that of the City Council, and the other covering the rest of Derbyshire. Whilst recognising that a single PCT may have some advantages, the Commission considers that these are outweighed by the advantages for Derby people of two PCTs. The Commission supports the reasons given in favour of the two PCTs by the witnesses to its review. In particular members wished to note the comments in favour of two PCTs made in respect of each of the following criteria:

a. **Secure high quality, safe services**

- The Central and Greater Derby PCTs already provide excellent services. They have a proven track record and can hit the ground running. They have driven standards higher and reduced waiting lists and mortality from killer diseases. Despite financial pressures they have secured expensive drugs, such as statins, under clinical guidelines

- Co-terminosity with the City Council offers huge benefits. It enables the organisations to jointly identify needs of the population and to develop priorities and action plans. It also reduces the barriers that limit working in partnerships and pooling resources

- Local relationships are essential to ensure better standards of provision. Providers being closer to the people will ensure appropriate commissioning. In general it is better for the organisation to be located in the area it serves.

b. **Improve health and reduce inequalities**

- There are distinct differences in the makeup of the population between city and county. Derby has higher levels of deprivation, significantly greater numbers of people from ethnic minorities and higher levels of health problems. Drug abuse in cities tends to be more prevalent – needing specialist services, the same applies to rough sleepers, asylum seekers and refugees. These could best be addressed by a City PCT. It is essential to target deprived wards – which can be best done by working at local level. LSP working and Local Area Agreements in Derby have been recognised as top in the region and nationally are highly rated.

- There are clear differences in the health needs of the county and the city. Diseases such as coronary heart disease and diabetes are more prevalent in the Black and Minority Ethnic communities. The shortest life expectancy in the county is found in Derby. It also has some of the most deprived wards of the region. We need to concentrate efforts at the local level to tackle inequalities. A Derby based PCT coterminous with the city boundary will be better positioned to deal with local needs.

- The Derby PCTs have already made a great deal of investment in the deprived areas of the city, these include the Healthy Living Centre in Derwent and the primary care resource centres in Sinfin and Allenton. It is also proposed to establish a walk in centre at the DRI.

c. **Improve the engagement of GPs and the roll-out of practice based commissioning**

- Practice based commissioning requires local intelligence and a knowledge of delivery to be successful. There is no advantage in gathering local intelligence and sending it to larger organisation to make the decisions.

- Derby PCTs are effective in engaging clinicians and will expand services such as nurse triage and prescriptions. It will improve GP working conditions and allow them to tackle the needs of the whole community. A City PCT would like them to work in locality neighbourhoods.

- A larger structure would have more resources but could lose local intelligence. Bigger isn't always better, otherwise why limit it at the county level and not have one health body for the whole region.

- The needs of inner city areas of Derby are different from the rest of the County, although Chesterfield has similar but not the same level of problems.

d. **Improve public involvement**

- Local politicians should be more accountable, as their input is vital to the proper administration of public services.

- Some stability in the NHS is needed as public may not understand how the services are structured. Accountability is important, eg, the role of Overview and Scrutiny in holding the PCTs to account is valuable.

- More remote services might inhibit the development of public and patient involvement. Derbyshire is one of the longest

counties in England and would involve significant travelling. People will be reluctant to travel long distances to attend meetings.

e. **Manage financial balance and risk**

- Derby PCTs have an excellent track record of financial management. There is least risk with this option. Derby PCTs have managed finance and risk effectively in the past and there is no reason to assume why this shouldn't continue in the future. It already has a good system with established procedures, protocols and trust between partners in the city which helps with risk management.

- Derby is moving further towards area working and will be easier to integrate on co-terminosity. Why fix something that is not broken?

- It is easier when working on common budget bases to prioritise where savings and/or investment should be made. When the boundaries coincide this, management is easier. However defining borders won't always meet requirements of all stakeholders.

f. **Improve co-ordination with Social Services**

- Improving co-ordination is the critical mass in the whole proposition. The delivery of a co-ordinated service will be far more reliably achieved by co-ordinating an already successful team in Derby Social Services coterminous with PCT. The government white paper, LAA and DCP all support co-terminosity which is an important factor.

- The clarity of vision applied to this issue is critical, the ability of Derby Social Services to focus locally and direct interface with a similarly focused PCT will give much better option for Derby City.

- There is already good partnership working in the city, such as on the Local Area Agreement. Derby PCTs work well with social services. It has pooled budgets such as for people with learning needs. The current situation is working well so why change. Partnership working would be made more difficult by one PCT having to work in many different areas.

g. **Deliver at least 15% reduction in management and administrative costs**

- This is the most challenging aspect of an informed response because there are so many unknowns. However, the ability of

Derby PCTs to deliver to budget is a matter of record and there is no reason to think that this ability will not translate over to a PCT with city boundaries. The changes from 8 to 2 PCTs in Derbyshire will enable a cost saving.

- The unitary and county councils have been successful in delivering to budget and making savings, so why shouldn't two PCTs. There will be some cross border services but they should be able to achieve the savings

- There probably won't be any saving during the first couple of years as the changes bed in.

Overall, which option serves Derby best

Members have a strong belief that a single Derbyshire PCT cannot deliver the service levels necessary to meet the expectations of the people of Derby City, whilst a PCT coterminous with city boundary would address children and adult services for Derby. They are of the view that the health issues of people from ethnic minority communities and other disadvantaged communities in Derby don't exist to the same level elsewhere in the County.

Members felt that the evidence from some of the health professionals failed to understand nature of the services being provided by the local authorities which required co-terminosity.

Commission members unanimously supported two PCTs, one for the Derby coterminous with the city council boundaries and one for the rest of the county. The Commission recommends that the Council Cabinet take all possible actions to ensure that the reorganisation of the Derbyshire PCTs results in the creation of a PCT for Derby with its boundary coterminous with that of the City Council.